Medway NHS Foundation Trust

Medway Maritime Hospital

Quality Report

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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	Requires improvement
Medical care (including older people's care)	Good
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Medway Maritime Hospital as part of the Medway NHS Foundation Trust inspection on 29, 30 November 5,8,10 and 17 December 2016. Medway NHS Foundation Trust was identified as a mortality outlier for both the hospital standardised mortality ratio (HSMR) and the summary hospital mortality indicator (SHMI) for 2011 and 2012. Consequently, Professor Sir Bruce Keogh (NHS England National Medical Director) carried out a rapid responsive review of the trust in May 2013 and the findings resulted in the trust being placed into special measures in July 2013. The Care Quality Commission (CQC) then undertook two comprehensive inspections of Medway Maritime Hospital in April 2014 and August 2015. The trust was rated inadequate overall at both of these inspections.

In August 2015 the trust was rated inadequate overall because of concerns relating to patient safety, the organisational culture and governance throughout the trust. Since this inspection the CQC has maintained a heightened programme of engagement and monitoring of data and concerns raised directly with us. The trust was also subject to additional scrutiny and support from the local clinical commissioning groups, NHSE and NHSI through a monthly Quality Oversight Committee which monitored the implementation of action plans to address the shortcomings identified.

This inspection was specifically designed to test the requirement for the continued application of special measures at the trust.

We have now rated Medway Maritime Hospital as 'Requires Improvement' overall. This is based on an aggregation of the ratings for the eight core services we inspected. We were able to see evidence of positive changes taking place across the hospital. However, there were still areas that required improvements so patients received consistently safe care.

The hospital had made improvements to flow through the introduction of a new model for treating medical patients. This was implemented in April 2016 and made significant improvements to the way in which patients' care was managed.

We found effective systems to assess and respond to patient risk, and significant improvement in this area since our last inspection. These included daily checking for signs of deteriorating health, medical emergencies or challenging behaviour. The hospital had introduced "safety huddles" on the wards and improved staff training in recognising and responding to deteriorating patients. We observed staff recognised and responded appropriately to any deterioration in the condition of patients. Early warning scores were now consistently used across the hospital.

The trust had introduced a new frailty pathway to provide appropriate care for the significant number of patients with complex needs. This enabled staff to treat patients quickly to avoid the need for admission to hospital. The trust had improved their discharge planning and the hospitals delayed transfer of care rate was one of the lowest in England. However, in Surgery the service did not always use the facilities and premises appropriately due to a lack of available beds.

There had been improvements made to the management of patients in the Emergency department (ED). At our previous inspection we found that patients were routinely placed in a corridor where the delivery of safe care had been compromised. At this inspection we found that the corridor was no longer used to treat patients. We also found handovers and safety briefings in ED were effective and ensured staff managed risks to people who used the department. The process of triaging patients had also improved.

The trust had introduced several recruitment strategies. However, staff recruitment continued to be problematic with high levels of bank and agency use in some areas. In some departments staffing did not meet with the recognised standards and guidance. For example, in the emergency department medical staffing did not meet the Royal College of

Summary of findings

Emergency Medicine minimum requirements for consultant cover, the cardiac care unit (CCU) did not have consistent access to a medical team and in the maternity unit where staffing regularly did not meet its target of ratio of staff to patients, as recommended by Birthrate Plus. In the 2016 staff survey, which included a range of clinical and non-clinical staff, 76% of respondents said there were not enough staff to do their job properly.

There was openness and transparency about safety. Staff understood and fulfilled their responsibilities to report incidents and near misses and were supported when they did. There were effective systems in place to report incidents which were monitored and reviewed. Staff across the hospital gave examples of learning from incidents. Staff understood the principles of Duty of Candour regulations and were confident in applying the practical elements of this legislation.

At our previous inspection , we identified a lack of clinical oversight for patients waiting longer than the targets set for cancer and 18 week pathways. We saw a process of clinical oversight had been introduced and was embedded in the process of monitoring patient pathways. This included weekly patient tracking list meetings, and electronic flags on computer systems to alert staff to patients exceeding their target dates.

Although we saw improvement since our last inspection improvement was still required in relation to staff consistently having appraisals and completing mandatory training in line with trust policy.

We found care and treatment across the hospital was mostly planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Regular monitoring and audit ensured consistency of practice There were formal systems for collecting comparative data regarding patient outcomes. The hospital routinely monitored and collected information about patient outcomes and used this information to improve care. Benchmarking data showed patient outcomes were mostly similar to national averages. Data supplied demonstrated continuous improvement in some areas since the previous year.

Clinical governance systems, meeting structures and directorate risk registers formed part of the quality assurance and risk management system. Senior staff used the systems effectively to identify and mitigate risk.

At our last inspection we found significant failings in the hospitals estates and facilities management. At this inspection we found there had been improvements, although we still found areas that required attention. The directorate had made some significant changes. These included restructuring the directorate, bringing external contracts in-house (e.g. fire safety and training and a local security management specialist), creating and recruiting a new internal facilities audit team to improve auditing systems, revision of the terms of reference for estates and facilities groups, reviewing policies, and the housekeeping operating plan.

At our last inspection we had significant concerns about fire safety. Fire safety had been significantly improved at this inspection. Kent Fire & Rescue had undertaken a peer to peer review of Fire Safety at the trust. A Fire Action Plan had been created and presented to the trust Board in January 2017 which addressed key fire safety issues. Quarterly fire Safety reports will be provided to the trust Board in future.

Although the hospital was visibly clean, we found instances where clinical environments were not meeting the National Specifications of Cleanliness (NSC). This meant there was inconsistency in the auditing of cleaning standards across the very high risk areas and potentially an increase in the risk of hospital acquired infections.

There were specific areas of the hospital where staff were not feeling the positive impact of changes and where morale was low. This was more evident in theatre staff who were often working beyond the end of their shifts and band five nurses, who were feeling the impact of staff shortages and were often asked to move wards at short notice to cover shortages elsewhere. However, large numbers off staff joined a range of focus groups held at the hospital from different professional groups and we spoke with individual staff as we went around the hospital. The majority of staff we spoke with reported improvements in the organisational culture and were positive about developments at the trust.

We saw several areas of outstanding practice including:

Summary of findings

- The neonatal unit improved their breast-feeding at discharge compliance rates from one of the lowest rates in the country to the highest. A critical care consultant, nurse practitioner, GP lay member and physiotherapist led an innovative programme to improve patient rehabilitation during their ICU admission and after discharge. This included a training and awareness session for all area GPs and a business case to recruit a dedicated rehabilitation coordinator. In addition, a critical care consultant had developed app software to be used on digital tablets to help communication and rehabilitation led by nurses. The consultant was due to present this at a critical care nurses rehabilitation group to gather feedback and plan a national launch.
- Critical care services had a research portfolio that placed them as the highest recruiter in Kent. Research projects were local, national and international and the service had been recognised as the best performer of the 24 hospitals participating in the national provision of psychological support to people in intensive care (POPPI) study. Research projects for 2016/17 included a study of patients over the age of 80 cared for in intensive care; a review of end of life care practices; a respiratory study and a study on abdominal sepsis.
- The 'Stop Oasis Morbidity Project' (STOMP) project had reduced the number of first time mothers suffering third degree perineum tears. The project had been shortlisted for the Royal College of Midwifery Award 2017, Johnson's Award for Excellence.
- Team Aurelia was a multidisciplinary team. Women who were identified in the antenatal period as requiring an elective caesarean section would be referred to team Aurelia. Women were seen by an anaesthetist prior to surgery and an enhanced recovery process was followed to minimise women's hospital stays following surgery.
- The bereavement suite, Abigail's Place, provided the "gold standard" in the provision of care for parents and families who experience a still birth. The suite created a realistic home environment for parents to spend time with their child.
- The frailty and the ambulatory services, which required multidisciplinary working to ensure the needs of this patient group, were met. The individualised care and pathway given to patients attending with broken hips. The care ensured this group of patients' needs were met on entering the department until admission to a ward. The development and implementation of the associate practitioner role.

Action the hospital MUST take to improve

- Ensure flooring within services for children and young people is intact, in accordance with Department of Health's Health Building Note 00-09.
- Ensure all staff clean their hands at the point of care in accordance with the WHO 'five moments for hand hygiene'.
- Review the provision for children in the recovery area of theatres and Sunderland Day Unit to ensure compliance with the Royal College of Surgeons, standards for children's surgery.
- Ensure staff record medicine fridge temperatures daily to ensure medicines remain safe to use.
- Ensure compliance with recommendations when isolating patients with healthcare associated infections.
- Ensure that all staff have appropriate mandatory training, with particular reference to adult safeguarding level two and children safeguarding levels two where compliance was below the hospital target of 80%. Ensure that all staff receive an annual appraisal.
- Ensure that an appropriate policy is in place ensuring that patients transferred to the diagnostic imaging department from the emergency department are accompanied by an appropriate medical professional.
- Ensure the intensive care unit meets the minimum staffing requirements of the Intensive Care Society, including in the provision of a supernumerary nurse in charge.

Summary of findings

- Ensure staffing levels in the CCU maintain a nurse to patient ration of 1:2 at all times.
- Ensure that consultant cover in the emergency department meets the minimum requirements of 16 hours per day, as established by the Royal College of Emergency Medicine.
- Ensure fire safety is a priority. Although the trust has taken steps to make improvements we found some areas where fire safety and staff understanding needed to be improved.
- The trust must ensure people using services should not have to share sleeping accommodation with others of the opposite sex. All staff to be trained and clear of the regulation regarding same sex accommodation.
- Ensure clinical areas are maintained in a clean and hygienic state, and the monitoring of cleaning standards falls in line with national guidance.
- Take action to ensure emergency equipment (including drugs) are appropriately checked and maintained.

Action the hospital SHOULD take to improve

- Ensure the electronic flagging system for safeguarding children in the children's emergency department is fully embedded into practice.
- Review safeguarding paperwork to ensure it can be easily identified in patient's records.
- Ensure there is a system in place to identify Looked after Children (LAC) in the children's emergency department.
- Enhance play specialist provision in line with national guidance.
- Ensure children's names and ages or not visible to the public, in compliance with the trusts 'Code of conduct for Employees in Respect of Confidentiality' policy.
- Ensure compliance with NICE QS94, and ensure children, young people and their parents or carers are able to make an informed choice when choosing meals, by providing them with details about the nutritional content.
- Identify risks for the outpatient risk register.
- Begin monitoring the availability of patient records in outpatient clinics.
- Ensure that referral to treatment times improve in line with the national targets.
- Monitor the turnaround times for production of clinic letters to GPs following clinic appointments.
- Ensure there is sufficient resource in allied health professionals teams to meet the rehabilitation needs of patients.
- Ensure medical cover in the CCU is provided to an extent that nurses are fully supported to provided safe levels of care.
- Medicines and IV fluids should be stored securely and safely. Intravenous (IV) fluids were stored in a draw on a corridor on pearl ward this was not secure as it did not ensure that IV fluids could not be tampered with. We found ampoules of metoclopramide and ranitidine, drugs commonly used for stomach problems, stored in a box together. This created a risk that patients may have been given the incorrect medicine.
- Ensure equipment cleaning is thorough, including the undersides of equipment.
- Ensure complaints are responded to in accordance with the trust's policy for responding to complaints.
- Meet the national standards for Referral to treatment times (RTT) for medical care services and continue to reduce the average length of stay of patients.

Summary of findings

- The driving gas for nebulised therapy should be specified in individual prescriptions as can be harmful to the patient.
- Continue to address issues with flow to improve performance against national standards.
- Repair/replace the two patient call bells in the majors overflow area.
- Install a hearing loop in the emergency department reception area.
- Consider how staff are made aware of internal escalation processes.
- Take action to ensure patients recover from surgery in appropriate wards where their care needs can be met.
- The trust should take action to ensure there is sufficient access to equipment. In particular, sufficient sling hoists for patients on Arethusa and Pembroke Wards and sufficient access to computers for staff throughout the surgical directorate.

It is apparent that the trust is on a journey of improvement and significant progress is being made both clinically and in the trust's governance.

I would therefore recommend that, from a quality perspective, Medway NHS Foundation Trust, is now taken out of special measures.

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	Requires improvement 	At our previous inspection in 2015, overall we rated the ED as inadequate. On this inspection we have changed the rating to requires improvement. This reflects significant improvements in staffing levels, maintaining the dignity and respect of patients, the clinical assessment of patients, monitoring of patients, reporting culture and the medical and nursing leadership. At this inspection overall we rated urgent and emergency services as requires improvement because: • Consultant cover did not meet the minimum requirements of the Royal College of Emergency Medicine and there was a significant shortage of middle grade doctors. The staffing level and was not always appropriate within the resuscitation area. • Care provided for patients suffering with sepsis (infection) was not always in accordance with National Institute for Health and Care Excellence. There was mixed compliance with infection control practices during busy times. • Staff were unaware of escalation processes used during busy times within the ED. • The hospital consistently failed to meet the Department of Health target that 95% of patients be admitted, transferred or discharged within four hours. However, a programme of significant development was underway to improve all aspects of the service times, including triage, assessment and treatment. • There was inadequate flow and capacity through the department; however, this was mainly due to a lack of inpatient beds. There were occasions when the number of patients requiring treatment in the majors area and resuscitation areas exceeded the number of cubicles available. Patients experienced significant delays whilst awaiting specialist review or to be placed in a bed on a ward. However, the trust had undertaken a number of initiatives to increase

Summary of findings

flow and capacity since our last inspection. At the time of inspection there was building work underway, which would significantly improve capacity within the ED in the future.

- There was no effective system that ensured medicine fridge temperatures were monitored daily. There was no effective system that ensured staff checked the emergency equipment in the minors area daily.
- Medical staff had not undertaken an appropriate level of safeguarding training.
- There was no effective system to ensure fire safety checks were undertaken or effective systems to mitigate fire risks.
- There was no hearing loop in the reception area for patients with hearing difficulties.
- Mandatory training compliance did not meet the trust's own targets.

However:

- Openness and transparency about safety was encouraged. Staff understood their responsibilities in relation to incident reporting. Incidents were investigated appropriately by staff with the necessary clinical knowledge and learning was shared.
- There was consistent evidence the duty of candour was used in relation to incidents to maintain transparency and communication with patients and relatives.
- An education programme was available to staff and included practical competency training. Practice development nurses and senior staff supported staff to undertake professional and academic development in line with their specialist interests. This included degree programmes in ED care and preceptorship courses for newly qualified nurses.
- A range of improvements had been made to quality, safety and training. Staff had undertaken additional training for example in the management of patients with sepsis (infection).
- Ambulatory care was available to help avoid unnecessary time patients spent within the ED and hospital admissions.

Summary of findings

- A frailty service had been introduced to address the needs of the local population. This service aimed to reduce the need for hospital attendances and admissions and ensure patients had better access to home or community services.
- There was a clear vision and strategy and staff were positive they were heading in the right direction of continued improvement. The culture of the department had improved, there was a no blame culture and staff morale had improved.
- There was evidence of multi-disciplinary working with staff working together to problem solve and develop services which improved outcomes for patients'.
- There was a focus on patient safety and there were systems in place to review patients regularly, which ensured a deteriorating patient was recognised. Record keeping was comprehensive and audited regularly. Decision making about the care and treatment of patients was clearly documented.
- There had been an effective nurse recruitment programme, and there had been a marked reduction in the use of agency nurses.
- Feedback from patients was generally positive about the way staff treated patients'. We saw staff treated patients with dignity, respect and kindness during all interactions. Patients told us they felt safe, supported and cared for by staff.
- The practice of using the corridor to care and treat patients had stopped.
- The department had improved its waiting time from arrival to initial assessment; this had been highlighted as an area that required improvement at our previous inspections.

Medical care (including older people's care)

Good

At our previous inspection in 2015 we rated medical care services as inadequate. On this inspection we have changed the rating to good because we have identified improvements in the service. We have seen significant changes in key areas to keep people safe and provide effective well led care. The reporting and learning of incidents was embedded in practice, medicines were stored appropriately, the service participated in local and national audits

Summary of findings

and patient outcomes were monitored. Additionally the service was responsive to patient's individual needs, discharge planning was evident and a clear leadership strategy was in place.
At this inspection, overall we rated medical care as good because:

- We found learning from incidents embedded in practice and rates of harm free care had improved. We observed medicines were appropriately stored and confidential patient records were generally stored securely.
- Clinical environments were visibly clean. Staff in all departments used appropriate hand hygiene techniques and complied with the trust's policies and guidance on the use of personal protective equipment.
- Mandatory training was being completed which meant staff had the necessary current skills to do their job. Staff were aware of their responsibilities concerning the protection of people in vulnerable circumstances.
- Overall we judged there was sufficient medical and nursing staff with the appropriate skill mix to meet the needs of the patients on a day to day basis, although there was a reliance on temporary staff.
- We found care and treatment reflected current national guidance. There were formal systems for collecting comparative data regarding patient outcomes. Services were generally available seven days a week. There were adequate arrangements to ensure patients received adequate pain relief and had enough to eat and drink.
- We observed staff interactions and relationships with patients and those close to them were caring and supportive. They responded with compassion to pain, emotional distress and other fundamental needs. Staff treated patients with dignity and respect and people felt supported and cared for as a result.
- Services were responsive to people's needs as patients were able to access the care they needed and there was adequate management

Summary of findings

of demand and patient flow throughout the hospital. Discharge planning had improved since our last inspection with a reduction in levels of delayed transfer of care.

- The vision and values of the organisation had been developed and were understood by staff. The leadership of the service had been restructured which provided stability for staff. This meant there was a clear focus on achieving objectives. Governance processes were evident at ward, divisional, hospital and corporate level. This allowed for monitoring of the service and learning from incidents, complaints and results of audits. Staff were positive about working for the trust, and spoke with pride about how far the trust had come in such a short time. They told us they now felt valued and that their opinion mattered.

However:

- Patients were frequently treated in mixed sex wards and there was a lack of understanding by staff of the regulations regarding same sex accommodation. The trust had reduced the average length of stay of medical care patients since the last inspection but this remained worse than the national average. Additionally medical care services were not meeting national standards for referral to treatment times (RTT).
- Although visibly clean, we found instances where clinical environments were not meeting the National Specifications of Cleanliness (NSC). This meant there was inconsistency of cleaning standards across the very high risk areas and potentially an increase in the risk of hospital acquired infections.
- We saw the trust was not following national guidelines for the gas used to administer nebulisers. We found individual prescriptions did not clarify this and could be harmful to patients.
- There were inconsistencies in the suitable number of staff receiving training at the

appropriate level for safeguarding vulnerable adults. Local managers did not always support staff in their development as not all staff received a regular annual appraisal.

Surgery

Requires improvement

At our previous inspection in 2015, we rated the surgical services overall as inadequate. Following significant improvements in key areas including incident reporting and learning, assessing and responding to patient risk, complaints, leadership, culture and staff engagement.
At this inspection overall we rated surgical services as requires improvement because:

- The service did not always use facilities and premises appropriately due to a lack of available beds. There were inappropriate ward placements, patients staying overnight in the recovery areas in main theatres and mixed-sex accommodation breaches. Patients also had bed moves at inappropriate times such as during the night.
- Problems with access and flow meant operating lists rarely ran on time.
- Medicines storage and management arrangements were not always sufficiently robust. We found out-of-date emergency drugs in main theatres and an unlocked drugs cupboard containing medicines to take out on Phoenix Ward. We also saw evidence of intravenous drug administration on Phoenix Ward that was not in line with Nursing and Midwifery Council (NMC) Standards for Medicines Management.
- The shortage of permanent nursing staff may have left the service vulnerable to spells of understaffing. However, in most areas, we saw the service used agency staff appropriately to fill the gaps.
- Staff did not receive mandatory training in identifying and reporting female genital mutilation (FGM). As a result, some clinical staff lacked awareness of FGM and their legal duty to report it.
- The trust failed to meet the national specifications for cleanliness in the NHS (NSC) regarding the frequency of audits in theatres.

Summary of findings

Infection prevention and control measures were not effective in some areas. For example, there were repeated infections on Phoenix Ward.

- Bedside handovers on the surgical wards did not always maintain patients' privacy and confidentiality.
- Not all leaders had the necessary experience, knowledge, capacity or capability to lead effectively. However, the trust recognised this and had introduced training to support and develop leaders, such as matron development days.

However:

- The service encouraged openness and transparency about safety. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. We saw evidence of learning from incidents and a positive culture of incident reporting and learning.
- The service assessed, monitored and managed risks to patients. This included daily checking of signs of deteriorating health, medical emergencies or behaviour that challenged.
- The service planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Regular monitoring and audit ensured consistency of practice.
- The service routinely monitored and collected information about patient outcomes. The service used this information to improve care. Benchmarking data showed patient outcomes were similar to national averages. The trust's performance had improved in some areas since the previous year.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.
- The trust had cleared its backlog of complaints and complaint response times were beginning to meet trust targets. We also saw evidence of learning from complaints.

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- The service made reasonable adjustments and took action to remove barriers for patients who found it hard to use or access services. This included translation services, services for patients living with dementia and facilities for bariatric patients.
- Staff in all areas knew and understood the trust's vision and values.

Critical care

Requires improvement

At our previous inspection in 2015 we rated the critical care service overall as requires improvement. This reflected insufficient medical staffing and cramped conditions on the MHDU, delayed flow of patients through critical care due to insufficient ward capacity and no strategy to direct improvements in the service. At this inspection we also rated the service as requires improvement. However, we found improvements had been made in a number of areas. This included improvements in leadership and governance structures, safety equipment and processes and a significant improvement in patient mortality.
At this inspection overall we rated critical care services as requires improvement because:

- Nurse staffing cover did not always meet the minimum requirements of the Intensive Care Society (ICS) core standards for intensive care medicine. This included the ratio of nurses to patients and the availability of a supernumerary nurse in charge.
- The cardiac care unit (CCU) did not have consistent presence from the medical team and at times nurses struggled to cope with the acuity of patients combined with their lack of resources. An informal agreement existed that enabled them to ask doctors in the adjacent intensive care unit for help and although an operational policy was in place for the CCU, we did not see this used or have a positive impact on how the unit operated.
- There were gaps in fire safety and evacuation planning, including a lack of control and oversight of fire risks in the environment and a significant proportion of staff without up to date fire safety training.

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- Due to short staffing in the allied health professionals (AHP) team, patients in the intensive care unit (ICU) did not receive the minimum amount of physiotherapy per day as recommended by the ICS and there were often delays in initial assessments such as swallowing and choking risk. This also meant there was not routine AHP presence at ward rounds, handovers or in multidisciplinary meetings.
- Between November 2015 and October 2016, bed occupancy was higher than the national average in every month and at 100% of capacity in four months.
- Between September 2015 and August 2016, 31% of patients experienced a discharge delay of over 24 hours. In the same period, 17% of discharges took place out of hours between 10pm and 6.59am.

However:

- There was evidence of tangible and sustained improvement in leadership and governance. For example, a new critical care programme had established a clinical director post and a more multidisciplinary triumvirate model of leadership to link clinical and non-clinical staff.
- A range of improvements had been made to quality, safety and training. This included training in sepsis and shock for foundation-level doctors and the delivery of a regional intensive care course.
- Patient mortality rates had significantly improved in the medical high dependency unit following improved consultant availability and discharge planning.
- Consultant intensivist cover met the requirements of the Intensive Care Society core standards for intensive care medicine in the time to initial review, ratio of consultants to patients and the accreditation of consultants with the Faculty of Intensive Care Medicine.
- Practice development nurses and senior staff supported clinicians to undertake professional

and academic development in line with their specialist interests. This included degree programmes in the CCU and post-registration qualifications in the ICU.

- Clinical staff benchmarked care and treatment against national guidance and used local audits to identify areas for improvement. For example, improved interprofessional understanding between dieticians, speech and language therapists and the catering contractor led to improved nutrition for patients.
- Staff provided consistently compassionate and kind care, treatment and involved patients and relatives in care planning where possible. This included in discussions around decision-making in line with National Institute of Health and Care Excellence (NICE) guidance.
- Overall numbers of complaints were very low; with only two formal complaints receive between all critical care services between August 2015 and July 2016.
- Feedback from staff about the culture of the service was variable but most of the individuals we spoke with agreed bullying and harassment had decreased and was no longer tolerated.

Maternity and gynaecology

Good

At our previous inspection in 2015 we rated the service as good. On this inspection we maintained a rating of good as the overall quality of care for patients had been maintained.
At this inspection, overall we rated maternity and gynaecology services as good. This was because:

- People were being protected from avoidable harm and abuse.
- Openness and transparency about safety was encouraged. Staff understood their responsibilities in relation to incident reporting. Incidents were investigated appropriately by staff with the necessary clinical knowledge who had received training in leading such investigations. We were given examples of where changes to practice had been made following incidents.

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- Overall, medicines practice met practice guidelines. However, we found two areas where medicines were not stored appropriately.
- The services, wards and departments were clean and, overall, staff adhered to infection control policies and protocols. However, we found some areas that had not been cleaned appropriately following spillages, and areas which were not cleaned to required standards. We also found that staff were not always washing their hands in line with trust policy.
- Performance demonstrated a consistent track record and steady improvements in safety. Record keeping was comprehensive and audited on a regular basis.
- Decision making about the care and treatment of patients was clearly documented. The service used systems of observation to drive improvement in the timely identification of patients at risk of unexpected deterioration. It had allowed for oversight of patients with elevated risk and concerns were escalated for review by the medical teams.
- Treatment and care was generally provided in accordance with the National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) evidence-based national guidelines. Maternity and gynaecology had an MDT approach in the care of women and babies.
- There was a range of national and local audits with action plans. In response to audit results action plans were reviewed and monitored providing evidence of good outcomes for children and young people.
- Leadership was good and staff told us about being supported and enjoyed being part of a team. There was evidence of multi-disciplinary working with staff working together to problem solve and develop child-centred evidence based services which improved outcomes for children and young people.

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- Development opportunities and clinical training was accessible and there was evidence of staff being supported and developed in order to improve services provided to women.
- Feedback from women and their families was continually positive about the way staff treated people. We saw staff treated women with dignity, respect and kindness during all interactions. Women and families told us they felt safe, supported and cared for by staff.
- There was an embedded culture of caring, which was demonstrated by the team winning the Johnson's Excellence in maternity care award at the annual RCM national awards. Staff listened and responded to women's needs as shown by the introduction of the 'Induction of Labour Team' and the 'Patient Satisfaction Following Emergency Caesarean Section' project.

However:

- The maternity service was not meeting it ratio of staff to patients every month.
- There were no guidelines in place in regards to babies' identification.
- The maternity unit had closed on seven occasions between April 2015 and July 2016 due to the neonatal unit (NNU) being closed. However, the service had followed trust procedures in regards to unit closures.

Services for children and young people

Good

At our previous inspection in 2015, we rated the services for children and young people overall as good. On this inspection, we have maintained the overall rating as good, as the overall standard and quality of care has been maintained.
At this inspection overall we rated services for children and young people as good because:

- Risk was managed and incidents were reported and acted upon with feedback and learning provided to staff.
- There were effective systems in place to report incidents. Incidents were monitored and reviewed and staff gave examples of learning

Summary of findings

from incidents. Staff understood the principles of Duty of Candour regulations, were confident in applying the practical elements of the legislation.

- Treatment and care were effective and delivered in accordance with National Institute of Health and Care Excellence (NICE) guidelines and other best practice guidelines. There was effective multidisciplinary team working within the service and with other agencies. The service also participated in national audits and implemented local audits such as infection control audits.
- Staffing levels and skill mix were planned, implemented, and reviewed to keep children and young people safe at all times.
- We found all clinical areas visibly clean and the equipment was fit for purpose and well maintained.
- We saw that parents were fully informed prior to consent being obtained and that nursing and medical records had been completed appropriately and in line with each individual child's needs.
- Staff skills and competence were examined and staff were supported to obtain new skills and share best practice.
- We observed good team working both within the services for children and young people and externally with other wards and departments that children had contact with.
- All parents and young people spoke highly of the approach and commitment of the staff that provided a service to their children. We saw good interactions between staff and children, young people and their families. The caring attitude of all staff was obvious in every department we visited. Staff had expertise in caring and communicating with children and young people. Support and equipment was also provided for mothers on the neonatal unit to assist with breast-feeding.
- There were clear governance arrangements in place that monitored the outcome of audits, complaints, incidents, and lessons learned

Summary of findings

throughout the service. Staff were positive about the culture in children's and young people's services and felt supported by senior managers in the trust.

However:

- A recommendation from the previous report was there should be an electronic flagging system for safeguarding arrangements in the children's emergency department. On this inspection, an electronic flagging system had been implemented but was not yet fully embedded into practice.
- There was no flagging system to identify Looked after Children (LAC) in the children's emergency department, as staff in children's emergency department told us they relied on children or their parents/carers to inform them.
- A recommendation from the previous report was children's services should enhance play specialist provision in line with national guidance. The play specialist provision had not been enhanced since the previous inspection. Safeguarding documentation was on yellow paper along with other documents including consent forms and day care unit documentation for paediatric surgery; this made it difficult to distinguish safeguarding documentation in children and young people's notes.
- The service was not complying with National Institute for Health and Care Excellence (NICE) Quality Standard (QS) 94, as children were not given a menu to read, and we told the meal choices. This did not allow children and young people or their parents and carers to make informed choice when choosing meals, as they are not provided with the details about the nutritional content. Children and parents we spoke with told us they had a low opinion of the quality of meals provided.
- There was no dedicated paediatrics recovery area in theatres. There was no segregation of children from adults in the recovery areas of the theatres. This meant children were directly opposite adult post-operation patients, other

than a drawn curtain. In addition, parents were not always able to be with their children in the recovery room due to adult post-operative patients being present. This was not in accordance with The Royal College of Surgeons, standards for children's surgery.
- We saw children's names and ages on a white board, which was visible to the public. This did not comply with the trusts 'Code of conduct for Employees in Respect of Confidentiality' policy.
- Fridge temperatures on medicine fridges were not consistently recorded.

End of life care

Requires improvement

At our previous inspection in 2015, we rated end of life care (EoLC) overall as requires improvement and said the trust had to improve compliance with anticipatory medication, provide EoLC training to hospital staff and full seven-day services.
On this inspection we have rated EoLC as requires improvement, because:

- While there had been considerable work done to improve the service, we found the governance structure was not well established. It remained unclear that EoLC governance could be fully demonstrated at this stage and we concluded it was too soon to tell if the measures being implemented translated to established systems that effectively monitored and managed clinical quality and performance.
- Senior managers readily and transparently acknowledged this and stated EoLC was on an improvement 'journey', which was consistent with our own observations and comments made to us by staff and patients.
- Side rooms and interview rooms were not always available for patients at the end of their lives or their families. Facilities were not available for relatives to stay by the bedside and the hospital did not always provide the appropriate surrounding and privacy relatives required.
- Patients did not have face-to-face palliative care services seven days a week.
- It was unclear if actions and discussions from the EoLC steering group were shared widely across teams.

Summary of findings

- Death certificates were not always issued in a timely way.

However:

- We found that the EoLC team had significantly increased in size and demonstrated a high level of specialist knowledge. There was a newly implemented leadership structure that had resulted in improved policy, procedures and a daily presence on the wards.
- There were sufficient staff with the right skills and staff had been provided with mandatory and additional training for their roles. Completion rates for mandatory training were better than trust targets.
- There was openness and transparency about safety. Staff understood and fulfilled their responsibilities to report incidents and near misses and were supported when they did.
- The departments we visited were visibly clean and there were appropriate systems to prevent and control healthcare associated infections. There was sufficient equipment available to meet patients' needs.
- Mortuary services had received investment that resulted in increased capacity and improved facilities.
- In the majority of patients' medical records, we found 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) orders prominently presented at the front of the record folder.
- Medicines were managed safely in accordance with legal requirements and anticipatory prescribing was utilised effectively.
- EoLC staff were sensitive, caring, and professional. Patients' complex symptoms were controlled and patients and those close to them were supported.
- Spiritual and religious support was available through the interfaith spiritual care team. The chapel, recuperation rooms and viewing suite in the mortuary were suitable to meet the needs of service users and their families.

Summary of findings

Outpatients and diagnostic imaging

Requires improvement

At our previous inspection in 2015, we rated outpatients and diagnostic imaging services as inadequate. On this inspection we have changed the rating to requires improvement because we have seen improvements in key areas such as assessing and responding to patient risk and learning from incidents, but improvements are still required in key areas such as access and risk management.

Overall we rated outpatient and diagnostic imaging departments as requires improvement. This was because:

- The vacancy, turnover and sickness rates for the departments were worse than the hospital's target. Nurse staffing levels for outpatients and diagnostic imaging were regularly below the planned levels.
- The patient led assessment of the care environment (PLACE) scores for condition, appearance and maintenance were worse than the national average.
- Environmental audits fell below the hospital target of 90%.
- The trust referral to treatment times (RTT) fell consistently below the 92% standard.
- The trust was performing worse than the operational standards set for cancer patients on two week, 62 day and 31 day treatment targets.
- Patients had been consistently waiting longer than the national average for diagnostic tests.
- Whilst the overall mandatory training target of 80% had been met by both departments, there were areas of poor compliance in safeguarding vulnerable adults and children, adult life support and infection control level two training.
- The hospital did not audit whether patient records were available for their consultations.
- Staff appraisal rates were worse than the hospital target for both outpatient and diagnostic imaging staff.

Summary of findings

- There were no risks identified for the outpatient department on the programme risk register.
- There was no strategy in place for the service, and although these were under development, staff we spoke with were unaware of these.

However:

- Since our last inspection, clinical oversight of patients waiting over 52 weeks had been instigated and embedded into the service.
- The departments had systems and processes in place to keep patients free from harm. All staff we spoke with understood the incident reporting process and there was evidence of learning from incidents.
- We observed good radiation compliance as per national policy and guidelines during our visit. A radiation protection supervisor was on site for each test and a radiation protection advisor was contactable if required. This was in line with ionising regulations, 1999 and radiation (medical exposure) regulations (IR(ME)R), 2000.
- The diagnostic imaging department had recently been re-accredited by Imaging Services Accreditation Scheme (ISAS).
- Staff interacted with patients in a caring and considerate manner, and respected their dignity. Patients told us they felt the staff cared for them and this was reflected in the department friends and family test results.
- Staff felt their line mangers were visible and approachable and staff spoke of improvement in the overall culture at the hospital.

Medway Maritime 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; and Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to Medway Maritime Hospital

Medway Maritime Hospital is located in Gillingham, Kent. The trust primarily serves a population of 384,300 people in the Medway and Swale area. The health of people in Medway Unitary Authority is mixed with 13 national indicators of health scoring better and six worse than the England average. Deprivation is similar to the England average and about 11,085 children (21%) live in poverty. Life expectancy for both men and women is lower than the England average.

The trust has a total of 655 beds spread across various core services of which 19 are surgical day case beds. The complement of in-patient beds comprises 300 medical beds 164 surgical beds, 66 children's beds, 69 maternity beds and 25 critical care bed.

Medway NHS Foundation Trust has five registered locations, the Medway Maritime Hospital, Woodlands Special Needs Nursery, and the Orchards Centre . On this occasion we only inspected the Medway Maritime Hospital. In addition to standard specialties at the trust the trust provides the following specialist services: Macmillan cancer care unit, West Kent centre for urology, West Kent vascular centre, regional neonatal intensive care unit, foetal medicine unit and stroke services for the local population.

In the 2015/16 financial year, the trust had an income of £255,017,000 and costs of £307,531,000. This has resulted in a deficit of £52,514,000. The trust predicts it will have a deficit of £43,839,000 in 2016/17. Whilst the financial situation impacts on how the trust provides services, CQC does not report on this aspect of the trust's work. Our remit is to focus on the quality and safety of the services that are being provided.

Our inspection team

Our inspection team was led by:

Chair: Dr Martin Cooper

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

The team of 44 included CQC managers and inspectors and a variety of specialists including doctors, consultants, a consultant paediatrician, a consultant obstetrician and gynaecologist , a consultant in emergency medicine, a professor of respiratory medicine and patient centred care, lead nurse specialist in pain management, consultant nurses, lead and specialist nurses and matrons, consultant midwives, senior NHS managers including directors of estates and facilities , along with a pharmacist, a radiographer and two experts by experience.

Detailed findings

How we carried out this inspection

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

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

The inspection team inspected the following eight core services at the Medway Maritime Hospital:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients and Diagnostic Imaging

Before the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), Monitor, NHS England, Local Area Team (LAT), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch. We carried out the announced inspection visit between 29 and 30 November 2016. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually when they requested this.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out unannounced inspections on 5,8,10 and 17 December 2016. We looked at how the hospital was run out of hours and, the levels and grades of staff available and the care provided.

Facts and data about Medway Maritime Hospital

Between April 2015 and March 2016 the trust had 83,326 A&E attendances, 63,459 inpatient admissions, 495,999 outpatient attendances,4,920 births and 975 referrals to the specialist palliative care team.

As at September 2016, the trust employed 3,747.2 whole-time equivalent (WTE) staff out of an establishment of 4,506 WTE. The overall vacancy rate at the trust was 16.8%. The trust's sickness levels between May 2015 and April 2016 were generally lower than the England average. Sickness levels ranged from a low of 3.2% in May 2015 to a high of 4.5% in October 2015.

Nursing and Midwifery staffing recorded in September 2016 showed there were 1055.9 WTE nursing and midwifery staff in post which represented 75% of the planned establishment. The trust target for vacancy rate was 8%. As at July 2016 the trust reported a vacancy rate of 25% for nursing and midwifery staff which was well above the trust target. The trust target for turnover rate was 8%. Between October 2015 and September 2016 the trust reported a turnover rate of 12% for nursing and midwifery staff which was above the trust target. The trust target for sickness rate was 4%. Between October 2015 and September 2016 the trust reported a sickness rate of 4% for nursing and midwifery staff in line with the trust target.

Medical staffing recorded in September 2016 showed there were 462.9 WTE medical staff in post which represented 83% of the planned establishment. The trust target for vacancy rate is 8%. As at July 2016 the trust reported a vacancy rate of 17% for medical and dental staff which was above the trust target. The trust target for

turnover rate is 8%. Between October 2015 and September 2016 the trust reported a turnover rate of 5% for medical and dental staff which was below the trust target. The trust target for sickness rate was 4%. Between October 2015 and September 2016 the trust reported a sickness rate of 0.7% for medical and dental staff which was below the trust target.

The proportion of consultant staff reported to be working at the trust was lower than the England average (36% compared to the England average of 42%) and for junior (foundation year 1-2) staff it was higher than the England average (17% compared to the England average of 14%).

Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Between September 2015 and August 2016 the trust reported no incidents which were classified as never events.

The trust reported 58 serious incidents (SIs)which met the reporting criteria set by NHS England between September 2015 and August 2016 in accordance with the Serious Incident Framework 2015. Of these, the most common type of incident reported was slips, trips and falls (24%).

There were 4,752 incidents reported to The National Reporting and Learning System (NRLS) between July 2015 and June 2016. The Patient Safety Thermometer is used to record the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Data from the Patient Safety Thermometer showed that the trust had reported 85 pressure ulcers, 15 falls with harm and 26 urinary tract infections in patients with a catheter between August 2015 and August 2016. The prevalence rate of pressure ulcers over time has reduced which may have resulted due to a change in processes.

There were four cases of MRSA reported between August 2015 and July 2016 . Trusts have a target of preventing all MRSA infections, so the trust failed to meet this target within the period. Additionally, the trust reported 18 MSSA infections and nine C.Difficile infections over the same period.

The trust supplied their training completion data as of 18 October 2016. The board performance report states that the trust target for mandatory training (including safeguarding training) is 80%. The trust did not provide the data by staff group. With regard to safeguarding training, 76% of staff had completed safeguarding adults level 1, which was below the trust target. Seventy seven percent of eligible staff had completed safeguarding adults level 2, which was below the trust target. Eighty nine percent of staff had completed safeguarding children level 1, which was above the trust target, however 76% of eligible staff had completed safeguarding children level 2, which was below the trust target. Eighty three percent of eligible staff had completed safeguarding children level 3, which was better than the trust target.

All Deprivation of Liberty (DOLS) training at the trust is delivered as part of the mandatory adult safeguarding modules. As at 18 November 2016 81.4% of staff had completed Mental Capacity Act (MCA) training.

The trust supplied training completion data as of 18 October 2016The trust did not provide the data by staff group. The data shows that overall training completion was at 83%, above the trust target. Eight out of 18 modules fell below the 80% target. These modules included adult life support (69%), infection control level 2 (70%), manual handling – 5 year (78%), newborn life support (69%), paediatric life support (62%).

The trust target for completion of staff appraisals is 95%. Between April 2015 and March 2016 the trust reported a staff appraisal completion rate of 73% and between April 2016 and September 2016 the appraisal rate was 78%, both below the trust target.

Some staff are required to complete Emergency Preparedness Resilience and Response (EPPR) training. As at 21 November 2016 1,067 staff had completed this training, however the trust did not provide figures for how many staff required this training.

As at 6 September 2016 there were four outstanding mortality alerts where action plans were being followed up by the local inspection team. Mortality alerts are raised when there is a trends in the death rate for specific conditions or operations. There were alerts were for the following categories: Chronic obstructive pulmonary disease and bronchiectasis (Dr Foster, Sep 13, Fluid and

electrolyte disorders (Dr Foster, Dec 13), Intestinal obstruction without hernia (Dr Foster, Nov 13, Septicaemia (except in labour) (Dr Foster, Sep 12). Following our inspection all four cases were closed.

In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for four of the 34 questions, in the middle 60% for 16 questions and in the bottom 20% for 14 questions.

The trust performed in the top 20% of trusts for possible side effects explained in an understandable way, patient given the name of the clinical nurse specialist in charge of their care, GP given enough information about patient`s condition and treatment and patients did not think hospital staff deliberately misinformed them.

The trust performed about the same as the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to cleanliness and worse than the England average for food, privacy, dignity and wellbeing and facilities. Performance relating to food and privacy, dignity and respect deteriorated by 10% in 2016 compared to 2015 whilst performance relating to facilities improved by 7%.

In the CQC Inpatient Survey 2015, the trust performed about the same as other trusts for 11 questions out of 12. There was no data available for the trust for the remaining question relating to discharge delays.

The trust was one of the best performing hospitals for rates of delayed discharges. The main reasons for delayed transfer of care at the trust between August 2015 and July 2016 were patient or family trust (34% compared to an England average of 13%), followed by waiting further NHS non-acute care (17% compared to an England average of 18%).

Bed occupancy rates were consistently above the England average between Q3 2014/15 and Q4 2015/16 with rates ranging from 95.5% in Q3 2014/15 to 99.7% in Q2 2015/16.

Between August 2015 and July 2016 the trust took an average of 77 days to investigate and close complaints. This was not in line with the trust's complaints policy which sets a target response time of 30 days, unless the complainant agrees to a longer period. However, the trust had worked hard to clear the complaints backlog which they had completed by the date of our inspection.

Sixty eight per cent 68% of complaints with an outcome were upheld, 14% (54) were partially upheld and 18% were not upheld. The most common area for complaint was the outpatients department (115 complaints) followed by the accident & emergency department (97 complaints). The most frequently occurring themes were lack of care/attention and treatment (mentioned in 168 complaints) and the attitude of nursing staff (mentioned in 43 complaints).

In the NHS Staff Survey 2015, the trust performed about the same as other trusts in 11 questions and worse than other trusts in 21 questions. When compared to the 2015 results the 2016 staff survey showed significant improvements had been made with 44 significant results that were better than the previous survey and one which was worse. It should be noted the 2015 results for Medway were very poor. Therefore, despite the 44 significant improvements the trust still performs poorly compared to the average. For example, the "Your Organisation" section saw five of the seven indicators improve significantly compared to the previous year. However compared to the average four of the seven are still significantly lower than the average.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Medway Maritime Hospital (MMH) has a five-bedded resuscitation area, 11 cubicles for major emergencies (majors), 12 majors overflow trolleys, four cubicles for minor injuries (minors), a mental health assessment room and two triage/rapid assessment rooms. There is an ambulatory care ward near to the ED department, where staff stream patients from the ED if appropriate. The ambulatory care ward undertakes day case assessments, rapid access clinics, inpatient stays and facilitated early discharge. There is a majors waiting area and a minors waiting area. There is a designated paediatric resuscitation bay within the resuscitation area and a separate paediatric ED. There is an x-ray facility in the ED.

The trust's adult emergency departments saw 106,099 patients between April 2015 and March 2016, this included all patients presenting to ED including those referred to MedOcc from ED Triage. Of these 78% were aged 17 years and over and 22% were aged under 17 years. Of these attendances, nearly 20% were admitted to hospital.

We inspected the paediatric emergency department separately to the adult ED. We reported our findings on the paediatric emergency department in the children and young person report.

Patients arrive via four different methods: walk into the department on foot, via ambulance and taken to the majors area, via ambulance and taken to the resuscitation area or via the helipad on the hospital roof. Patients who arrive on foot are booked in by the receptionist and then triaged by a nurse or an associate practitioner. Patients who arrive by ambulance are triaged by a nurse and then directed to the appropriate treatment area. The ED team meets patients arriving by helicopter and escorts them to the ED. Trauma and emergency surgery is available on site, and the hospital provides a range of specialist services, including those for paediatric patients.

We last inspected the ED in September 2015 and rated the service overall inadequate. This reflected that although the department had undertaken initiatives the long-standing capacity issues continued to impact on the flow through the department and resulted in significant delays. In addition, there was a lack of multidisciplinary working and the environment was not adequate which compromised patients' privacy and dignity.

To come to our judgement, we spoke with 35 clinical and non-clinical staff. This included nurses, doctors and healthcare assistants at all levels, clerical staff, locum and permanent doctors at all levels, domestic staff, associate practitioners. Prior to our inspection, we undertook 12 focus groups where staff shared their experiences and staff from the ED participated in these. We also spoke with eight patients, four relatives and spent time observing care being delivered. We reviewed 22 sets of patient notes and other individual items of evidence, for example, medication charts. After our announced inspection, we returned to the ED on an unannounced basis at a weekend. The evidence we gathered from both visits is included here.

Urgent and emergency services

Summary of findings

At our previous inspection in September 2015, overall we rated the ED as inadequate. On this inspection we have changed the rating to requires improvement. This reflects significant improvements in staffing levels, maintaining the dignity and respect of patients, the clinical assessment of patients, monitoring of patients, reporting culture and the medical and nursing leadership.

At this inspection overall we rated urgent and emergency services as requires improvement because:

- Consultant cover did not meet the minimum requirements of the Royal College of Emergency Medicine and there was a significant shortage of middle grade doctors. The staffing level and was not always appropriate within the resuscitation area.
- Care provided for patients suffering with sepsis (infection) was not always in accordance with National Institute for Health and Care Excellence guidelines. There was mixed compliance with infection control practices during busy times.
- Staff were unaware of escalation processes used during busy times within the ED.
- The hospital consistently failed to meet the Department of Health target that 95% of patients be admitted, transferred or discharged within four hours. However, a programme of significant development was underway to improve all aspects of the service times, including triage, assessment and treatment.
- There was inadequate flow and capacity through the department; however, this was mainly due to a lack of inpatient beds. There were occasions when the number of patients requiring treatment in the majors area and resuscitation areas exceeded the number of cubicles available. Patients experienced significant delays whilst awaiting specialist review or to be placed in a bed on a ward. However, the trust had undertaken a number of initiatives to increase flow and capacity since our last inspection. At the time of inspection there was building work underway, which would significantly improve capacity within the ED in the future.
- There was no effective system that ensured medicine fridge temperatures were monitored daily. There was no effective system that ensured staff checked the emergency equipment in the minors area daily.
- Medical staff had not undertaken an appropriate level of safeguarding training.
- There was no effective system to ensure fire safety checks were undertaken or effective systems to mitigate fire risks.
- There was no hearing loop in the reception area for patients with hearing difficulties.
- Mandatory training compliance did not meet the trust's own targets.

However:

- Openness and transparency about safety was encouraged. Staff understood their responsibilities in relation to incident reporting. Incidents were investigated appropriately by staff with the necessary clinical knowledge and learning was shared.
- There was consistent evidence the duty of candour was used in relation to incidents to maintain transparency and communication with patients and relatives.
- An education programme was available to staff and included practical competency training. Practice development nurses and senior staff supported staff to undertake professional and academic development in line with their specialist interests. This included degree programmes in ED care and preceptorship courses for newly qualified nurses.
- A range of improvements had been made to quality, safety and training. Staff had undertaken additional training for example in the management of patients with sepsis (infection).
- Ambulatory care was available to help avoid unnecessary time patients spent within the ED and hospital admissions.

Urgent and emergency services

- A frailty service had been introduced to address the needs of the local population. This service aimed to reduce the need for hospital attendances and admissions and ensure patients had better access to home or community services.
- There was a clear vision and strategy and staff were positive they were heading in the right direction of continued improvement. The culture of the department had improved, there was a no blame culture and staff morale had improved.
- There was evidence of multi-disciplinary working with staff working together to problem solve and develop services which improved outcomes for patients.
- There was a focus on patient safety and there were systems in place to review patients regularly, which ensured a deteriorating patient was recognised. Record keeping was comprehensive and audited regularly. Decision making about the care and treatment of patients was clearly documented.
- There had been an effective nurse recruitment programme, and there had been a marked reduction in the use of agency nurses.
- Feedback from patients was generally positive about the way staff treated patients. We saw staff treated patients with dignity, respect and kindness during all interactions. Patients told us they felt safe, supported and cared for by staff.
- The practice of using the corridor to care and treat patients had stopped.
- The department had improved its waiting time from arrival to initial assessment; this had been highlighted as an area that required improvement at our previous inspections.

Are urgent and emergency services safe?

Requires improvement

At our previous inspection in September 2015, we rated safety as inadequate. On this inspection we have changed the rating to requires improvement this reflects significant improvements made in how incidents were reported and investigated, a focus on learning from incidents, the triage and streaming of patients' and increased staffing levels.

At this inspection we rated urgent and emergency services 'requires improvement' for safe because:

- The department did not meet the Royal College of Emergency Medicine minimum requirements for consultant cover. A shortage of middle grade doctors was recognised on the unit's risk register and there was a heavy reliance on locum doctor cover. The staffing level and skill mix was not always appropriate within the resuscitation area.
- There were lapses in infection control practices during busy times.
- There was no effective system that ensured staff monitored medicine fridge temperatures or checked the emergency trolley in the minors area daily.
- Medical staff had not undertaken an appropriate level of adult safeguarding training.
- There was no effective system to ensure fire safety checks were undertaken nor an effective system to mitigate fire risks.

However:

- There was a strong culture of incident reporting and there were daily discussions regarding incidents with all levels of staff. The management team received a daily list of all incidents that had been reported the previous day.
- The department had effective systems to assess and respond to patient risk. We observed staff recognised and responded appropriately to any deterioration in the condition of patients. Early warning scores were consistently used in the department which was an improvement since our last inspection.

- There was a current policy and equipment to support the department in the event of a major incident. Staff had received major incident training and were able to describe the policy to use.
- Handovers and safety briefings were effective and ensured staff managed risks to people who used the department.
- Nurse staffing levels were much better but continued to pose a challenge. However, the trust had introduced several recruitment strategies.
- The use of the corridor to care and treat patients had stopped.

Incidents

- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Between September 2015 and August 2016, staff did not report any incidents classified as Never Events for the emergency department (ED).
- In accordance with the Serious Incident Framework 2015, the trust reported 24 serious incidents (SIs) in urgent and emergency care between September 2015 and August 2016 that met the reporting criteria set by NHS England. Of these, the most common type of incident reported was diagnostic incident including delay (including failure to act on test results; nine incidents). The second most common type was treatment delays (six). This was followed by major incident/ emergency preparedness, resilience and response/ suspension of services.
- There were eight cases that resulted in an unexpected or potentially avoidable death. Of these four were diagnostic incident including delay (including failure to act on test results) and three were treatment delays. The other was due to sub-optimal care of the deteriorating patient. In all SI cases, senior clinical staff had undertaken investigations with those involved and used reflective exercises to identify where additional training and supervision was needed. We saw from meeting minutes of the Programme Board meeting that SIs were a standard agenda item for discussion. We reviewed the information provided to us by the hospital regarding open SI investigations. At the time of inspection there were three open SI investigations related to ED that were awaiting executive sign off.
- A trust SI policy was awaiting approval and therefore still in draft. However, there was a standard operating procedure (SOP) which set out the process for dealing with an SI. Staff used an electronic reporting system to submit incident details, agency and locum staff were able to report incidents.
- There was a system and process for reporting of incidents. Staff understood the mechanism of reporting incidents both at junior and senior level. The form was accessible for all staff including agency and locum staff via an electronic online system. Identification details were not required in order to complete the form, for example, patient, relative, and visitor. This meant if an incident occurred and the identity of somebody was unknown, it did not stop the incident from being reported and investigated.
- Staff told us they were encouraged to report incidents and were able to tell us of changes that had been made as a result of incidents. For example, a member of staff explained how the paperwork for patients presenting with sepsis (infection) was changed as a result of an incident.
- Between September 2015 and August 2016, staff reported 234 incidents in the emergency department. The majority of incidents resulted in no harm (162, 69%). There was a higher number of incidents reported in January 2016, February 2016 and April 2016. The increase represented a higher number of incidents reported that resulted in no harm. This would support what staff told us during our inspection, that they are now reporting more low harm and no harm incidents, as they had been encouraged to do so by senior staff. It was important to report all incidents even if no harm occurred as it meant any themes of incidents could be identified and practices changed to prevent reoccurrence.
- There were five incidents that resulted in severe harm and nine incidents that resulted in death. The incidents mainly related to patients having a delay in treatment or

diagnosis and teams (surgery/medicine) not taking responsibility for the patient. There was also one patient whose diagnosis was incorrect and in one incident, there was no high dependency bed available.

- The main themes that came out of all incidents were delay/failure to monitor the patient, lack of/unclear documentation, failure to prioritise patient, failure to act appropriately and teams (surgery/medicine) not taking responsibility for the patient).
- To prevent reoccurrence of these incidents multidisciplinary working had improved and safety rounds had been introduced which meant a consultant reviewed patients and any deterioration in a patient's condition would be identified. In addition, patients' were no longer left waiting for assessment and treatment within the corridor where their condition was not monitored.
- Senior staff were sent details daily of all the incidents reported the previous day, this meant they could be reviewed and action taken promptly. This was an improvement since our last inspection when this did not happen.
- At our last inspection, we highlighted that although recommendations from incidents were discussed at quality and safety meetings there was no formal log of these. The EMPB meeting minutes clearly stated what the recommendations were and who was responsible for ensuring the recommendations were implemented. This was an improved framework of learning from incidents since our last inspection and ensured changes were made to prevent reoccurrence.
- There was a clinical governance notice board within the department which displayed relevant information regarding incidents that staff could read.
- In the 2016 staff survey, 65% of staff in the acute and continuing care directorate (AACD) said in the last month they had not seen errors, near misses and incidents that could hurt patients. In the same survey, 54% of AACD staff felt the organisation treated staff involved in incidents fairly. Sixty six percent of AACD staff felt the organisation took action to ensure incidents were not repeated.

Safety thermometer

- The NHS Safety Thermometer is a monthly point prevalent audit of avoidable harm including new pressure ulcers, catheter urinary tract infections (C.UTIs) and falls.
- The NHS Safety Thermometer information for measuring, monitoring and analysing harm to patients and harm free care was collected monthly.
- Data from the Patient Safety Thermometer showed that the trust reported no pressure ulcers, falls with harm or urinary tract infections in patients with a catheter in urgent and emergency care between August 2015 and August 2016.

Cleanliness, infection control and hygiene

- The ED participated in monthly hand hygiene audits that assessed staff on their hand washing and hygiene practices against the trust's infection control policy. Between April 2016 and September 2016, the ED achieved an average of 60% compliance, which was worse than the trust's minimum target of 90%. The worst month was May when there was 39% compliance. Poor hand hygiene was also highlighted as a risk at our previous inspections the varied compliance does not demonstrate a sustained improvement. Staff were reminded of the importance of hand hygiene at handovers.
- During our inspection, we saw that during busy times staff did not always wash their hands or use alcohol hand sanitiser in between patients. For example, whilst observing in the resuscitation area, there was seven occasions when staff did not wash their hands in line with World Health Organisation guidance (Five Moments of Hand Hygiene) or use alcohol hand sanitiser. The breaches in hand hygiene we observed meant patients were at higher and avoidable risk of developing an infection.
- We checked six alcohol hand sanitiser dispensers, which were all full and working.
- All members of staff we saw in clinical areas were bare below the elbows (BBE) to prevent the spread of infections in accordance with national guidance.
- There was an adequate supply of personal protective equipment (PPE) within the department, for example, gloves and aprons and we saw staff using them appropriately. During our last inspection, we observed a

number of instances when staff did not use personal protective equipment (PPE) when preparing intravenous medication in accordance with trust policy. During this inspection, we observed staff consistently used PPE in accordance with trust policy.

- The department undertook an infection control audit in August 2016.The overall compliance was 74%, which was worse than the trust target of 90%. The areas with the highest compliance were the waiting area (100%) and the kitchen (94%), the lowest compliance was the decontamination shower (42%). Staff used the decontamination shower as a storage area as it had been unused for over a month. We saw there was an action plan to address areas of poor compliance highlighted within the report. There were 20 actions listed in the plan. However, staff had not taken action on points listed, despite the relative ease of fixing some of them. For example, the spill kit was out of date and needed replacing and this had not been done.
- Decontamination products were stored appropriately and securely and were risk assessed using the control of substances hazardous to health (COSHH) guidelines.
- We saw there was specific ED housekeeping cleaning schedules displayed. In November 2016, we saw there was 100% compliance. The cleaning schedule set out the specific tasks that had to be undertaken and the schedule was then signed off by the nurse in charge as completed. This meant there was a system to ensure staff completed cleaning to the required standard.
- One hundred percent of clinical and non-clinical staff were compliant with infection control and prevention (IPC) training, which was better than the trust target of 80%. Fifty-six percent of medical staff were compliant with IPC training this was worse than the trust target.
- The department appeared visibly clean in all areas during our inspection.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment surfaces in between patients and we witnessed staff using these.
- Staff separated all clinical waste into different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations.
- Sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We checked six sharp bin containers and all were clearly labelled to ensure appropriate disposal and traceability.
- Housekeepers and clinical staff used 'I'm clean' stickers to indicate when an item of equipment was clean and ready for use. We saw this procedure was consistently used in all ED areas.
- An IPC link nurse attended the trust's IPC meetings and shared relevant learning within the department via departmental meetings and handovers. This ensured staff were informed of any IPC issues that may affect their department.

Environment and equipment

- The electronics and medical engineering (EME) department managed the servicing and electrical testing of ED equipment. The electrical testing and servicing of equipment was done at the same time. We checked 14 items of electrical equipment and found they were all up to date with servicing and electrical safety checks. All equipment had a sticker indicating when servicing and electrical testing was next due.
- The EME department provided support to the ED department regarding equipment. During our inspection, we witnessed them replacing a faulty defibrillator. The trust had a five-year equipment replacement programme, this demonstrated there was a process to replace equipment as it became old and was no longer safe to use.
- Staff were able to describe the reporting process should a piece of equipment be faulty and a replacement required. Staff we spoke with confirmed they had access to the equipment they required to meet peoples' care needs.
- Different areas within ED had portable resuscitation trolleys, the trolleys contained medication and equipment for use in the event of a cardiac arrest. The resuscitation trolleys all had tamper evident tags to alert staff to any potential removal of equipment.
- Daily check sheets were completed for the trolleys in the majors area and the resuscitation area, this ensured equipment was available and in date. Documented daily safety checks of resuscitation trollies was inconsistent in the minors area, on six occasions daily

checks were not undertaken between 01 October and 29 November 2016. This meant there was no assurance that equipment was available and ready to use in the event of an emergency.

- The major treatment area had eleven cubicles for monitoring and treating patients. All cubicles had monitoring equipment, which ensured staff monitored patients' vital signs such as blood pressure and pulse. The nursing station was central to the majors area and had unobstructed views of all cubicles, this meant staff could observe the patients' condition.
- The resuscitation area had five bays. All had monitors and equipment was organised clearly to ensure quick availability in an emergency. There was equipment available for staff in the event of a patient requiring resuscitation.
- The resuscitation area was very cramped, we saw ambulance crews having difficulty transferring patients from the ambulance trolley to the cubicle trolley. This was consistent with our findings on previous inspections. However, building work was underway which included the re development of the ED, with completion expected in December 2017.
- There was a specific room dedicated for the use of patients who presented with a mental health illness. The room was compliant with the Quality Standards for Liaison Psychiatry Services Fourth Edition 2014. For example, there were two doors, panic alarms and no ligature points (anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation). This meant there was a safe place to assess and treat patients presenting with a mental health illness.
- During an unannounced inspection on 10 December 2016, we saw there was a fire door propped open in the majors escalation area. The fire door was external and led to a raised concrete area with steps. This meant there was a potential risk that patients' who may not be able to assess danger could injure themselves if they went through the open door. We raised this issue with the nurse in charge who said they were not aware that it was open and would have challenged it being open if she had noticed it. The trust told us staff opened the door to allow increased ventilation into the area for patient comfort. Since our inspection, staff have been reminded to ensure all fire doors were kept closed and a notice had been placed on this door to remind staff.
- Cubicles 17 and 20 in the majors escalation area did not have a patient call bell. This meant patients could not call for help if required.

Medicines

- The trust had a medicine management policy that was in date and referenced national guidance, for example: General Medical Council (2013), Good practice in prescribing and managing medical devices and Nurse & Midwifery Council (2006), Standards for proficiency for nurse and midwife prescribers.
- We checked temperature monitoring charts for the medicine fridges and found there were some gaps in the daily checking process. Staff had not checked the fridge in the resuscitation department for two days in September, three days in October and four days in November. The fridge in the minors department was missing daily checks on eight occasions within the last 30 days. This did not provide assurance the department stored refrigerated medicines within the correct temperature range to maintain their function and safety. There was an information folder stored with the medicine fridges that outlined what action staff should take if the fridge was not within the safe temperature range. We saw the fridges were within the correct temperature range, staff were able to tell us what the safe temperature was. All fridges we found were locked, which prevented unauthorised access to the medicines.
- Registered nurses used Patient Group Directions (PGDs) to provide pain relief during triage and to supply medicines to take away within the minor injuries unit. A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor. PGDs were within their review dates and had been appropriately approved by the organisation. Individual staff were also appropriately approved to use PGDs.
- We saw medicines in the department were stored safely and securely in line with relevant legislation for the safe storage of medicines. The medicines room could only be accessed using a hospital security identity card.

- Opening dates were written on liquid medicines to ensure they were used within the correct expiry date.
- An appropriate range of emergency medicines was available. We saw there pre packed boxes which contained medicines for emergencies for example anaphylaxis (severe allergic reaction). This meant all the medicines required to deal with this emergency were available in one place.
- There was a poster reminding staff of critical medicines in the clinical rooms. Critical medicines must be given at a specific time and never omitted or delayed without a clinical reason, which has been discussed with the medical team. Examples of critical medicines include antibiotics and insulin. The posters provided a visual reminder for staff to consider if any patients required a critical medicine.
- We checked the controlled medicines (CD) cupboards. Controlled Drugs are medicines liable for misuse that required special management. We saw the CD cupboards were locked and checked a random sample of stock levels. The correct quantities were in stock according to the stock list and all were in-date. The CD books demonstrated complete records of the CD's. Staff had individually signed at each stage of the dispensary process. This was in line with The Department of Health guideline, safer management of CDs: A guide to good practice in secondary care.
- An audit from August 2016 showed the ED department had a red RAG status regarding management of controlled drugs. For example, counter-signatures not being obtained for CD entries. This was not consistent with what we found during our inspection, therefore staff had made improvements. RAG is a traffic light rating system for indicating the status of a variable using the red, amber, or green of traffic lights.
- We looked at ten medication charts, these were all completed comprehensively, dated, signed and had no missing doses. Patient allergies had been clearly noted on their paper notes, medication chart and on their identity band, which alerted staff to their allergy.
- Prescribing guidelines were developed in line with best practice (National Institute for Health and Care Excellence (NICE) and NHS Protect).
- Staff reported having good access to pharmacists when advice was required and adequate access to medicines. Pharmacy technicians undertook daily reviews of stock levels and ordered replenishments. A dedicated pharmacist for the ED department worked closely with staff to ensure they had the correct medicines available for use.
- We saw there were an adequate number of portable oxygen cylinders for the transfer of patients or for use in an emergency. We checked four cylinders, these were all in date, labelled and secured to a wall this was in accordance with the Health and Safety at Work Act 1974 and HTMO2 guideline.
- The trust had a pharmacy audit programme for 2016/17, which included 13 different audits related to medicines, for example, an audit of prescribing compliance with the medicines management policy. The audit programme included national and local medicine audits.

Records

- We looked at 22 patient records. These were comprehensive and well documented and included diagnosis and management plans.
- The department undertook weekly audits and between 1 February 2016 and 14 November 2016, 93% of patients had the date, time and signature completed on patients' records. This meant it was easy to identify who had seen the patient on what date and at what time. In the same audit in the same time period, staff documented 88% of patients' records in chronological order, which clearly showed the sequence of treatment and procedures. This meant that is was easy to identify from reading the patients records what had happened to them and when.
- Patient records were stored on a filing rack on the staff desk, which was in constant view of staff. This maintained security and prevented unauthorised access of patient records.
- The department used a number of patient pathway documents, which followed the path the patient took through a specific condition such as a fractured hip. This meant specific risks associated with these procedures were assessed. In addition, it meant all relevant information was in one place, which made finding relevant information easier.

- There was an adult initial assessment and care plan document, which was used for non-specific conditions. This ensured there was a standardised approach in the initial assessment of patients'.

Safeguarding

- All staff in urgent and emergency services had level 1 adult and child safeguarding training. Staff completed higher levels of training based on their job. For example, all nurses were required to complete adult and child safeguarding level 2. This in line with the Safeguarding Children and Young People – Roles and Competencies for Staff Intercollegiate Document updated in September 2010. One hundred percent of admin and clerical staff had completed level 1 adult and children safeguarding, this was better than the trust target of 80%. Eighty-nine percent of nursing and support staff had undertaken level 1 safeguarding adult training, which was better than the trust target of 80%. Seventy-eight percent of nursing staff had completed level 2 safeguarding adult training, which was worse than the trust target of 80%.
- Eighty-percent of nurses and support staff had completed safeguarding children level 2 training that was equal to the trust target and 76% had completed level 3 training that was worse than the trust target of 80%.
- Eighty-percent of medical staff had completed safeguarding children level 2 training that was equal to the trust target and 76% of staff had completed level 3 training that was worse than the trust target of 80%.
- Eighty-six percent of medical staff had completed level 1 adult safeguarding training, however they had not undertaken level 2 or level 3. This contravened the Adult Safeguarding Levels and Competencies for healthcare professionals Intercollegiate Document 2016 which states: Level 2 should be the minimum level of competence for all qualified healthcare staff. Level 1 training only provided a basic understanding of safeguarding principles, which meant doctors might not have the knowledge to identify signs of abuse. We were told this was an oversight by the trust and there was a plan in place to ensure medical staff undertook level 2 training.
- Safeguarding training included identifying and acting on abuse and neglect and Department of Health national professional guidance in female genital mutilation.
- The Director of Nursing was the Executive Lead for Safeguarding for both adults and children and was supported by the Head of Safeguarding.
- In previous inspections, we highlighted concerns regarding safeguarding arrangements in the trust. The trust commissioned a peer review of safeguarding arrangements in February 2016, which highlighted gaps in the trusts safeguarding arrangements. The recommendations from the review formed the basis of a trust safeguarding improvement plan. One of these recommendations was when a 16 or 17 year presented to the adult department, a safeguarding form was automatically printed. This meant staff were reminded to consider any safeguarding issues.
- The trust had also reviewed its safeguarding policies in April 2016, and integrated them into the Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway. This meant there was a multi-agency approach to the management of all aspects of safeguarding.
- The policy was compliant with the Care Act 2014 and included aspects of abuse, clarified roles and responsibilities across the different agencies and contained guidance and checklists.
- Staff we spoke with had a good awareness of safeguarding and were able to describe what action to take if they had any concerns. Detailed and up to date information was readily available to staff with regards to referring patients to out of hours crisis support teams, social workers and child protection duty officers.
- The trust had a Safeguarding and Protecting Children Policy, which was in date and was in line with statutory guidelines, for example, the National Service Framework Children (2004).
- Staff had access to body maps to document injuries to patients. Staff used body maps to help with assessment and investigate cases of unexplained bruising or injuries that were a safeguarding concern.

Mandatory training

- CQC highlighted mandatory training compliance as a concern on previous inspections. The overall compliance rates during this inspection had increased, but there were still areas that required improvement.
- There was a trust wide training programme, which was a combination of on line learning and face-to-face learning. Staff were given protected time on their rota to complete mandatory training to help them keep up to date. Staff reported their mandatory training was rarely cancelled because they were required to work clinically within the ED.
- Senior staff monitored completion rates for mandatory training of staff against the trust's minimum 80% target. Managers were able to show us up to date training records of all their staff, from these it was easy to identify who was not compliant with their training. Staff received emails from their managers or the practice educator when their training was due to expire. This meant staff had enough time to book the required training before it expired.
- Training compliance was displayed on a noticeboard within the department. This meant staff could see if the department was meeting the trust target.
- Administration and clerical staff had an overall mandatory training compliance of 91%, which was better than the trust target of 80%. Nursing and support staff were 83% compliant, which was better than the trust target. The department management team (76%) and medical staff (66%) both had an overall compliance that was worse than the trust target of 80%.
- The worst areas of compliance were fire training for the management team (67%) and adult life support training for nurses (65%).This meant they may not be aware of current protocols and their skills and knowledge might be out of date.
- In the 2016 staff survey, 99% of staff said they had undertaken mandatory training in the last 12 months, this was the same as the previous years staff survey results.

Assessing and responding to patient risk

- Staff transferred patients arriving by ambulance as a priority call or trauma call immediately through to the resuscitation area or to an allocated cubicle space. Ambulance crew phoned through in advance so an appropriate team could be alerted and prepared for their arrival.
- When patients arrive at the ED by ambulance, the national standard is that paramedics complete a handover with ED staff within 60 minutes of arrival. Between July 2016 and October 2016, an average of 1.5% of patients experienced a handover delay in excess of 60 minutes.
- Staff told us that the triage and streaming of patients had changed significantly since our last inspection. For example, one staff member said, "If the patient arrived in an ambulance that was used as a baseline". This meant if a patient arrived by ambulance it was an indicator that they were quite unwell. During this inspection we saw patients' underwent a thorough assessment on arrival to the ED.
- Between the hours of 10am and 6pm Monday to Friday, staff used a rapid assessment and process (RAP) system. A senior decision maker, either a doctor or nurse, who was able to assess and treat majors patients more quickly, led the RAP system. Staff spoke positively of the RAP system and there were plans to extend the operational hours. Outside of the RAP hours, patients arriving by ambulance or foot were triaged (decide the order of treatment) by a nurse or doctor. Based on the information received, a decision was made regarding which part of the department the patient should be treated.
- A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. The trust provided six weeks' worth of site reports which demonstrated that between 6 September 2015 and 18 September 2016, the trust reported 693 'black breaches'. There was a sharp increase between January and March 2016. In the latter month, the trust reported 159 'black breaches'. The trust reported 56 'black breaches' in August 2016 and 34 between 1 and 18 September 2016. There was an increased monthly number of 'black breaches' reported over the period which meant there was still a problem with access and flow within the ED.

Urgent and emergency services

- The National target is that 95% of patients have an initial assessment within 15 minutes from the time of arrival in the ED. Between November 2015 and October 2016 the trust met this target for four months out of the 12.
- However, the trust's median wait from arrival to initial assessment was consistently lower than the overall England median between November 2015 and October 2016. In October 2016, the median time to initial assessment was six minutes compared to the overall England median of seven minutes.
- Staff used a national early warning system (NEWS) which is a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support. All patient notes we reviewed had a NEWS score documented. This was an improvement since our last inspection when NEWS scoring was inconsistent.
- During our inspection, we observed several occasions when patients had triggered a review based on their NEWS score. On all occasions, staff responded to patients appropriately.
- Between 01 February 2016 and 14 November 2016, 97% of patients arriving by ambulance had a NEWS score. This meant the staff in the ED had a baseline NEWS score on arrival, which could be used to compare any deterioration of the patient.
- Staff spoke positively regarding the use of NEWS. One nurse said, "NEWS is the best thing ever and helps early identification of a deteriorating patient".
- Every patient who attended had an adult initial assessment and plan of care document completed. The document included details of the presenting complaint, initial assessment of vital signs on arrival, triage colour, national early warning scores (NEWS), allergies, plan of care and investigations required, where the patient should be placed and prioritisation and escalation flow chart. This meant staff that assessed patients had a clear flow chart to follow and were able to escalate patients who were unwell and required immediate treatment. The document contained important patient information in one place, which meant staff could access the information easily. Data supplied by the trust demonstrated that between 22 February and 07 November 2016, on average 81% of patients had the NEWS and triage colour plan followed.
- The initial assessment document completed by staff contained a prioritisation and escalation flow chart. This meant patients had a NEWS score calculated at initial assessment, which corresponded to a triage colour category. For example, a patient with a NEWS score of more than seven were given a red triage category, the highest possible and a NEWS score of less than two was non-urgent white triage category. Each triage colour category detailed tasks and actions. This meant staff had prompts and a flow chart to follow for the management and treatment of patients. We reviewed 23 sets of patients' records, all patients had a completed initial assessment and plan of care document. Trust data showed between 22 February and 07 November 2016, staff allocated the correct triage colour to 98% of patients on presentation but this was not consistent with our findings.
- During our unannounced inspection, we saw one patient had been assessed and had a NEWS score of seven but the patient was triaged incorrectly as green. This meant that the severity of the patient's illness and early treatment could have been missed. We raised this issue with the site manager who said they would investigate how this occurred. The nurse in charge of the shift informed us that she had raised the error with the nurse who had undertaken the assessment and she was "Confident in their ability to triage correctly".
- During our unannounced inspection, we observed a patient in the main waiting room that looked unwell. The patient was triaged and sent to the majors waiting area where they waited for 32 minutes. The initial assessment calculated a NEWS score of six, however when the patients observations were repeated in the waiting area their NEWS score was nine. The nurse in charge was informed and the patient was transferred to the majors area for immediate treatment. We spoke to the nurse who had undertaken the initial assessment who said they had calculated the NEWS score incorrectly, as they had not included the patient's temperature. This meant there was a delay of 32 minutes before the patient received treatment. We raised this issue with the trust who said the reason the

patient had to wait in the waiting area was because of the overall trust position at this time was extremely busy having been in black escalation for the majority of the day due to increased activity and reduced flow. The trust undertook a review of the care this patient received and found the patient had received appropriate care and treatment.

- On previous inspections, we found a corridor had been used as an escalation area to place patients when the department was full. We had raised concerns regarding the safety of patients whilst in the corridor. Staff had not used the corridor to care for patients' since October 2016. There was now a Majors Escalation Area (MEA), which was an overflow area adjacent to majors that had 12 trolleys. The trust had an ED Majors Escalation Area Procedure (MEAP), which set out the criteria and management of patients cared for in the MEA. The MEAP stated that patients suitable for the MEA must have a NEWS score of less than four We found generally this was adhered to and exceptions had undergone a risk assessment and had a clear escalation plan documented.
- Every two hours the lead nurse undertook safety rounds. The lead nurse selected random patients and checked there was a recent NEWS score and there was a treatment plan. This meant the lead nurse was able to respond to any changes in a patient's condition since their last assessment.
- The doctor in charge of the department also undertook safety rounds, we observed one of these during our inspection. The doctor reviewed all the patients' paperwork, blood results, x-rays, checked investigations had been requested, ensured a treatment plan was in place and if necessary referred to a specialist team. This meant staff undertook an additional assessment that ensured patients were monitored and any changes were highlighted. In addition, it also meant the doctor in charge knew the condition of all patients within the department and could prioritise accordingly.
- There was an electronic computer system used in the ED, which tracked the patients and gave an overall picture of the patients within the department. It was possible from the system to see how many patients were in the department and how many were due to arrive by ambulance. This meant staff could plan and allocate patients accordingly. During our inspections we asked the doctor in charge how they knew which patients in the department were the most unwell. The doctor in charge demonstrated that it was possible to add alerts next to a patients name on the computer system, this acted as a visual prompt to remind staff. For example, we saw high NEWS scores were highlighted.
- Ambulance staff rung the ED priority telephone to notify the department that an unwell patient was on route to the hospital. We saw a qualified member of staff answered it and took a brief handover of the patient's condition from the ambulance staff, which they documented. The patient was then discussed with the doctor in charge who allocated a doctor to assess the patient when they arrived. This meant there was not a delay in the assessment and treatment of the patient on arrival.
- The trust had a surge and escalation plan, the plan was in date and referenced national guidance for example, NHS England (South) Surge Management Framework. The plan sets out the trust response to managing variation in demand and capacity. It included a trust escalation flow chart with four different levels of escalation, green being the lowest level of escalation and black the highest. During our inspections, staff were not able to consistently tell us what level escalation they were currently on. We asked three members of staff within the ED who did not know and one member of staff did not know how to access the surge and escalation plan. We asked a member of staff what action was taken when the ED was on black escalation and their response was "We request beds and wait". Another staff member replied "We all know what to do" when asked what the different levels of escalation were. This meant staff did not have an awareness of the different levels of escalation and what actions should be taken.
- Patients suffering from a mental health illness who attend the ED were assessed with a specific risk assessment tool. This ensured staff placed the patient in the most appropriate location within the department and assessed whether a registered mental health nurse was required.
- The trust had made improvements on the management of sepsis patients, for example the use of the sepsis-screening tool and a greater awareness amongst clinical staff. However, the data provided regarding compliance with all elements of the Sepsis Six required

improvement. In addition, there was inconsistent evidence the sepsis (infection) checklist was always used appropriately. We reviewed four patients who were undergoing treatment for sepsis and one patient who had arrived eight hours ago had not been started on the pathway. This meant the patient was at risk of delayed treatment and it was not clear that an adequate medical assessment had taken place.

- It was acknowledged during our inspections that surges in activity and a lack of capacity may of influenced compliance for example patients receiving antibiotics within one hour. Nursing and medical staff had a good understanding of the high-risk patients within the department and were able to demonstrate this to us.
- We saw in patients' records that patients had a falls risk assessment this was in line with NICE guideline CG16.
- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified. We saw evidence of this from the records we reviewed during our inspection.
- The department used a communication tool called Situation Background Assessment Recommendations (SBAR) (a technique that can be used to facilitate prompt and appropriate communication) for both medical and nursing staff to use when escalating concerns about a patient's condition. We observed staff using this tool for example, when a junior doctor was discussing a patient with a consultant.
- Staff told us a member of the surgical team did not always attend trauma calls when they were in theatre. During our inspection, we witnessed a trauma call and we did not observe a surgeon in attendance. Trauma patients need rapid assessment from a surgeon to decide if surgery was required. We raised this issue with the trust, the surgical team reviewed the way they responded to trauma calls. Between 8am and 5pm weekdays and 10am and 10pm, a bleep was held by a member of the surgical team who is not rostered to work in theatres. Outside of these hours, the surgical registrar held the bleep.
- Staff completed pressure ulcer risk assessments as part of each patient's admission documentation. Staff used a body map to document any skin damage. All the patients' records we reviewed had a completed pressure ulcer assessment.
- We saw there was other completed risk assessments undertaken within patients records for example falls risk and venous thromboembolism (VTE).

Nursing staffing

- As of 24 November 2016, there was a staffing establishment of 115.11 whole time equivalent (WTE) and there was 98.88 WTE in post. This demonstrated an overall vacancy rate of 14%, which had been significantly reduced from 56% in August 2016.
- Between April 2015 and March 2016, the trust reported a nursing bank and agency usage rate of 34% in the ED.
- Senior staff accepted that a high number of agency staff presented the risk of a lack of continuity and said that they tried to book the same agency nurses regularly. We spoke to two agency nurses who told us they had both worked in the department regularly for a number of months Senior staff told us if an agency nurse did not have the necessary skills and knowledge to work in the department they would not be booked again.
- The highest vacancies were band six nurses with a vacancy rate of 42%; the second highest vacancy rate was band seven nurses (29%). There had been a recent recruitment of 19.8 WTE band five nurses. When they were in post, the overall band five vacancy rate would be 3%.This was an improvement from our last inspection when the vacancy rate was 50% for band five nurses.
- There were 11 incidents reported which related to staff shortages between September 2015 and August 2016, this was a decrease from 34 incidents reported between September 2014 and August 2015.
- The minor injury unit was staff by emergency nurse practitioners (ENP's) 24 hours a day, seven days a week and doctors provided support when required.
- The ED used a combination of NICE guidance and national benchmarking to determine safe and appropriate staffing levels. The department had reviewed the times that the department was busiest and

this was reflected in staffing allocation. Nursing staff figures on the ED were: Qualified nurse to patient ratio of 1:4, a nurse co-coordinator on each shift 24 hours a day, seven days a week and a band seven sister in a supervisory role. Clinical support workers supported nursing staff on each shift.

- The trust told us that the resuscitation department was staffed according to NICE guidelines of one qualified nurse to two patients. On inspection, we saw two nurses were allocated to the resuscitation area however, there were no cover arrangements. Therefore, when one nurse went on a break, the other nurse was looking after five patients. During our inspection, the resuscitation area was full, a trauma call patient had arrived and there was only one nurse. We brought this to the attention of the matron who organised another nurse to work in the area however; there was a delay of ten minutes. Although staffing levels within the resuscitation department reflected NICE guidelines, there was not an effective system, which ensured adequate cover during break times.
- Difficulties recruiting band five and band six nurses was highlighted on the ED risk register and was last reviewed in June 2916. The trust recognised the risk of over reliance on a temporary workforce affected consistency of nursing practices, as well as the increased level of supervision required by high numbers of agency nurses. The department had measures in place that mitigated the risk, for example, having a senior nurse on every shift in a supernumerary role to provide supervision and support.
- In between the time, the data was supplied and the inspection, an extensive recruitment campaign had been undertaken as well as a review of the establishment significant improvements in recruitment and vacancy rates had occurred since our last inspection and this was something the senior team was proud of. The trust had an active recruitment drive to address the high vacancy rate. For example, partnerships with local universities to recruit newly qualified nurse and the trust held open days for nurses every other month for nurses considering coming to work at the trust.
- Between September 2014 and August 2015, 55 clinical incidents related to staff shortages compared to 11 reported between September 2015 and August 2016. This showed a significant improvement. Staff told us staffing on a day-to-day basis had improved within the last 12 months.
- There were four medical handovers between staff daily, these occurred at shift changes. We observed one of these handovers, which was well organised, comprehensive and highlighted the patients most at risk within the department.
- Nurse handovers took place twice daily and senior nurses used this time to discuss any safety issues or service pressures with staff. In addition, senior nurses checked the experience and skill mix of staff to ensure areas were staffed appropriately.
- In the 2016 staff survey, 28% of staff said there was enough staff in the organisation to do their job properly, this was an improvement from the previous years staff survey result (23%).
- Because of staff feedback and a high number of incidents reporting violence and aggression, the trust completed a security review. The leadership team developed an action plan to address the issues highlighted within the security review. Actions included, a new security policy had been agreed by the executive team at the beginning of November 2016.The policy aimed to set out agreed processes in order to tackle violence and aggression towards staff from patients'. This demonstrated the leadership team took the security of their staff seriously.

Medical staffing

- The ED did not meet the requirements of Royal College of Emergency Medicine (RCEM) which states consultant cover must be provided a minimum of 16 hours per day. On weekdays, consultants were typically present from 8am to 11.30pm and on weekends from 12pm to 8pm. A consultant was on call at all other times. There was a dedicated supernumerary consultant in charge of every shift and led the handovers, safety rounds and board rounds.
- Overnight cover in the ED was provided by a senior specialty doctor, trainee and middle grade doctor with support from additional specialty middle grade doctors.

- There were 12 junior doctors in addition to middle grade and speciality doctors, who covered staggered shifts (variable work hours) on 24-hour cycles between 8am and 8am.
- There was flexibility in consultant cover at times of demand, for example, we saw on an unannounced visit at the weekend, an extra consultant was working to support new junior doctors.
- The proportion of consultant staff working in the trust's ED was reported to be lower than the overall England proportion (19% compared to 26% for England as a whole).This was a reflection of the consultant vacancies. The proportion of junior doctors working in the service (25%) was about the same as the overall England proportion (23%).
- Where a consultant was not present for a handover, for example at the weekend, a registrar took the lead. We observed a handover, which included consultants, registrars, junior doctors and the nurse in charge. The registrar reviewed medical, nurse staffing in the ED and identified patients with deteriorating or priority needs for immediate review.
- As of July 2016, the trust reported a vacancy rate of 19% for medical staff in ED this was worse than the trust target of 8%.
- Staff included gaps in medical staffing on the ED risk register, which management reviewed in September 2016. To mitigate this risk, existing consultants provided additional cover and long-term agency was used which ensured consistency.
- Between April 2015 and March 2016 bank and locum agency usage was varied and ranged between 17% (September 2015) and 44% (July 2015) per month in the ED.
- Locum doctors told us they enjoyed working within MMH ED as they felt supported by the consultants and felt like they were one of the team.
- Medical staff however spoke negatively about some of the speciality doctors, for example, the surgical and medical teams. It was thought by staff that the medical model was a contributory factor in them reviewing patients particularly out of hours, when it was felt there was not enough doctors. We were given an example regarding the surgical team, out of hours the on-call doctors who accepted referrals were assisting in theatres and not able to accept referrals. This meant patients' were delayed awaiting speciality assessment, which also had an adverse effect on flow within the ED.

Major incident awareness and training

- The trust had an Emergency Preparedness, Resilience and Response policy which had a current implementation date and a review date.
- Major incident and decontamination equipment was available on site in line with NHS England guidance on chemical, biological, radiological and nuclear (CBRN) provision. A CBRN link nurse was in post and conducted practical training with clinical staff on the use of CBRN protection suits and with clerical staff on major incident planning. Staff were trained to put up decontamination tents and we observed the training during our inspection.
- The mandatory training data we were provided did not include major incident training compliance. This meant the department could not be assured who was up to date with major incident training.
- We reviewed the major incident equipment, which was stored in a cupboard. It was clearly organised and well set out allowing staff easy access to everything they required. Staff checked the equipment monthly, which ensured the equipment, was within date.
- Between November 2015 and October 2016, there were 34 occasions when security staff security attended the ED. During 2015/16, reported incidents indicated that 23% of all physical assault incidents took place in the ED. Between August 2015 and July 2016, staff reported four incidents, which related to experiencing aggression or violence, this was a reduction to the previous year.
- The trust arranged an external review of physical security arrangements within ED in June and July 2016. The key issues identified during the review were, the main reception desk was not fit for purpose, giving no protection to staff and also posing a risk to both staff and patients, lack of panic or personal alarms putting clinical staff at risk, unsecured interim ambulance access doors and low compliance with conflict resolution training. In November 2016, the trust formulated an action plan to address the issues raised in the external review. For example, a warning notice

escalation system was developed. Staff gave patients or visitors who were violent or aggressive either an orange or a red warning card. Patients' issued with a red card were only entitled to life saving care at the hospital. This demonstrated the trust took the security of their staff seriously and had taken action to address the issues.

- Security officers were available 24 hours a day, seven days a week. This meant ED staff had rapid access to security support if needed to help with violent or threatening patients. We saw security officers within the ED during our inspection. The majority of staff felt safe whilst working within the department and said security officers responded quickly when requested.
- Conflict resolution training was part of mandatory training, completion rates were 93% for administration staff and 90% for nursing staff. This was better than the trust target of 80%. Seventy-two percent of ED medical staff and 67% of the ED management team had undertaken conflict resolution training. This was worse than the trust target of 80%.
- We asked the trust to provide evidence that weekly fire safety logs within the ED were undertaken. The trust did not supply this information because they were not currently undertaken. This meant there were no assurances that fire exits and fire doors, firefighting equipment checks, and emergency lighting functioned.
- Staff completed a fire safety risk assessment in August 2016 where management identified several risks and non-compliance with legal minimum legal standards. For example, there were insufficient extinguishers, not all extinguishers were present, correctly mounted or signed. The recommendation was that additional units be installed when the building works were completed. This did not give adequate assurance that the risk was mitigated during the building work.
- Fire safety training was part of mandatory training. All staff groups except the ED management team had met the 80% trust target training compliance.
- There were no fire wardens specifically for the ED. However, there was a weekly rota of the responsible fire officers.
- Monthly multidisciplinary simulation sessions were undertaken which focused on lessons learnt and recent ED real cases were undertaken.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

At our last inspection in September 2015, we rated effective as requires improvement. On this inspection we have changed the rating to good this reflected improvements to staff training and competence, assessing patients individual needs and the development of new job roles.

At this inspection we rated urgent and emergency services 'good' for effective because:

- A local audit programme was in place that sought to assess care and treatment according to a range of factors, including national guidance and benchmarks.
- Policies and procedures were in line with national guidance and were easily accessible.
- Multidisciplinary working was embedded in the department and an experienced team of professionals cared for patients'.
- A crisis response team, frailty team and rapid discharge team also provided specialist support.
- Staff were qualified and had the skills they needed to carry out their roles. Staff were supported to maintain and further develop their professional skills and experience.
- Patients' had comprehensive assessments of their needs and their care and treatment was regularly reviewed and updated.
- Staff generally demonstrated a good level of knowledge of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards.

However:

- Care provided for patients suffering with sepsis (infection) was not always in accordance with National Institute for Health and Care Excellence guidelines.

- The trust's unplanned re-attendance rate to the emergency department (ED) within seven days worse than both the national standard and the England average.
- Appraisal rates for nursing staff were 82% which was worse than the trust target.

Evidence-based care and treatment

- Initial assessment of patients with different conditions were undertaken against standard checklists in a booklet adapted from Royal College of Emergency Medicine (RCEM) guidelines. This included the care for patients with head injury, suspected stroke, chest and abdominal pain and sepsis. For each condition, there was clear guidance of the time by which assessment should be made and under which criteria a senior doctor should be informed.
- The department undertook individual audits, which were used to benchmark and assess care and patient outcomes against a range of targets and standards. This included those set by the National Clinical Audit and Patient Outcomes Programme, the National Institute for Health and Care Excellence (NICE) and compliance with the College of Emergency Medicine (CEM) Guidelines the Society for Acute Medicines.
- We examined audit reports provided by the trust and saw managers had identified areas for improvement and there were plans for staff to carry out re-audits. Managers communicated audit report findings via meetings, displays, board rounds, emails and staff team briefings. Local audit information was displayed for staff and was used to highlight areas of good practice and areas where improvement was needed.
- The trust policy was to follow the internationally recognised Red Flag Sepsis (infection) screening and action tool, which may indicate the need for Sepsis Six Pathway. If a patient had a NEWS score of over five a sepsis screen was automatically undertaken. The Sepsis Six Pathway is a bundle of medical therapies designed to treat and reduce the mortality of patients with sepsis. The components of the sepsis six were; blood cultures, check full blood count and lactate, intravenous (into the vein) fluid challenge, intravenous antibiotics, monitor urine output and give oxygen.
- We reviewed a sample of 22 patient records and found most patients had received care in line with national guidance. However, staff did not treat four patients in line with the 'Sepsis Six' guidelines. We raised this with the clinical team who undertook a view of the care these patients received and gave assurances that any lapses would be highlighted to the staff concerned.
- The National Institute for Health and Care Excellence (NICE) guideline NG51 states staff must give a broad-spectrum antimicrobial (antibiotics) at the maximum recommended dose without delay (within one hour of identifying that they meet any high risk criteria in an acute hospital setting). We reviewed notes of seven patients who met the high-risk criteria, four (44%) of these patients had not been given antibiotics within one hour. This meant the NICE guideline was not followed and there was a delay in patients receiving antibiotics.
- Between October 2015 and October 2016, 391 patients' triggered the sepsis pathway. This meant the department had a system to highlight patients who triggered the sepsis care bundle and could monitor the care and treatment they received.
- Data supplied demonstrated between December 2015 and November 2016, 53% of sepsis patients had all completion of all six bundles. This meant that just under half of patients who attended with sepsis were not receiving treatment in line with NICE guidance. This was consistent with our findings.
- Staff had an 'identifying sepsis red flag card' in their hospital identification case. This meant staff had easy access to reference material regarding sepsis signs and symptoms.
- Staff understood the National Institute for Health and Care Excellence (NICE) guidelines for sepsis and stated these were referred to in discussions about care and treatment. We observed instances of this during treatment plan discussions and handovers.
- Emergency nurse practitioners (ENPs) worked in accordance with national best practice guidance issued by NICE, for example the treatment of head injuries. This guidance was readily available to ENPs in the department.

- Staff treated patients with fractured hips in line with Hip fracture: management CG124. For example, staff fast tracked patients within the ED to a dedicated ward.
- There were specialist clinical pathways and protocols for the care of patients attending with specific conditions. For example, fractured hip these were designed to specifically assess risks associated with this specific fracture.

Pain relief

- In the CQC ED Survey, the trust scored 5.6 (out of 10) for the question "How many minutes after you requested pain relief medication did it take before you got it?" This was about the same as other trusts.
- The trust scored 6.8 (out of 10) for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.
- We saw patients' records that showed pain had been risk assessed using the scale 0 – 10 (zero being no pain and 10 being extreme pain at rest) found within the NEWS chart and medication was given as prescribed. We observed staff asking patients if they were in pain and patients told us they were provided with pain relief in a timely manner and staff returned to ask if their pain had been relieved.
- Between 01 February 2016 and 14 November 2016, 74% of patients received a pain assessment. This meant not all patients had a formal pain assessment or did not require one.
- Patients we spoke to told us that they were offered pain relief and felt that their pain had been managed appropriately. This was an improvement since our last inspection when it was not always possible to give pain relief to patients in the corridor.

Nutrition and hydration

- Staff used the Malnutrition Universal Screening Tool (MUST) to assess patient's risk of malnutrition. If a patient was at risk of malnutrition or had specific dietary needs they were referred to a dietician. Staff made referrals to dieticians when required.
- Staff said they made referrals to the speech and language team (SALT) when they have concerns regarding a patient's ability to swallow.
- In the CQC A&E Survey, the trust scored 7.1 (out of 10) for the question "Were you able to get suitable food or drinks when you were in the A&E Department?" This was about the same as other trusts.
- Staff regularly offered drinks and food to patients. We saw that hospital volunteers undertook regular refreshment rounds, offering patients hot drinks and snacks.

Patient outcomes

- The trust contributed to the Trauma Audit and Research Network (TARN), which aims to reduce unnecessary mortality through effective management and treatment of patient injuries following trauma. In the reporting period quarter four 2015/16, 68% of all TARN eligible patients were submitted this was about the same as the England average.
- Sixty percent of patients received a computerised tomography (CT) scan within 60 minutes of arrival in line with NICE guideline CG176,this was better than the England mean average (58%).
- Seventy-eight percent of trauma teams were led by a specialist trainee register (middle grade specialist doctor), this was better than the England mean average (55%).
- One hundred percent of patients were transferred to a specialist major trauma centre within 12 hours of referral, this was better than the England mean average (69%).
- In the Procedural Sedation in Adults Clinical audit 2015/6, the RCEM set a target of 100% compliance with all seven standards. Procedural sedation is when a sedative with or without a pain killer is given to a patient that allows the patient to tolerate an unpleasant procedure to be undertaken. The department demonstrated zero compliance with all seven standards, and therefore improvement was needed in the practice of procedural sedation in the ED.
- The venous thromboembolism (VTE) audit 2015/16 for patients with lower limb immobilisation demonstrated the need for improvement in the care of patients with lower limb immobilisation who may be at risk of

developing VTE. For example, 60% of patients with lower limb immobilisation had a VTE risk assessment undertaken and 3% of patients' had a VTE risk level documented.

Competent staff

- Overall, in the ED, 93% of staff had received an appraisal in the previous 12 months. This was worse than the trust target of 95%. Nursing staff had the lowest appraisal rate (82%).
- We reviewed 14 staff appraisals, which included a six monthly review to check progress. The appraisals were thorough and had clear objectives and milestones to be achieved. Senior staff tried to undertake appraisals at quieter times of the year and in line with university application time frames. This meant there was opportunity for course applications to be made prior to the university semester commencing.
- In the 2016 staff survey, 40% of staff said during their appraisal/performance review the organisational values were definitely discussed, this was better than the previous years staff survey (29%).
- New staff were given an ED welcome pack, which contained role specific competency documents, policies and health and safety guidelines. Management kept electronic records of staff inductions. We reviewed 14 of these and they were all comprehensive.
- The department had an in depth induction pack for bank and agency registered nurses and health care assistants (HCAs). We saw nine completed copies, which included various competency assessments including drug administration, NEWS score and hand hygiene. This gave assurances that agency nurses were able to provide safe care within ED.
- We spoke with staff that had recently started working within ED and all were positive regarding the induction they had received. We spoke with two junior doctors who had only worked within the ED for two days and both said they had received a thorough induction.
- Junior doctors spoke positively about teaching and learning opportunities in the ED. They had access to scheduled weekly teaching sessions and daily board rounds, which incorporated teaching. Locum doctors also had access to these teaching opportunities.
- Newly qualified nurses who worked within the ED undertook an 18-month preceptorship programme and a development pathway in emergency care essentials. A preceptorship programme is a period of time to guide and support all newly qualified practitioners to make the transition from student to develop their practice further. The emergency care essential syllabus gave newly qualified nurses the skills and knowledge required to work within the ED.
- There was a newly appointed emergency nurse practitioner/practice development nurse who supported new starters to develop their skills and knowledge.
- Nurses and healthcare assistants undertook additional training to work in link roles in areas they had a special interest. This included keeping up to date with new policies and procedures in this area, assisting with audits and attending training sessions so they could brief their colleagues in the ED. Link nurses were in post for 14 areas that covered medical treatment and care as well as the department itself, including organ donation, infection control, learning and development and clinical incidents.
- Staff told us the In-house education sessions such as plastering techniques and sepsis management were undertaken.
- The department was developing an assistant practitioner (AP) role. AP's undertook clinical work in domains that have previously only been within the remit of registered professionals. The AP's in the department undertook a year's advanced diploma training and were assessed by qualified staff performing competency-based tasks. AP's worked under the day-to-day supervision of a registered member of staff. The AP role was intended to free up nurses to make better use of their professional skills and improve patient outcomes. The AP's we spoke to were all undertaking their training, all said they felt supported in their training and were positive about the new role. We saw AP's asking qualified members of staff for help and guidance, the AP's documented these discussions in patients' notes, which include the qualified member of staff's name.

- Staff said that since our last inspection there had been a huge investment in education and training, particularly amongst nursing staff. It was felt by senior staff that this had helped the recruitment of nursing staff.
- There was an education noticeboard within the department, which contained details of what courses and study days were available and who to contact if staff wanted to undertake these.
- Nursing staff had live feedback forms completed by senior staff, which gave feedback on their performance during their shift. This meant areas of improvement could be identified and positive performances highlighted.
- In the 2016 staff survey, 77% of staff said they had received training, learning and development in the last 12 months, this showed an improvement from the previous years staff survey (70%).
- In the 2016 staff survey, 34% of staff said they after their appraisal/performance review they felt their work was valued, this showed an improvement from the previous years staff survey (28%).

Multidisciplinary working

- There was a specific care pathway for patients attending with a broken hip. The ambulance crew telephoned a dedicated AP if they thought a patient had a broken hip., The AP then communicated this to members of the multidisciplinary team (MDT). For example, the x-ray department, ward manager and orthopaedic surgeon. This meant the MDT were expecting the arrival of the patient and investigations and treatment commenced as soon as the patient arrived in the department.
- There was a specific stroke specialist nurse assigned to the ED 24 hours a day, seven days a week. This meant there was a fast assessment by a specialist who was able to access the specialist stroke team for prompt assessment and treatment.
- Staff had access to support from speech and language therapists and dietetics in the hospital.
- A dedicated pharmacist worked in the ED who provided oversight of medicines management and support for staff who experienced a medication error.
- ENPs, staff nurses and AP's worked together to pool their skills in response to the demands of the department and to enable them to develop their professional skills. For example, an AP worked with the triage nurse on each shift and another AP worked with the ENP in minor injuries.
- There were three cardiac nurse practitioners available in the hospital seven days a week. The practitioner assisted with triage, reviewed diagnostics and took bloods. They could also liaise directly with consultants for advice.
- Mental health liaison nurses were available 24 hours a day, seven days a week. The nurses were provided by another organisation. There was a mental health crisis team, made up of psychiatric nurses, social workers and support workers. They carried out mental health assessments and provided support- until another team was available or the help was no longer required.
- A paediatric mental health liaison service saw all children under the age of 16 and adolescents with mental health needs.
- Staff could access the learning disability lead, critical care team, pain management team, intravenous infusion team, social workers and safeguarding teams who were able to provide advice and support. The ED had access to the rapid assessment unit, which was supported by a team of specialist doctors, physiotherapists, occupational therapists, nurse practitioners and social workers. This provided support to patients who needed early assessment and treatment, which enabled early discharge. It also supported patients who needed additional care or a community package of care in place before they could be safely discharged.
- Overall, staff reported good multidisciplinary working with other services within the trust and with external organisations, such as local authorities and general practitioners. However, staff felt the timely review of patients' from specialist teams hindered the flow and performance of the department. Positive examples of MDT working included the interaction between the department and imaging staff.
- Board rounds were undertaken three times a day, which gave the MDT the opportunity to meet together and discuss any issues, and we observed one of these during our inspection.

Urgent and emergency services

Seven-day services

- The emergency department was open 24 hours a day, seven days a week.
- The trust had undertaken a full review of the seven days services clinical standards over the last year. Emergency teams reviewed all admissions within 14 hours of arrival at the hospital. This was in line with the clinical services seven-day standard 3, 2016, which requires staff to assess all emergency inpatients for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker.
- An emergency ambulatory service assessed and treated suitable patients referred from ED and a doctor assessed all GP referrals, with consultant presence 12 hours per day, five days a week.
- A GP led unit saw patients referred by ED 24 hours a day, seven days a week.
- All imaging and pathology tests were available 24 hours a day, seven days a week.
- There was a variety of networks that could be accessed 24-hours a day seven days a week, for example the head injury network.
- The pharmacy department was open to staff and patients from 10am until 3pm on Saturdays and 10am until 1.30pm on Sundays.
- A pharmacist was on call via switchboard (pager or mobile phone) from 5pm until 8.45am the following day. At weekends, the pharmacist was on call from Friday 5pm until 8.45am on Monday.

Access to information

- Staff had access to the local authority safeguarding system that highlighted children on the child protection register and those who had an active safeguarding alert.
- Clinicians had electronic access to patient histories and the computer system identified any patients known to be at risk or living with a condition such as dementia, and we saw staff using this system.
- Laboratory and other medical investigation records were accessed electronically, including past test results from previous visits. We were told that the availability of computer terminals was sufficient and software systems used by the trust were suitable for their needs.
- Information for GP's was sent electronically and patients were given a copy of their discharge summary and staff demonstrated this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a Deprivation of Liberty Safeguards (DoLS) policy, which was in date. The policy was in line with Department of Health (DoLS Code of Practice 2009).
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- All Deprivation of Liberty (DoLS) training at the trust was delivered under the mandatory adult safeguarding modules.
- We did not see any completed a Mental Capacity Act (2005) (MCA) assessments during our inspection. However, we saw that the MCA assessment and dementia screening tool was incorporated into the adult initial assessment and care plan document.
- Seventy-nine percent of medical staff had completed MCA training, broadly in line with the trust target of 80%. Ninety percent of nursing staff had completed MCA training, which was better than the trust target. Twenty-five percent of management staff had completed MCA training, which was much worse than the trust target.
- We saw there was a noticeboard, which contained information for staff regarding the MCA and contained contact details should staff require advice.
- The ED did not undertake any consent audits. This meant there was no assurance that patients were giving valid consent to procedures.

Urgent and emergency services

Are urgent and emergency services caring?

Good

At our last inspection in September 2015, we rated caring as requires improvement. On this inspection we have changed the rating to good this reflected significant improvements made in maintaining privacy and dignity of patients'.

On this inspection we rated urgent and emergency services as 'good' for caring because:

- Patients understood their care, treatment and condition. Patients and staff worked together to plan care and there was shared decision-making about care and treatment.
- Patients were treated courteously and their privacy was maintained. Patients were able to make informed decisions about the treatment they received.
- Emotional support services were available for patients and their relatives.
- Staff responded compassionately when patients required help and supported them to meet their basic personal needs when required.

Compassionate care

- The trusts urgent and emergency care Friends and Family Test (FFT) performance was consistently around 10% worse than the England average each month between September 2015 and August 2016. This performance was consistent with previous inspections. This indicated that the public opinion of the ED had not improved since our last inspection. Comments we received from patients were not consistent with the FFT findings. Patients' told us they felt supported and well cared for.
- We received positive comments from patients we spoke with about their care, comments included "Although it's very busy the care is excellent". Staff displayed thank you cards in the department, all of which contained positive comments.
- Staff treated them compassionately and we saw staff responding to patients in a timely and appropriate manner. For example, when a patient requested a bedpan staff provided it within a couple of minutes.
- We observed staff treating patients with dignity and respect. For example, a nurse took the time to explain to a patient living with a learning disability that taking their blood pressure would not hurt and demonstrated putting the blood pressure cuff on their own arm. During another observation, a doctor apologised to a patient for the delay they had experienced and assured them staff would treat them quickly, this had a calming effect on the patient.
- The patient tracking and information system ensured patient privacy was protected. For example, if a patient was admitted with an alert, such as a safeguarding or child protection alert, a discreet symbol was marked on the information board. This prompted staff to check electronic records for information about the patient's situation.
- We saw there were posters displayed informing patients of their right to request a chaperone during examinations.
- The most recent patient led assessment of the care environment (PLACE) score, completed in 2016 scored 70% for privacy, dignity and wellbeing at Medway Maritime Hospital (MMH), which was worse than the national average of 84%. However, during all of our observations during inspection we found patients' privacy and dignity was maintained.
- Staff said patients' dignity and respect had improved since patients were no longer cared for in a corridor. However, patients who walked into the department discussed their reason for attendance with a receptionist at the front desk, situated a very short distance from the chairs of the waiting room. This meant a people sitting in the waiting room might over hear a patients' reason for attendance, compromising their privacy. When the building work has been completed this will no longer be an issue.
- A relative's room was available for private conversations. There were patient information screens within the waiting areas, this ensured patients knew how long they had to wait to be seen by a doctor and how many patients' were waiting to be seen.

Urgent and emergency services

Understanding and involvement of patients and those close to them

- During our observations, all staff routinely involved patients and their relatives in plans and decisions about their care and treatment. For example, one nurse explained to a patient the importance of taking regular painkillers when they were discharged home. In another observation, we saw a doctor explaining to a patient that they had broken their wrist and showed them their x-rays to explain where the break was and what treatment was required.
- The rapid discharge team worked closely with family members to ensure discharge packages were appropriate, including what would make them and their family member feel safe.
- Staff considered discharge planning as soon as a patient attended the ED. Staff discussed planning with patients and relatives to ensure appropriate arrangements were in place. This also reflected patient centred care and that patients' individual needs were taken into consideration.
- We observed a nurse asking a relative what activities the patients normally undertook themselves, for example, could they wash and dress themselves before they became ill. This meant staff knew what the 'normal baseline' of the patient was.
- We observed nurses, doctors and other professionals introducing themselves to patients at all times and explaining to patients and their relatives about their care and treatment options.

Emotional support

- Staff provided immediate signposting to support services, including emergency counselling services. We saw there were a variety of posters that gave details on how patients could access support groups, for example, smoking cessation.
- Bereavement and multi-faith chaplaincy services were available on site to provide emotional support to families and their carers.
- There was a variety of specialist nurses available that provided support and advice for patients. Staff said usually there was a prompt response when they referred a patient to one of the specialist nurses.
- The hospital had a group of volunteers that were available to provide reassurance and support. For example, we saw volunteers provided patients' with refreshments. This gave patients the opportunity to have a conversation with the volunteers who provided reassurance.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

At our last inspection in September 2015, we rated responsive as inadequate. On this inspection we have changed the rating to requires improvements, this reflected improvements in the implementation of the medical model which better meets the needs of the local population. In addition, although access and flow still remained a problem innovative ways of working had been implemented.

At this inspection we rated urgent and emergency services as 'requires improvement' for responsive because:

- The flow of patients through the department required improvement. Patients' experienced significant delays whilst awaiting specialist review or to be placed on a ward.
- Performance against the Department of Health that 95% of patients were treated, admitted or discharged within four hours was poor.
- There was no hearing loop in the reception area for patients with hearing difficulties.

However:

- There was a frailty pathway to help provide appropriate care for the significant number of patients with related needs.
- Staff used comfort rounds that ensured patients were safe and had their care needs met.
- The service had responded to continual high demand and adapted the way services were delivered to minimise the effects of this.

Urgent and emergency services

Service planning and delivery to meet the needs of local people

- In the summer of 2016, building work began to refurbishment the majors area of the ED. Once the redevelopment has been completed the ED will consist of 24 bays in majors, seven bays in resuscitation and 10 bays in the clinical decisions unit (CDU).The development will provide additional capacity to cope with the increase of patients who attend. When the building work has been completed, the people of the local community will receive care in a modern bigger ED, better equipped to meet their needs.
- The Emergency Ambulatory Service assessed and treated suitable patients referred from ED and a doctor assessed all GP referrals, with consultant presence 12 hours per day five days a week. This meant staff could refer patients to the facility, enabling the patient to be discharged on the same day, therefore avoiding an admission to hospital, which was beneficial for patients and the hospital.
- A standard operating procedure was in place between the air ambulance service and the ED to provide rapid transfer of trauma and severely medically unwell patients by helicopter.
- The ED had recently undertaken research on the demographics of the local population. This meant the ED could ensure facilities and services matched the local population. For example, staff ordered patient information leaflets in the most commonly spoken languages of the local population.

Meeting people's individual needs

- Staff had a good understanding of how to care for patients living with dementia or a learning difficulty. We observed staff spoke with patients calmly and slowly and cared for then in a quiet area. We saw an interaction between a nurse and a patient living with a learning disability. The nurse explained everything slowly and demonstrated on themselves what was going to happen, for example putting the blood pressure cuff on their arm. The nurse was honest when explaining for example when taking a blood test that it might hurt a bit but it would not last long. This meant the patient knew what to expect, the nurse encouraged the carer to distract the patient to help the patient relax.
- There were 'dementia champions' who had undertaken additional training to ensure patients living with dementia had their needs met. Dementia champions acted as a resource for help and advice for other staff.
- We observed a nurse speaking to a patients' carer to gain information on the best way to communicate with the patient.
- The 2016 patient led assessment of the care environment (PLACE) showed Medway Maritime Hospital scored 63% for dementia care, which was worse than the national average of 75%. The trust did not supply department specific PLACE data.
- The ED used the butterfly scheme where staff placed a butterfly symbol by the patient's name to identify patients living with dementia or memory impairment. Its purpose was to improve patient safety and well-being in hospital. This was also a discreet way of conveying information without making it obvious that a patient suffered with dementia.
- There was a living with dementia information board in the department. This included information on recognising the condition and best practice guidance for effective and compassionate communication. In addition, there were details of support groups available for relatives and carers of patients living with dementia.
- The electronic tracking system used within the ED allowed alerts to be assigned to patients. For example if a patient was living with dementia or a learning difficulty there was a visual aid to alert staff.
- Staff described changes to care when treating patients living with dementia or a learning difficulty, for example, staff used a different pain assessment tool where patients pointed to pictures of faces that reflected their level of pain.
- We saw a nurse using a patients' health passport. The passport contained essential information regarding the patient for example, how they communicated, how to know if they were in pain, what they enjoyed doing and what their food and drink preferences were. The passport meant staff were informed of the patient's individual needs.
- Patients had access to a shower and the department kept a stock of basic personal care items, for example, toothbrush and toothpaste.

- Staff used a dementia screening tool and the Glasgow coma scale (GCS) to document cognitive function. We observed staff assessing patients' cognitive function and calculating a GCS score. We did not observe patients undergoing dementia screening during our inspection
- There was a league of friends shop located within the ED that provided refreshments and essential items for patients and relatives.
- There were posters that displayed details on how a patient could refer themselves to an alcohol misuse service.
- A designated purpose built room was available in the ED for patients with mental health needs or risks. The room had been designed and built to meet the needs of patients with mental health needs or risks, for example, there were no ligature points.
- Staff ensured patients had a call bell within reach, as part of two hourly comfort rounds. We checked 12 patients who all had their call bell within reach. However, there were two bays in the majors overflow area, which did not have call bells. Therefore, patients within these bays could not easily call for assistance.
- The department was clearly signposted so it was easy for people to find their way around.
- There was no hearing loop available at the reception desk for patients' with a hearing impairment. Reception staff described a recent incident when a patient with a hearing impairment attended the ED and had to write everything down. This caused difficulties for reception staff, the patient and caused a delay in the patient receiving treatment.
- The local area had above average rates of smoking and the trust was committed to supporting smoking cessation initiatives. The trust asked people who used to the hospital to undertake a survey regarding smoking on the hospital premises. The results of this survey demonstrated that 55% of people supported the hospital going smoke free. This showed that the trust had engaged with the public and wanted to improve the environment. At the time of inspection, the hospital premises were smoke free and managers encouraged staff to challenge people they saw smoking. During our inspection, we saw staff challenging people smoking and staff said they felt empowered to challenge it.
- The trust participated in the 'hello my name is campaign' this meant staff introduced themselves to patients and visitors in the hospital. This meant that patients' knew the name of the member of staff and their role.

Access and flow

- Between July 2016 and October 2016, there was 3,285 ambulance handovers, 54% of handovers occurred between 0 and 15 minutes after arrival at MMH, 38% occurred within 15 and 30 minutes, 6.5% occurred within 30 and 45 minutes and 1.5% occurred between 45 and 60 minutes. This meant that during this period, staff undertook only 54% of ambulance handovers within the national target of 15 minutes.
- Medway Maritime hospital had fewer ambulance turnarounds over 30 minutes and over 60 minutes compared to the average for all trusts under the South East Coast Ambulance Service NHS Foundation Trust (SECAmb). It was the sixth best performing hospital (out of 29 hospitals) for turnaround times over 30 minutes and it ranked 15th out of 29 for turnaround times over 60 minutes.
- The Royal College of Emergency Medicine recommends the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust was similar to the 60-minute time to treatment standard between October 2015 and September 2016, with the exception of February and March 2016 when it was more than 60 minutes.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The trust breached the standard every month between September 2015 and August 2016. The worst performance (75%) was in March 2016 and the best performance (91%) was in December 2015. Between September 2015 and August 2016, the trust performed well below the England average. However, from March 2016 the trust's performance was similar to the England average.
- The Department of Health's standard for emergency departments is to admit patients to a specialty ward, unit or service within 12 hours of being assessed by a specialist and the decision to admit being made. When a patient waits longer than this in ED, this is called a

breach. The percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average in 11 of the 12 months between September 2015 and August 2016. Between February and August 2016, performance against this metric showed a trend of decline. In July 2016, 44% and in August 2016, 40% of patients waited between four and 12 hours from the decision to admit until being admitted. Over the 12 months, two patients waited more than 12 hours from the decision to admit until being admitted. Matrons, service managers and site practitioners used the bed meetings to monitor and prevent 12-hour breaches. When a 12 hour breach did occur, staff declared a serious untoward incident (SUI). This meant there was a thorough investigation undertaken to identify the cause for the breach.

- The trust's monthly median total time in ED for admitted patients was consistently higher than the England average between January 2016 and October 2016. Between June and October 2016 there was an upward trend. In October 2016 the trust median was 418 minutes (six hours and 58 minutes), compared to the England median of 235 minutes (three hours and 55 minutes).
- The trust's monthly median total time in ED for all patients was similar to the England average between November 2015 and October 2016 and has followed the national trend over time.
- The national average for percentage of patients that leave the department before being seen (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they have to wait) varied between 2.9% and 3.5% between April and October 2016. Over the same period the trust's performance varied between 3.2% and 4.4%. Between April and October 2016 the trust consistently performed worse than England overall for this metric. The department felt the implementation of the new rapid assessment process would improve performance.
- CQC highlighted capacity and flow issues in ED during previous inspections. The ED had implemented new ways of working to tackle the issues. New streaming, triaging protocols and the ambulatory care unit had been introduced to try to help the ED meet the 95% target. In addition, building works had been completed which had created a separate ED for children and created more space for the adult ED. The corridor previously used to care for patients had stopped being used in October 2016 and there was a new majors overflow area.
- The trust implemented a new medical model in May 2016, the new approach aimed to improve patient care and experience and reduce patients' average length of stay in hospital. The medical model was a clinical pathway for patients who were admitted on an emergency basis to the hospital.
- As part of the new model, all patients who attended with a significant clinical presentation, for example chest pain, underwent a comprehensive assessment within 15 minutes of arrival. This helped ensure staff only admitted patients who really needed to be admitted and referred others patients for care and treatment elsewhere, such as ambulatory care, onsite GP practice or Medway on Call Care (MedOCC).
- The medical model also introduced board and ward rounds throughout the hospital. We observed a board round within the ED. It provided an opportunity for doctors, nurses and allied health professionals to come together and determine how best to use the resources available that day to progress each patient's journey through the hospital. Board rounds also provided a form for the multidisciplinary team to review the status of the department, staffing and high-risk patients.
- Staff spoke positively of the board rounds as it gave them time out of the department to "Take stock" of patients within the department and enabled discussion regarding managing the risks within the department.
- Delay in assessment of patients referred to specialist teams was identified on the urgent care service's risk register and was last reviewed in June 2016. To mitigate the risk the trust launched the new medical model in March 2016, as part of the trust recovery plan. The medical model facilitated prompt referral and reallocation to a designated specialist assessment area. In addition, the trust launched a new 'decision to admit' process. This clearly defined the point at which patients required admission and allowed for monitoring and audit of this process.

- Service managers, matrons and site practitioners attended bed meetings four times per day to coordinate discharges and admissions and this was observed by the inspection team.
- Doctors and the nurse in charge and attended a board round and safety huddle each morning. This meant all patients were reviewed and identified opportunities for safe transfer and discharge.
- Patients were given an expected date of discharge when they were admitted, enabling both patients and their families to plan accordingly. There were revised criteria and model for primary care streaming; this meant that only the people who required the services of ED were treated within the ED. Patients with less serious injuries were streamed to primary care services, which reduced the number of patients, treated within the ED.
- The flow of patients through the department had improved since our last inspection but still required improvement. It was recognised that the issues affecting this were outside of the department's direct control. The primary causes were due to lack of beds available across the hospital as well as waiting for speciality doctors to assess patients. We saw patients' who had been waiting extended periods within the ED whilst awaiting bed replacement; some patients had waited over 12 hours.
- Patients also spent extended periods of time in the ED due to a lack of community adult social care services. Staff told us this was worse at weekends due to lower levels of medical staffing and fewer social care resources. During our inspection, we were given examples of when this had occurred.
- Staff had designated one of the resuscitation bays for the care of children. However, we saw a number of occasions when staff used this bay for treating adults. This meant should a child require the bay it would not be available. Staff told us that if this happened they would move patients around to ensure the bay was available.
- Staff felt the redevelopment of the majors area, which created more space, would improve patient flow throughout the ED.

Learning from complaints and concerns

- Between August 2015 and May 2016, the ED received 90 formal complaints. This represented 18% of all complaints received for all departments in the trust. Of the total complaints, the most common theme (30) related to lack of care/attention and treatment, the second most common theme (24) related to appropriateness of referral.
- The average time taken for the ED to respond to a complaint was 62 days. This was significantly higher than the target of 30 working days in the trust's complaints policy. This meant in the majority of cases, staff did not respond to complaints in a timely way. This was consistent with previous inspections and timely response to complaints still required improvement. However, senior staff said they had recently received training on how to investigate complaints and felt this would improve their ability to deal with complaints in a timely way. Previously staff had not received any training on how to respond to complaints. The increased staffing also meant senior staff could be released from clinical duties giving time to investigate complaints.
- Senior staff discussed complaints with staff as soon as they were received. This was done at safety huddles, handovers, department meetings and board rounds. We saw meeting minutes where complaints had been discussed and learning shared.
- Ward areas had 'you said we did' boards; displaying actions taken following patient feedback. For example, a patient had complained as they had waited for four hours to be told there was nothing wrong. The department had now implemented a new rapid assessment process, which would stop patients waiting so long for assessment.
- Staff displayed patient feedback and actions in the department for patients and visitors to see. This demonstrated the department was listening to patients' feedback on how staff could improve services, which was an improvement since our last inspection.
- There were monthly 'meet the matron' events, which also gave patients and relatives the opportunity to discuss concerns and complaints.

- Staff had installed television screens in waiting areas, which displayed information regarding waiting times. These were installed as a response to patients' complaining they were not informed of how long the expected wait to be seen was.

Are urgent and emergency services well-led?

Good

At our last inspection in September 2015, we rated well led as inadequate. On this inspection we have changed the rating to good, this reflected improvements in strategic nursing leadership, the focus on safety, understanding of risks and the investment in developing a skilled workforce.

On this inspection we rated urgent and emergency services as 'good' for well-led because:

- There was evidence of excellent innovative multi-disciplinary working with staff working together to problem solve and develop patient centred evidence based services which improved outcomes for patients.
- Staff responded quickly to the issues we raised during the inspection, to ensure they were addressed and took action.
- Staff were proud of the service they provided to patients and their families. Staff spoke positively about the improvements in leadership and culture, including developmental opportunities since our last inspection.
- There was an overarching local urgent care improvement programme plan, which was driven by the senior team.
- The senior team understood the risks in the department reviewed them regularly and proactively sought new practices to reduce or resolve risks. Staff were able to identify what their biggest risks were on the risk registrar and how they planned to mitigate risks.
- Staff and the department demonstrated a number of areas of innovation, including the creation of a new job role, new models of care and increased recruitment to improve quality of care and reduce waiting times.

However:

- Mandatory training compliance amongst the management team was below the trust target.
- There was varied results regarding leadership in the 2016 staff survey.

Leadership of service

- The leadership of the ED had been restructured nine months ago. The consultant nurse was also the educational lead for the ED and led on patient care and quality. A senior matron and matron supported the consultant nurse. In addition, there was a service manager who was responsible for the flow of patients. Band seven nurses led shifts.
- Staff told us any member of staff could approach each other for support or guidance and did not need to wait to ask a specific person. We saw health care assistants (HCA's) approaching consultants for advice, this meant staff worked together as a team regardless of their job role.
- We saw strong leadership, commitment and support from the senior team at department level. The senior staff were responsive, accessible and available to support staff during challenging situations. This was an improvement since our last inspection when staff said us they rarely saw tangible help from senior members of the senior team when they escalated concerns such as capacity issues.
- Managers we spoke with were knowledgeable about their patient's needs, as well as their staff needs. They were dedicated, experienced leaders and committed to their roles and responsibilities. This was an improvement since our last inspection when managers lacked insight into their service.
- Senior medical leadership was evident and the role of the consultant in charge was now embedded with clearly identifiable roles and responsibilities. All staff told us that the consultants worked as a team, led by example and were strong leaders.
- On previous inspections, consultants inconsistently wore their grey uniform and were therefore not easily identifiable. During this inspection including the unannounced inspection, we saw that consultants were wearing grey uniforms.

- The ED clinical lead was well respected and seen as an instrumental part of making positive changes. Doctors reported good working relationships with nurses and the service manager.
- Strategic nursing leadership was apparent and it was clear which areas of nursing care was managed by which member of the senior nursing team this had been absent in our last inspection.
- We saw the nurse in charge and consultant in charge working clinically within the department and saw them both wearing badges identifying them.
- The management team's compliance with mandatory training was below the trust target. This did not demonstrate to their staff the importance of ensuring mandatory training was up to date.
- In the 2016 trust staff survey, 76% of all staff said they knew who their managers were, this was an improvement from the previous years staff survey response (69%).In the same survey, 37% of all staff felt that communication between managers and staff was effective, this was an improvement from the previous years staff survey (26%).

Governance, risk management and quality measurement

- The emergency department (ED) was part of the acute and continuing care directorate (AACCD) the AACCD divided into four programmes. The ED was within the emergency medicine programme board (EMP), other services within the EMP included, ambulatory and short stay, care of the elderly/frailty/stroke, site and discharge teams and therapies.
- There was a management structure with five managers having overall leadership of the EMP, a clinical director, general manager, lead matron, head of therapies and a discharge matron. Each had a specific area of responsibility and clear lines of reporting and accountability.
- There was an EMP leadership and governance structure, the directorate management board had overarching responsibility. The EMP fed into the clinical directors' forum, quality and safety, business performance and mortality groups. These groups met monthly and fed into departmental meetings and governance meetings. There was a two way sharing of information between the groups within the overall strategy. We saw from meeting minutes, trends in incidents, complaints were identified and serious incidents, safeguarding, patient feedback and metrics were discussed. Meeting minutes included action logs. This meant it was clear who was responsible for ensuring an action was undertaken. This was an improvement since our last inspection when meeting minutes did not contain action logs.
- The senior team had a monthly Emergency Medicine Programme Board (EMPB) meeting to review incidents and identify trends. We saw from the meeting minutes that incidents and serious incidents(SI's) were a standard agenda item for discussion. Staff discussed incidents from the previous day at the 8am handover and if further incidents happened throughout the day, they were discussed at subsequent handovers. There were board rounds for times a day that medical staff attended. The board rounds gave doctors the opportunity to discuss any relevant issues in protected time away from the clinical environment. Staff told us that incidents and learning from incidents were discussed within this forum, we attended one of these meetings and witnessed a discussion regarding an incident. All staff were expected to attend an EMPB meeting quarterly and the roster was arranged to ensure this was possible. This meant that staff were kept informed of learning from incidents and SI's and had an active part in disseminating information to their colleagues.
- The departments performance indicators for example, 12 hour breaches were monitored through the EMPB, this meant there was a system which ensured performance was within the department was understood and action taken when required.
- Since our last inspection, the trust had launched a two-phrase trust recovery plan. Part of this plan included an urgent care improvement programme. The programme focused on improving the flow, safety and responsiveness of the ED.
- We saw that improvements had been made in data collection and the quality of the data collected. In previous inspections, there had been a discrepancy between data collected by the department and data

collected by the trust information team. The data produced at the time of this inspection was accurate and meant informed decisions could be made because of data findings.

- Staff understood and felt involved in governance processes.
- There was a comprehensive risk register for the EMP, which included all known areas of risk identified in the ED. Managers documented the risks and recorded the action being taken to reduce the level of risk. We saw there was 14 risks on the EMP risk register. Staff had all of these risks within the last 12 months. The register was up to date, identified the risk, the impact to the patient, the controls in place, with a nominated lead for each risk. Staff discussed the risk register at each departmental meeting and we saw evidence of this in meeting minutes. This was an improvement since our last inspection when staff did not date the risks on the register and only provided brief details of actions taken.
- The department produced weekly operational dashboard data, which managers shared with staff and discussed at meetings.
- The EMP held regular morbidity and mortality review meetings and these were well attended.

Vision and strategy for this service

- In the summer of 2016, building work began to refurbishment the majors area of the ED. Once the redevelopment has been completed the ED will consist of 24 bays in majors, seven bays in resuscitation and 10 bays in the clinical decisions unit (CDU).The staff and managers were passionate about the refurbishment and had a clear vision and strategy on how this would operate in order to improve patient experience and long standing capacity and flow problems.
- Staff described a vision of providing high quality care to patients in a modern bigger department once the refurbishment had been completed.
- Staff had a good awareness of the urgent care improvement programme. The programme included work streams, objectives and outcomes supported by a governance structure. Progress of the programme was monitored at departmental and EMP meetings. There was a noticeboard within the department, which showed progress made to date and forthcoming changes. This meant staff were kept informed of any changes that may affect them.
- Staff were aware of the overarching new vision and values of the trust, which had an acronym of BEST. This stood for bold, every person counts, sharing and open together. The values were incorporated into staff induction and the appraisal process. Staff were able to describe the values and how they embedded them into their practice. Staff said they thought the values empowered them to challenge poor practice and inappropriate behaviour from colleagues.
- Staff and managers were committed to exploring new innovations and different ways of working to find solutions to resolve issues hindering improvement.
- Staff displayed the values across the department and staff had them attached to their hospital identification badge.
- There was a high level unplanned care (EP) deliverables plan for July to November 2016.This was a comprehensive plan, which contained milestones and tasks to be undertaken. It detailed who was responsible for the task the current position and the expected completion date of the task. Progress of the plan was monitored through departmental and EMP meetings.

Culture within the service

- Staff morale was low at our last inspection. During this inspection, staff told us staff morale had improved and things were starting to settle down with teams starting to work together.
- Staff told us the department had been on under a lot of pressure for an extended period, but now felt empowered that they could make positive changes.
- The trust target for turnover rate was 8%. Between October 2015 and September 2016, the trust reported a turnover rate of 16% for nursing and midwifery staff in urgent and emergency care, which was above the trust target.

Urgent and emergency services

- The trust target for sickness rate was 4%. Between October 2015 and September 2016, the trust reported a sickness rate of 6% for nursing and midwifery staff in urgent and emergency care, which was above the trust target.
- Staff felt they were “Moving in the right direction” and had confidence the leadership team could improve the services provided to patients.
- During our last inspection senior nurses felt unsupported in their role and one told us, they had "Been left to get on with it." Senior nurses now felt supported and were confident when they requested help from the leadership team they would receive it.
- Staff were very positive about the senior executive team and said they felt comfortable to approach them and confident any concerns would be listened to and acted upon.
- Staff who had recently joined the department described it as a supportive place to work, where there was an emphasis on creating a learning and teaching culture. A mentor supported students and new starters whilst they settled into the department.
- We saw there were positive respectful interactions between all levels of staff.
- Domestic staff were employed by the trust, we spoke to four members of domestic staff who all took pride in their work.
- Staff described and open transparent culture where everyone felt comfortable to raise concerns without fear.
- We received positive feedback from medical staff about the consultants in the ED. Medical staff said they always felt supported and were always able to obtain consultant input when required. In addition, nursing staff found consultants supportive and always available for advice.

Public engagement

- Visitors were encouraged to submit suggestions and feedback to the department through comment cards and social media.
- Patients could complete the friends and family test (FFT) via either an electronic tablet or pen and paper, depending on preference.
- There were posters advertising dates for the monthly ‘meet the matron’ events. This gave patients and visitors the opportunity to share their experiences of the department with a matron.
- The service used a number of volunteers to assist with some areas of work across the department.
- We saw the trust was now engaging with Healthwatch England, and regularly invited Healthwatch England to have a stall within the hospital to gather feedback from visitors. Healthwatch England is a national independent champion for consumers and users of health and social care in England. This showed that the trust was committed to improving services for patients and that it was listening to the people who used their services.
- The trust organised ‘meet your governor’s’ coffee mornings, which invited people to come and feedback their experiences within the hospital.
- A hospital radiobroadcast to patients and the wider community. The radio station was run by volunteers and aimed to provide patients with entertainment and information. Programmes were run 24-hours a day, seven days a week.
- The trust agreed a community engagement strategy in 2016.The strategy aimed to inform, engage and consult the public before they make any significant changes that affect services, and to forge links with the diverse communities they serve.

Staff engagement

- The trust had a freedom to speak up guardian (FTSUG). The FTSUG had a key role in helping raise the profile of growing concerns in the organisation and provide confidential advice and support to staff in relation to concerns about patient safety and/or the way the trust handled their concern.
- Staff were aware of access to a confidential support line, manned by staff trained to listen and provide confidential advice and support for staff.
- Staff had developed an urgent care improvement programme noticeboard that showed future improvement plans and were proud of the changes made since our last inspection, which we saw. Previous ED staff survey findings had been negative, examples included, senior management fail to involve team in

decisions and feedback, staff not given feedback about changes made in response to reported errors, not involved in deciding changes that affect work and no appraisal/review in last 12 months. The senior leadership team had developed an action plan to address the issues raised within the staff survey. For example, over the past year, the frequency and regularity of the team meetings had increased with more detailed feedback from the team and actions taken and all appraisals had been booked. This demonstrated the leadership team had responded to the concerns raised by staff in the survey.

- The trust had launched a "MediLead" programme with the purpose of empowering junior doctors who were new to the trust to talk about their ideas with colleagues. Doctors applied to be part of the programme and as part of their application, each doctor identified a project to work on with the support of senior doctors, nurses and managers as part of their leadership development. An example of a project undertaken included, improving the training and quality of echocardiograms (heart tracing) (ECG's) performed by nurses and junior doctors, which benefited patients' in smoother diagnostics.
- There was a variety of news bulletins sent to staff both by the department and the trust. This ensured that staff were kept up to date with issues that affected them.
- The trust response rate in the 2016 staff survey was 50% which was the best response rate in over five years and was better than the average (40%).
- In the 2016 staff survey,61% of all staff said if a friend or relative needed treatment would be happy with the standard of care provided by the organisation, this was an improvement from the previous years staff survey(51%).
- In the same survey, 58% of all staff said they received regular updates on patient/service feedback in my department/directorate, this was an improvement from the previous years staff survey (55%).
- In the same survey, 88% of all staff said they knew what their responsibilities were, this was broadly in line with the previous years staff survey.
- In the same survey, 83% of all staff said they were able to do their job to a standard they were pleased with, this was an improvement from the previous years staff survey (79%).

Innovation, improvement and sustainability

- The trust introduced a new three-phase strategy early in 2015 to address the ongoing unsafe care practices within ED. An observational investigation undertaken during September 2015 identified serious concerns, highlighted in previous inspections.
- Phase one of redevelopment focused on establishing patient safety, a strategy was developed and implemented on the 22 February 2016. Several standing operating procedures were developed to guide clinical practice.
- Measures were put in place to risk assess patients on arrival with a new initial assessment and triage process and tool. This resulted in patients being allocated to an appropriate area and stopped seriously ill patients being left in a corridor. Since October 2016, the corridor has stopped being used to care for patients.
- In February 2016, the trust launched a new way of providing care for people within the ED, underpinned by a new triage system developed by a team of specialist clinicians and overseen by the educational lead and consultant nurse. The project was developed and launched to provide an improved service aimed at providing each patient with a high quality safe care that was respectful of individual dignity and respect. The project had made a number of changes, which were more responsive and met the needs of the local people. For example, the new rapid assessment process.
- A significant number of patients attended the ED with needs relating to frailty. To ensure they received appropriate care, an Acute Frailty Model was implemented. A frailty lead and team of frailty practitioners were in post to support discharge packages and reduce the risk of readmission.
- A multidisciplinary crisis response team had been launched, to prevent unnecessary hospital admissions. This meant staff could refer patients to the team who could visit patients at home and ensured support was provided in order for the patient to stay at home.

Urgent and emergency services

- A learning and development board was established with monthly meetings that began correlating strategy, education and staffing. This resulted in several educational initiatives that would improve leadership within the ED and that would promote understanding of the need to change including, a work-based MSc or BSc in Emergency Nursing, a minor injury course and a two day course for all new starters focusing on specialist knowledge.
- Multidisciplinary team away days and clinical governance sessions were undertaken. The band seven's in the ED had recently been on an away day. Many had worked at the trust for many years and said it was the first one they had been to. They described it as a positive experience and a chance to share ideas for future areas of development, for example, expanding the emergency nurse practitioner role.
- There had been the development of an 18-month newly qualified nurse programme. This was aimed at supporting the development of a new workforce.
- Two local universities approved the ED as a training area for student nurses from June 2016, as the hospital met their assurance requirements.
- The trust introduced policies to support increasingly effective patient management and safety in and out of the ED. For example the frailty service.
- Information technology systems had been put in place to support safety, flow and data collection.
- Managers used audits to closely monitor change and progression of new practices. These were fed back at a variety of meetings introduced to increase staff awareness of good practice. Staff we spoke with were aware of the changes and the impact these had on improving patient care.
- Phase two of the urgent care improvement programme was in progress and focused on improving operational performance and working towards the four hour admit or discharge 95% national standard.
- The department had developed and implemented the role of associate practitioner (AP). The AP role was intended to free up nurses to make better use of their professional skills and improve patient outcomes.
- The trust had launched a new medical model and the ED was a pivotal part of the model. The trust had designed the medical model to improve effectiveness and flow through the department.
- Physical space in the ED had been reorganised so when patients book in for treatment they were in a separate area of the ED away from the main entrance. This meant there was an area where staff could closely monitor patients and respond quickly if their condition worsened. This also gave ED patients a better overall experience.
- The major refurbishment of the ED was designed to further improve the use of space, with completion expected in December 2017.
- An education programme had been rolled out that included continuous professional training and development for every clinical member of staff.
- Medway Clinical Commissioning Group (CCG) and Swale CCG reported that significant improvements had been made within the ED. For example, the senior nursing team had an impact on the quality of care provided, nursing workforce was more stable with a significant increase in substantive staff employed. In addition, there was effective use of national early warning scores (NEWS), meaningful assessment of patients and improved ambulance turnaround times. However, they also reported that poor flow out of the department could inhibit sustained improvements in quality and safety of patient care.
- At this inspection, we saw there was a proactive approach to exploring different ways of working and the introduction of innovative projects and job roles.

Medical care (including older people's care)

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

Information about the service

The medical care service at Medway NHS Foundation Trust is managed by the acute and continuing care directorate. It provides a range of medical services including endoscopy, cardiology, cancer services, coronary care, gastroenterology, neurology and thoracic medicine. There are 296 medical care inpatient beds located across 13 wards and units. There are no day-case beds. The hospital had 26,340 admissions to medical care between April 2015 and March 2016.

The endoscopy service has Joint Advisory Group (JAG) accreditation and carries out approximately 10,000 procedures each year. Endoscopy involves looking inside the body for medical reasons using an endoscope. An endoscope is an instrument used to examine the interior of a hollow organ or cavity of the body. The most common procedures are colonoscopy (investigation of the large bowel), gastroscopy (investigation of the stomach) and flexible sigmoidoscopy (investigation of the left side of the bowel).

We inspected medical care services as part of our comprehensive inspection published in January 2016. At that inspection, we judged that overall the service was inadequate for all domains except caring, which we rated good. Since the last inspection the trust has closed 49 medical care inpatient beds and introduced a new medical model. The aim of the medical model is to improve the care and safety of patients while they are in hospital. For an individual patient this means no more than two consultants will manage their care, reducing mortality rates and improving discharge planning. The Lister Ambulatory Assessment Centre (AAC) is a key part in supporting the model. Patients can be treated in AAC for many conditions, such as deep vein thrombosis or chronic obstructive pulmonary disorder and be discharged the same day. This avoids unnecessary admissions and better use of hospital beds.

During our announced inspection, we visited a selection of wards including: Will Adams, Tennyson, Byron, Kingfisher, Wakeley, Harvey, Nelson, Dickens, Bronte, Keats, the admission and discharge lounge, Galton Day Unit (Chemotherapy Day Unit), the AAC and endoscopy. We carried out an unannounced inspection on 6 December 2016 where we revisited AAC, Will Adams and Bronte wards.

To help us understand and judge the quality of care in medical care services at Medway Maritime Hospital we used a variety of methods to gather evidence. We spoke with 72 members of staff and observed the care provided by medical, nursing and support staff in the departments visited. We interviewed the directorate management team. We spoke with 13 patients receiving medical care and five friends and family. We observed care and the environment and looked at the medical records and medicine administration records of 12 patients. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the hospital and trust.

Medical care (including older people's care)

Summary of findings

At our last inspection we rated medical care services as inadequate. On this inspection we have changed the rating to good because we have identified improvements in the service. We have seen significant changes in key areas to keep people safe and provide effective well led care. The reporting and learning of incidents was embedded in practice, medicines were stored appropriately, the service participated in local and national audits and patient outcomes were monitored. Additionally the service was responsive to patient's individual needs, discharge planning was evident and a clear leadership strategy was in place. Overall we rated medical care service at Medway NHS Foundation Trust as good because:

- We found learning from incidents embedded in practice and rates of harm free care had improved. We observed medicines were appropriately stored and confidential patient records were generally stored securely.
- Clinical environments were visibly clean. Staff in all departments used appropriate hand hygiene techniques and complied with the trust's policies and guidance on the use of personal protective equipment.
- Mandatory training was being completed which meant staff had the necessary current skills to do their job. Staff were aware of their responsibilities concerning the protection of people in vulnerable circumstances.
- Overall we judged there was sufficient medical and nursing staff with the appropriate skill mix to meet the needs of the patients on a day to day basis, although there was a reliance on temporary staff.
- We found care and treatment reflected current national guidance. There were formal systems for collecting comparative data regarding patient outcomes. Services were generally available seven days a week. There were adequate arrangements to ensure patients received adequate pain relief and had enough to eat and drink.
- We observed staff interactions and relationships with patients and those close to them were caring and supportive. They responded with compassion to pain, emotional distress and other fundamental needs. Staff treated patients with dignity and respect and people felt supported and cared for as a result.
- Services were responsive to people's needs as patients were able to access the care they needed and there was adequate management of demand and patient flow throughout the hospital. Discharge planning had improved since our last inspection with a reduction in levels of delayed transfer of care.
- The vision and values of the organisation had been developed and were understood by staff. The leadership of the service had been restructured which provided stability for staff. This meant there was a clear focus on achieving objectives. Governance processes were evident at ward, divisional, hospital and corporate level. This allowed for monitoring of the service and learning from incidents, complaints and results of audits. Staff were positive about working for the trust, and spoke with pride about how far the trust had come in such a short time. They told us they now felt valued and that their opinion mattered.

However:

- Patients were frequently treated in mixed sex wards and there was a lack of understanding by staff of the regulations regarding same sex accommodation. The trust had reduced the average length of stay of medical care patients since the last inspection but this remained worse than the national average. Additionally medical care services were not meeting national standards for referral to treatment times (RTT).
- Although visibly clean, we found instances where clinical environments were not meeting the National Specifications of Cleanliness (NSC). This meant there was inconsistency of cleaning standards across the very high risk areas and potentially an increase in the risk of hospital acquired infections.

Medical care (including older people's care)

- We saw the trust was not following national guidelines for the gas used to administer nebulisers. We found individual prescriptions did not clarify this and could be harmful to patients.
- There were inconsistencies in the suitable number of staff receiving training at the appropriate level for safeguarding vulnerable adults. Local managers did not always support staff in their development as not all staff received a regular annual appraisal.

Are medical care services safe?

Good

At our previous inspection in 2015, we rated the service as inadequate for safety. On this inspection, we have changed the rating to good because we have seen significant changes in key areas such as staffing levels, storage of medicines, risk of infection in clinical environments and the way incidents were monitored. We rated safe as Good because:

- The trust provided us with the incidents relating to medical care services at the hospital with evidence of learning achieved and the resulting changes in practice that took place. The trust used an electronic incident reporting system and learning was embedded. Staff gave us examples of how they reported incidents and the feedback they received. Staff informed us that they were encouraged to report incidents to enable learning as an organisation.
- Staff in all departments used appropriate hand hygiene techniques and complied with the trust's policies and guidance on the use of personal protective equipment.
- Medicines were stored appropriately with the relevant checks in place. Confidential patient records were generally securely stored.
- Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances.
- Mandatory training was being completed meaning staff had the necessary current skills to do their job.
- Overall, we judged there was sufficient medical staff with the appropriate skill mix to meet the needs of the patients on a day- to-day basis. We found there were sufficient numbers of nurses on duty based on the hospital's own assessment of need but there was still a reliance on temporary staff.

However:

- Although visibly clean, we found instances where clinical environments were not meeting the National

Specifications of Cleanliness (NSC). This meant there was inconsistency of cleaning standards across the very high risk areas and potentially an increase in the risk of hospital acquired infections.

- We saw the trust was not following national guidelines for the gas used to administer nebulisers. We found individual prescriptions did not clarify this and this could be harmful to patients.
- There were inconsistencies in the number of appropriate staff receiving appropriate training for safeguarding vulnerable adults.

Incidents

- Between September 2015 and August 2016, Medway NHS Foundation Trust did not report any incidents classified as Never Events for medicine. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Medway NHS Foundation Trust reported 16 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England between September 2015 and August 2016. Of these nine (56%) were slips trips and falls, three (19%) were grade 2 pressure ulcers and two (12%) related to delays in treatment.
- There were arrangements to ensure serious incidents were investigated promptly through a root cause analysis and actions were taken. We saw examples of these investigations and noted they were sufficiently thorough, identified lessons learnt and actions to be taken. Staff told us, and we saw from meeting minutes, information regarding serious incidents was shared with staff. We saw outcomes were discussed with staff in handovers and ward meetings. There was suitable discussion about the lessons learnt and changes in practice needed to prevent recurrence.
- The trust had an incident report writing policy and used an electronic incident reporting system. Staff told us the trust encouraged them to report incidents to help the whole organisation learn. We saw the incident reporting process had been embedded across the directorate. All staff, except agency staff, could access the system and staff gave us examples of how they reported incidents. Managers ensured staff received feedback. We saw staff discuss incidents at team meetings and daily safety huddles. Managers displayed incident data on staff notice boards.
- There were 1,846 safety incidents reported for medical care services between September 2015 and September 2016. Of these, staff reported nine as deaths, 17 resulting in severe harm, 63 as moderate harm, 515 as low harm and 1,242 resulted in no harm. The high numbers of low and no harm incidents reported suggested a good reporting culture. The most frequently reported incident type was slips, trips and falls (38%), followed by delay and/or failure to monitor (38%).
- Out of the 1,846 clinical incidents reported we looked at a sample of 341. The majority of incidents related to pressure ulcers (73) and patients' slips, trips and falls (74). Other incidents related to medication errors (43), documentation (40), staffing levels (21), failure to recognise the deteriorating patient (12) and nine incidents reported regarding aggressive patients.
- The trust had a monthly mortality meeting and a separate meeting with the clinical commissioning group (CCG). Each clinical speciality held monthly mortality and morbidity meetings where they reviewed the care of patients who had died or experienced complications during treatment. This was an improvement since our last inspection when meetings were not being held at the expected frequency. We looked at the minutes of these meetings, which showed staff had detailed discussions of the care of patients and learning and action points were identified.
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The trust apologised and informed people of the actions they

had taken. We reviewed a sample of trust wide clinical incidents, patient's notes and root cause analysis and saw evidence that staff had applied the duty of candour appropriately.

Safety thermometer

- The hospital used the NHS safety thermometer which is a national improvement tool for measuring, monitoring and analysing harm. It provides a monthly snapshot audit of the prevalence of avoidable harms and measures the proportion of patients that experience 'harm free' days from pressure ulcers, falls and catheter associated urinary tract infections.
- Since the inspection in August 2015 there was a trust wide promotion of awareness and collection of data. This meant ward staff were able to track trends in improvement, identify emerging concerns and reduce the rate of harm free care. The previous inspection showed the rate of harm free care was 86% and was consistently worse than the national average across the trust. At the time of this inspection, the data showed the position was improving trust wide and in August 2016, the average rate of harm free care had increased to 93% with a target of 95%
- Between November 2015 and November 2016 data from the safety thermometer showed the trust reported 37 pressure ulcers (grades 2, 3 and 4). The rate had reduced significantly and this was due to an increase of pressure awareness training received by staff. The hospital used a recognised pressure ulcer risk assessment guide for registered nurses for when a patient's condition changed and may be at risk of a pressure sore. Staff displayed pressure area aware posters, which they could refer to when required. The completion of the daily care round checklist ensured those at risk were monitored and repositioned on a two hourly regime. Staff on Bronte ward were proud to show us the information displayed which demonstrated the ward had been without a pressure sore for 400 days.
- A fall is defined as an unplanned or unintentional descent to the floor, with or without injury, regardless of cause. Data from the safety thermometer showed that the trust reported 10 falls with harm between November 2015 and November 2016. During August 2016 there were three falls reported with moderate or severe harm and the trust was in the process of completing the root cause analysis. There was a trust wide falls programme in place with a post fall protocol. Staff were able to show us how they could access the protocol and we saw patient records displayed a post fall checklist for relevant patients.
- The safety thermometer showed between November 2015 and November 2016, 17 urinary tract infections were recorded for patients with a catheter. The collection of the data enables the provider to monitor patients who had developed an infection since admission.
- Key safety information such as days since last fall, incidence of pressure damage or avoidable infection relevant to individual wards was displayed at ward entrances. We saw this was in a format that was easily understandable to patients and their families.

Cleanliness, infection control and hygiene

- All the areas we visited in the medical care services were visibly clean and tidy. We observed cleaning schedules and the results of cleaning audits were displayed in the clinical areas we visited.
- The National Specifications of Cleanliness (NSC) requires hospitals to risk rate clinical areas and sets out learning standards, frequencies and monitoring arrangements for each risk category. The NSC states that all very high risk areas have to be audited weekly and can drop to monthly if they pass the required percentage on a regular basis and managers are confident that the scores can be maintained. The NSC requires trusts to achieve a percentage pass rate of 95%. The trusts operational cleaning plan 2.11 Identifying risk states, 'the pass rate for this category is 98% and are to be audited weekly'. We found the trusts audit process was not following their operational cleaning plan or the guidance as set out in the NSC. We checked the monthly audits for 15 high risk areas between April and November 2016 and three of these were in medical care services. These three areas failed to meet the percentage required by the NSC and the trust and were Endoscopy (62.5%), Bronte ward (25%) and Lawrence ward (50%). We saw there was no evidence of re-auditing of any of the areas that failed to meet the required standard. In section 2.14 of the trusts operational cleaning plan it

states, 'if an area falls below the expected category pass rate a re-audit must be undertaken within 48 hours for very high risk functional areas'. This meant there was inconsistency of cleaning standards across the very high risk areas with an increase in the risk of hospital acquired infections. However, since our last inspection the trust had reviewed their auditing process and enhanced the standards and targets required.

- We saw staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines on hand hygiene in health care. We looked at the results of the acute and continuing care directorate monthly hand hygiene audits. The overall score between April and November 2016 was 98%. We looked at 15 areas and the results ranged from 66% to 100%. We saw the hand hygiene audit scores were displayed in ward areas and generally these were above 93%.
- There were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. Information was displayed demonstrating the 'five moments for hand hygiene' near hand washing sinks. Sanitising hand gel was readily available throughout the wards and the hospital.
- On wards we visited we found some patients were isolated for infection control reasons. These patients were nursed in single rooms and we saw necessary precautions were clearly displayed on the doors and staff observed these precautions. We saw personal protective equipment was available for all staff and staff used it in an appropriate manner. We noted staff used soap and water after contact with patients with infections when hand sanitizer would have been ineffective.
- People in hospital are particularly at risk of an MRSA infection and screening is usually carried out in people who need to be admitted to hospital for planned or emergency care as per national guidance. We saw staff on the wards swabbing appropriate patients and the results of the trust wide audits for MRSA screening compliance between April and November 2016. The medical care wards scored 94% for admission screening, 90% for weekly screening for relevant patients and 61% for patient management.
- The trust had a target of no cases of MRSA blood stream infection for 2016/17. Between April and September 2016 there were two cases reported and were both attributed to the trust. There were eight MSSA blood stream infections during the same period.
- During April to September 2016 there were 13 cases of C difficile related diarrhoea infection on admission and three of these were after 72 hours admission. This was worse than the trust target of two per month.
- We saw patients with indwelling devices such as urinary catheters had care planned as care bundles in line with Department of Health Guidance Saving Lives 2011. We saw these care bundles in use and saw they were consistently completed by staff. The trust audited saving lives compliance on a monthly basis and between April and November 2016, 80% of relevant wards in the directorate were compliant and 87% trust wide. This showed that care was being given in accordance with national guidelines.
- There were systems to ensure commodes were kept clean. We saw completed checklists which showed they were thoroughly cleaned each day irrespective of use and periodic checks by a senior nurse. There were monthly commode cleaning audits and we saw the results between April and November 2016. The results ranged from 78% to 100% with an average score of 93%. The majority of areas scored 100%. We saw staff clean commodes after each use using disinfectant wipes and 'I am clean' labels applied. We checked a number of commodes and they were all visibly clean.
- Equipment which was shared between patients was cleaned after each use using disinfectant wipes. We observed staff doing this. We saw staff clean equipment between patient uses and apply 'I'm clean' labels. This indicated equipment was clean and ready for use. All the equipment we looked at was visibly clean.
- We saw disposable curtains used in all ward areas, dates on them indicated they had been changed within six months in accordance with industry standards and trust policy.

- Waste in the wards and clinical areas were separated and in different coloured bags to identify the different categories of waste. This was in accordance with the Department of Health (DH) Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.
- We saw sharps bins were available in treatment and clinical areas where sharps may be used. This demonstrated compliance with health and safety sharps regulations 2013, 5(1)d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the labels on sharps bins had been fully completed which ensured traceability of each container.
- The endoscopy suite had separate clean and dirty utility areas for the preparation and cleaning of equipment which minimised the risks of infection to patients. Staff transported dirty endoscopes from the treatment area to the dirty area in a covered, solid walled, leak proof container. This was in line with the Health and Safety Executive (HSE) Standards and Recommended Practices for Endoscope reprocessing Units, QPSD-D-005-2.2.
- In the endoscopy department, we saw there were adequate systems to ensure that endoscopes were safely decontaminated. We saw documentary evidence showing that the use of scopes was tracked and the use of a specific endoscope was linked to each procedure. Staff we spoke with could explain the correct decontamination process. Staff stored scopes safely in a drying cabinet for up to three days. There were processes in place to ensure staff reprocessed scopes at the appropriate time.
- We saw mandatory training records which showed us by October 2016, 96% non-clinical and 77% clinical staff in the directorate had completed infection control training. The trust target was 80%.

Environment and equipment

- Emergency equipment was located on all wards and in the endoscopy unit. The resuscitation trolleys contained all the required equipment including a defibrillator, to manage a medical emergency such as a cardiac arrest. We saw the trolleys were secure and fully stocked and ready for immediate use. All equipment needed was available, as indicated by an equipment list. All consumables were in date. There was a system for checking these daily with a more thorough weekly check. We saw the fully completed records of checks. Staff checked the trolley on the endoscopy unit was checked on the days the department was open. The records clearly stated 'not in use' on the days the unit was not open.
- Managers assessed staff to ensure competency before they used any medical devices, for example the glucometer, a medical device used for determining the approximate concentration of glucose in the blood. We saw examples of competency assessments in staff records, which were kept in ward areas.
- Staff reported no problems with equipment and felt they had enough equipment to run the service. We were told there were no issues around securing the necessary equipment for individual patients, for example pressure relieving mattresses and hoists. Staff on Dickens ward told us the service from the equipment library was efficient.
- We saw clinical equipment was maintained by the electrical medical equipment department and maintenance assurance for the equipment was provided by a colour coded labelling system. All the equipment we looked at had a green label which showed the equipment was serviced and in date. An amber label showed the service was due and scheduled, and red showed the service was out of date. All staff checked the equipment before use and reported equipment found to be non-compliant.
- The mattresses used by the hospital were fit for purpose and provided protection from infection and pressure damage. Staff could access specialist mattresses for patients where the risk of pressure damage was particularly high.
- At the previous inspection, we observed some wards were cramped, old and in some cases difficult to maintain. There was insufficient storage space and the decorative state of the ward was variable. We saw on this inspection the maintenance department had responded to this and there was an ongoing programme of maintenance and repairs. Staff generally used storage areas appropriately.

- Access to clinical areas was controlled by entry phone systems. We noted that all systems were working. We saw posters reminding visitors not to let other visitors 'tailgate' on entry. We were asked to show our identification when we entered ward areas. Therefore, staff controlled the access of unauthorised people to ward areas and access to patients to ensure their safety.
- We saw the records of food fridge temperatures on Dickens ward. They were consistently checked and within safe range.
- The endoscopy lead told us the number and size of endoscopes met the needs of the service. We saw a variety of scopes available to perform a variety of examinations. We saw equipment was maintained by an external contractor and we saw the equipment was labelled to show it had been maintained at the required frequencies. We saw competency certificates in endoscopy which indicated staff were competent in a variety of procedures and in the decontamination of equipment.

Medicines

- The trust had a medicines management policy dated 2016. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of drugs. We observed the administration of medicines met the guidance issued by the Nursing and Midwifery Council standards of medicines management 2015.
- The trust had a medicines management for controlled drugs (CD's) policy, procedures and guidance dated 2015. CD's are medicines that are liable for misuse and have additional legal requirements regarding their storage, prescription and administration. We saw on the wards we visited, Galton Day Unit (Chemotherapy Day Unit) and the endoscopy department, two members of qualified staff completed CD checks daily. We saw CD stock books were completed to record the checks and were signed and witnessed throughout books. We saw on ACC the checks were completed daily by permanent day time staff. Spot checks on balances during the inspection showed contents of the cupboards matched the registers.
- Medicines were stored securely to minimise unauthorised access. We saw medicine cupboards, fridges and trolleys were locked. The nurse in charge on the wards and department areas held the keys and only authorised staff had access to keys to the cupboards. Doors to medicine rooms had a key pad lock and only authorised staff had access. We saw the doors were secure and locked. Bedside medicines storage containers for patients own medicines were also locked.
- We saw medicines trolleys and fridges were clean and tidy. We found all the items stored were within date and there was a system of expiry date checks by pharmacy.
- The prescriptions we looked at met legal requirements and were legible, signed and contained information about people's allergies. We saw on Galton Day Unit prescriptions were stored securely and serial numbers tracked in line with national guidance. In ACC community prescriptions were tracked to ensure access to them was controlled and no prescription forms were missing.
- We checked four prescription charts on Harvey ward and one chart showed a missed dose for a critical medicine. This had not been picked up by staff on the ward. Additionally the dates of administration of medicines were not always written on prescription charts. This meant medicines to be administered for a specific period could be missed or administered for a period longer than prescribed.
- On Galton Day Unit we looked at three prescription charts and we saw on one prescription chart, the final release check of a batch of chemotherapy medicine had not been documented. This meant it was not possible to know if this final check had taken place.
- There were suitable arrangements for the management of chemotherapy medicines on Galton Day Unit. Colour coded chemotherapy bags were used to identify whether chemotherapy was to be delivered to a ward or the day unit. Chemotherapy was stored in a designated refrigerator separate from other medicines as per national legislation.
- Staff gave chemotherapy drugs directly into a patient's vein. A complication of this is a leakage of the drug

from the vein in to the surrounding tissue and is called extravasation. Specialised kits were available so any extravasation events could be dealt with immediately to minimise the risk of harm to the patient.

- Some chemotherapy drugs are harmful to patients and staff. We saw the Galton Day Unit, had kits readily available to deal with chemotherapy spills. Staff had received training in how to use the kit and we saw records which indicated staff checked the kits weekly to ensure they were ready for use.
- We saw there were systems to ensure the secure management of medicines no longer required. On Galton day Unit medicine waste was handled appropriately and on Harvey ward a medicine waste bin was available. However, this was not locked away which meant unauthorised people could access its contents.
- Staff we spoke with told us they knew to obtain advice from the pharmacist or doctor before administering covert medicines. Covert is the term used when medicines are crushed and administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them.
- The trust took part in the NHS medication safety thermometer which follows a three step process in order to identify harm occurring from medication error. The hospital collected data across the whole hospital every three months and the most recent audit was August 2016. Data collection looked at completeness of medicines reconciliation, allergy status, medication omission and identifying harm from high risk medicines. The audit showed the hospital was worse than the national average for all omitted doses, omitted doses excluding valid clinical reason and refused, and medications received within 24 hours. The hospital was better than the national average for omitted critical medicines and documentation of allergy status. Recommended actions were: medications to be ordered in a timely fashion, nurses' documentation of medications administered or missed doses, and disseminate information from audit to matrons and ward managers so areas that required improvement would action this.
- The trust had collaborated with clinical staff to ensure improvements in ward based medicines management. The impact of this was a reduction of omitted critical medicine doses, down to 3.7% in July 2016, medicine reconciliation within 24 hours was 76% and recording of allergy status was 99%. All 12 prescription charts we looked at had allergy status recorded.
- Agency pharmacy staff were not used in clinical areas and each ward had a named pharmacist. However we were told the admissions and discharge lounge did not have a dedicated pharmacist and staff had to liaise with different pharmacists for different specialities. This resulted in delays in receiving medications which delayed discharge.
- On our last inspection, we found staff were not monitoring the ambient room temperatures and the fridge temperatures where medicines were stored. On this inspection we checked temperature monitoring charts for the medicine fridge for the last month in all areas we visited. Generally, staff recorded and monitored fridge temperatures on a daily basis. We saw the medicine fridge in Keats ward had not been checked for five out of 29 days in November. We asked members of staff to explain the purpose of checking the temperatures and they were able to describe the safe temperature ranges for the fridge and at what temperatures they should take action. This provided assurance the wards stored refrigerated medicines within the correct temperature range to maintain their function and safety.
- We saw in all areas visited ambient room temperatures were not being monitored. This meant medicines were potentially being stored at above the manufactures recommended temperatures which could make them less effective. However we were provided with assurances the checking of temperatures was to start hospital wide on 1 December 2016. In the departments we visited we were shown the thermometers and records provided for this task.
- We saw on Bronte ward patients were prescribed nebulisers. However the records did not say whether these were to be driven by oxygen or air and there was no space on the patients notes to specify the driving gas. The National Patient Safety Agency and National

and International Guidelines on the Management of asthma and COPD (the commonest conditions for which a nebuliser is prescribed) state it is important to take care when selecting which gas to use depending on patients individual needs. This meant staff were not taking sufficient precautions to ensure the correct nebuliser driver was used.

Records

- We looked at 12 sets of patient records which were multi-disciplinary and we saw doctors, nurses and therapists contributed to a single document. The records were well maintained and easy to navigate. They 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. The records we viewed were comprehensive, contemporaneous and reflected the care and treatment patients received. However, some of the records we saw on Bronte ward had loose sheets which were at risk of being detached from the rest of the record. Additionally in all the notes we saw the signatures of clinical staff were often not legible and names had not been printed.
- We saw on Wakeley ward admission packs were pre prepared ready for when patients were admitted. These contained pathology request forms, MRSA swabs and assessments for mental capacity, bed rails and evaluation scale for constipation and diarrhoea.
- Staff on the endoscopy unit kept full scope-tracking and traceability records. These indicated each stage of the decontamination process. We saw the audit scope log book was completed and up to date. The service audited these records and we saw results of these audits, which indicated all stages of the process were completed. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014).
- On our last inspection we found confidential patient records were not securely stored. On this inspection we saw paper records were generally stored in locked trolleys and kept securely at the staff stations, which were in constant sight of staff. This maintained security and prevented unauthorised access of patient records. However when we visited Byron ward we saw six sets of patient records left on top of a medicine trolley. The staff did not notice us looking at these records. This meant the records were not secured as per information governance and patients confidentiality was at risk.
- We saw mandatory training records which showed us by October 2016, 86% staff in the directorate had completed information governance training. The trust target was 80%.

Safeguarding

- The trust held an adult safeguarding awareness week in October 2016, and staff we spoke with had a good understanding of what a safeguarding concern might be and who to report this to. We saw there were posters displayed in ward areas advising staff and the public of the steps to take if they felt a person in vulnerable circumstances was being abused, or at risk of abuse. Patients we spoke with told us they felt safe in the hospital.
- Care support workers and registered nurses were able to tell us the steps they would take if they suspected abuse. They knew where to find relevant safeguarding policies and contact numbers using the internal computer system. We were given examples how staff had recognised potentially abusive situations and escalated concerns. Staff went on to tell us how investigations were undertaken and how they participated in these. They told us about the protection plans they introduced in these situations. We saw safeguarding was part of the agenda for the monthly directorate meeting.
- We saw mandatory training records which showed staff in the directorate was worse than the trust target for safeguarding adults. For level 1, 73% of staff were up to date and those requiring level 2 training, 65% were up to date. We also noted 90% (better than the target) were current with safeguarding children level 1; however, those requiring level 2 training, 73% were up to date. Staff in medical care services were not required to be trained to level 3 for safeguarding children.

Mandatory training

- The trust had a programme of mandatory training which staff were required to undertake at specified frequencies, for example annually or biannually. There

was some variation in exact requirements depending on job role, for example, clinical staff were required to train to level 3 in safeguarding children but administration staff were only required to complete level 2. The training programme covered statutory requirements, such as fire training. Managers discussed training at appraisals to ensure staff were aware of the mandatory training they were required to undertake. Much of the training was available as on-line learning packages. Staff we spoke with described the ease of accessing the electronic training packages. Staff on Bronte ward told us they did not get protected time for online training. If they were unable to complete training in working time, they could access the system from home for which they were paid.

- We spoke with ward managers who monitored the completion of mandatory training for their teams. We saw they had electronic systems, which recorded the training that was required, and its completion dates. We saw there was a Red/Amber/Green system in operation to alert them and staff when training was due, or overdue.
- We looked at the mandatory training rates. Between September 2015 and October 2016, overall 83% of all staff were categorised as green and therefore had met the trust target of 80%.
- Agency staff were not included in mandatory training monitoring by the trust. However, the hospital received assurances that all appropriate training had been undertaken by the relevant agencies.

Assessing and responding to patient risk

- We saw in the 12 patient records we reviewed there were risk assessments in key safety areas using nationally validated tools. For example staff assessed the risk of falls and pressure damage. We noted when risks were identified relevant care plans which included control measures were generated. We checked a sample of these control measures and found them to be in place. We saw risk assessments were reviewed and repeated within appropriate and recommended timescales.
- We saw the risks of venous thromboembolism (VTE) were assessed for each patient and appropriate prophylactic measures were in place as a result of this, for example the use of anti-coagulant medication when required.
- Risks, such as falls, were communicated to staff using a symbol displayed on a magnetic whiteboard above each patient's bed.
- We found patients physiological parameters such as pulse and temperature were monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 Acutely Ill Patients in Hospital. We watched observations being taken and noted the technique used to monitor their condition would give accurate results. We checked observation charts and saw physiological parameters were conducted at appropriate frequencies.
- Guidance from NICE CG50 Acutely Ill Patients in Hospital, recommends the use of an early warning scoring system to identify patients whose condition may be deteriorating. The hospital had implemented an education programme of the National Early Warning System (NEWS) and we saw this was routinely used for inpatients where appropriate. We noted on observation charts these scores were calculated consistently and accurately. We tracked several instances of increased scoring, indicating a potential deterioration, and saw where escalation protocols were followed, or the rationale for not doing so was documented. This indicated potential deterioration in a patient's condition was escalated.
- The majority of wards were audited monthly to monitor if observations and NEWS were completed within 12 hourly intervals for all patients. The audit monitored if the NEWS score triggered an action plan for the patient. The audits showed 93% compliance across the hospital between February and August 2016.
- There were arrangements for staff to access a critical care outreach team to support and advice in the care of the very sick or deteriorating patients 24 hours a day. We saw examples of patient's records where the outreach team had responded to requests to support

staff in the care of acutely unwell or deteriorating patients. Ward staff told us the outreach team was easy to contact and responded quickly to calls for assistance and they valued the support they provided.

- We saw there was adequate resuscitation equipment and it was easily accessible. Staff knew where they were located.
- We saw an alert system could be quickly cascaded through the hospital to ensure they were working within the national framework for the Medicines and Healthcare Products Regulatory Agency (MHRA). This is responsible for ensuring that medicines and medical devices work and are safe.
- The endoscopy service allocated two appointments on the daily schedules the unit was open for emergency appointments. Out of hours patients were added to the emergency surgical list where one theatre was reserved for emergencies.
- We saw all wards we visited had safety huddles at several points throughout the day. The huddles included all members of the multidisciplinary team and encouraged a two way conversation about patients in their care and allowed staff to have an overview of risks to all patients, not just those allocated to them on that particular shift. We saw these huddles operating. We saw topics such as a deteriorating patient's condition, risks of falls, pressure area care, mental capacity, medicines issues and infection risks were covered. This meant throughout the day risks to patients were being communicated and mitigated in real time. Staff on Wakeley and Keats wards told us the safety huddles had improved patient safety. Additionally safety briefs and board rounds on the wards by senior nurses supported hospital staff at night. An audit by the senior resuscitation officer demonstrated the huddles were embedded into daily practice.
- We saw mandatory training records which showed as of October 2016, 62% clinical staff in the directorate were categorised as red (i.e. not up to date) with adult life support training. This meant patients were at risk as staff were not up to date with current best practice.

Nursing staffing

- As of August 2016 medical care services there were 143.3 whole time equivalents (WTE) registered nurses and 166.6 WTE non-registered staff. All wards in medical care services used an electronic ward rostering system. Senior nurses told us this enabled them to have a much clearer overview of current and future staffing issues.
- The trust used an acuity tool to determine safer staffing numbers and was based on a standard of registered nurse to patient ratios of 1:8 recommended by NICE and a ratio of 6:4 registered nurses to support workers recommended by the Royal College of Nursing. Overall we found in medical care services there were sufficient numbers of nurses on duty based on their own assessment of need but there was a reliance on temporary staff.
- Information received from the trust showed shift fill rates were expressed as the percentage by which the actual number of staff on shift fell below the level budgeted for. This was consistently higher than 20% and below 30% for qualified nursing staff, and varied between six and 10% for unqualified nursing staff.
- Staff from agencies filled gaps in nursing rotas. There was a quality framework to ensure agencies used met minimum standards in their operation and staff had the necessary skills, qualifications and experience to do their job and were of good character. Between April 2015 and March 2016, the trust reported a nursing bank and agency usage rate of 29% for medical care services. This was a reduction of 12% of total pay spend since our last inspection.
- The ACC was staffed by permanent staff for day shifts. However the ward was frequently used as an escalation area. This meant the ward was open at night and staffed solely by agency staff. We visited the ward on our unannounced visit and saw the ward was at full capacity with 15 patients present. There were three registered nurses and one support worker present and all were agency staff. The member of staff who had worked there the most often was the senior member of staff.
- We saw the off duty for staff on Will Adams, Dickens and Nelson wards. We saw the staffing levels consisted mainly of agency staff but ward managers told us these were regularly used agency staff. Staff told us

that these regular agency staff were nearly always employed by other local hospitals and were therefore not willing to consider joining the permanent Medway staff.

- We saw there was a comprehensive induction booklet given to agency staff on arrival to the ward which set out operational arrangements and expectations of how the nurse would work and report their actions. We saw these in use on ward areas. We spoke with three agency nurses on our unannounced inspection, who confirmed they had completed their induction booklet. Staff electronically recorded when induction booklets were completed, which could be accessed to check. This was demonstrated to us.
- The endoscopy service was provided by a team of 25 which included a nurse endoscopy specialist, nurses, ward clerks, care support workers and decontamination technicians.
- Managers acknowledged the recruitment and retention of registered nurses to medical care services was a major issue that had an impact on the operation of the service by all grades of staff we spoke with. The trust continued to have oversees recruitment campaigns and were in the process of recruiting regular agency staff to permanent staff. We spoke with two members of staff who confirmed this is what had happened to them.
- There were arrangements for nursing staff to hand over to the following shift. We attended a handover meeting and saw all relevant information to allow staff to meet the immediate needs of patients safely was communicated.

Medical staffing

- Overall, we judged there was sufficient medical staff with an appropriate skill mix to meet the needs of the patients on a day-to-day basis.
- We reviewed the medical staffing skill mix data. Consultants represented 42% of the medical workforce, which was better than the national average of 37%. Rates for junior doctors and registrars were similar to the national average.
- Locum staff, many of whom were employed on a long term basis and helped to ensure continuity of care, generally covered vacancies for specialities in the medical rotas. The highest bank and locum usage was seen in diabetes and endocrine with the highest usage seen in March 2016 with a usage rate of 43%.
- Medical staff for the endoscopy unit included a colorectal surgeon and a gastroenterologist.
- We saw there were three consultants present on the ACC each day the unit was open except when the ward was being used as an escalation ward. The medical registrar was based predominantly in the emergency department. Outside of these hours the consultant on call for the general internal medicine rota provided medical cover.
- Speciality consultants such as cardiologists, renal and respiratory medicine consultants provided an in-reach service to patients on ACC. This ensured patients were seen and reviewed by consultants with relevant skills and expertise in their condition. They also saw patients who were waiting for a bed on their speciality wards daily.
- We spoke with junior doctors who told us there were always two registrars rostered both day and night to cover medical care wards. In addition there were two senior house officers on duty at night. Ward cover varied from ward to ward between 8.30am and 5pm. The standard staffing per speciality ward team was one consultant, one registrar, one senior house officer and one junior doctor across the medical wards.
- Medical outlier wards were covered by two consultants and two junior doctors to support wards housing outlying medical patients between the hours of 9am and 5pm.
- The medical staffing on call shift patterns within the medical care service consisted of one consultant on call over a 24 hour period, contactable by phone and visited when required between 8pm and 8am.
- We saw there were suitable systems for medical staff to hand over care from one shift to the next. There was a handover meeting at 8am where the night team handed patients to the ACC team, in-reach consultants and relevant junior doctors.

Major incident awareness and training

- Fire training was part of mandatory training. We saw records that showed as of October 2016, 87% staff in the directorate had completed fire training, better than the trust target of 80%.
- Staff received face to face and e-learning for fire training and ward evacuation training. We saw in the entrance to wards the fire plan was displayed and the fire officer visited the wards regularly to check compliance and the environment.
- We saw specific equipment was supplied to appropriate wards for evacuation in an emergency. For example, Will Adams ward showed us a specialist mattress to enable the evacuation of patients down the stairs. They showed us records of the training received for the equipment.
- Some staff were required to complete Emergency Preparedness Resilience and Response (EPPR) training. As of 21 November 2016, we saw 157 medical care staff had completed this training. However the trust did not provide figures for how many staff were required to complete this training.

Are medical care services effective?

Good

At our previous inspection in 2015, we rated the service as inadequate for effective. On this inspection, we have changed the rating to good because we have seen significant changes in key areas such as evidence based care, local and national audits and improved patient outcomes.We rated effective as Good because:

- We found care and treatment reflected current national guidance. There were formal systems in place for collecting comparative data regarding patient outcomes.
- Staff worked with other health professionals to provide services for patients. Patients were cared for by staff who had undergone specialist training for the role and who had their competency reviewed.
- Patients received adequate pain relief. Their nutritional status was assessed and patients received food and drink which met their needs in sufficient quantities.
- There were arrangements that enabled patients to access advice and support seven days a week, 24 hours per day.
- Patients provided informed, written consent before commencing their treatment. Where patients lacked capacity to make decisions, staff were able to explain what steps to take to ensure relevant legal requirements were met.

However:

- Managers did not always support staff in their development as not all staff had received an appraisal.

Evidence-based care and treatment

- We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. For example National Institute for Health and Care Excellence (NICE) guidance CG161: falls in older people assessing risk and prevention, QS24: nutrition support in adults, QS3: VTE in adults reducing the risk in hospital, QS66: intravenous (IV) in adults in hospital therapy, QS90: urinary tract infections (UTI) in adults, QS2: stroke quality standard and the Royal College of Physicians national clinical guidelines for stroke.
- We reviewed a range of clinical policies and found that all expected topics were covered by a policy framework, either locally or at trust wide level. We were shown protocols used in the Lister Ambulatory Assessment Centre (AAC). We noted they were referenced and based on relevant NICE guidance.
- Staff were able to access national and local guidelines through the trust's internal computer system. This was readily available to all staff. Staff demonstrated how they could access the system to look for current trust guidelines. We noted there were appropriate links in place to access national guidelines if needed.
- Patient records showed the care patients received was consistent with NICE guidelines and protocols in use at the hospital.
- The hospital participated in National Audits including Sentinel Stroke National Audit Programme (SSNAP), Heart Failure Audit, National Diabetes Inpatient Audit, the Myocardial Ischaemia National Audit Project

(MINAP) and the Lung Cancer Audit. Although this showed medical care services were engaged in a programme of clinical audit as part of their governance arrangements, we were not shown an action plan detailing how the hospital planned to improve the audit results.

- We found in addition to national audits there was a range of local audit activity which was given due consideration and prompted changes to practice and other actions. For example, the quality and safety team undertook a quality review of Harvey Ward (stroke ward) in April 2016, accompanied by a representative from the South East Stroke Network. The review was based on CQCs five domains of safe, effective, caring, responsive and well-led and had a particular focus on workforce, training, leadership, meeting patient needs and bed management. We saw the trust developed an action plan to resolve issues. On-going meetings were arranged between the trust and the CCG's Quality and Safety Team to monitor the plan and ensure on-going development of the service.
- The medical care services participated in the 'Think Glucose' audit, a national initiative to improve in-patient diabetes care, including the use of a 'traffic light' system to give guidance to hospital staff as to which patients should be referred to the in-patient diabetes specialist team. We saw the results for Byron ward who achieved 62% in June 2016 and 84% in October 2016. Staff explained the improvement was due to the introduction of a link nurse for diabetes on the ward who supported staffs awareness and discussed results at safety huddles.
- We saw there was a system for local audits to be formally presented at the directorates audit and governance meetings. This meant results and lessons learnt were shared to improve service.
- The endoscopic services demonstrated compliance with British Society of Gastroenterology (BSG) guidelines. The service had Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy accreditation incorporating the endoscopy global rating scale, which is the quality improvement and assessment tool for the GI endoscopy service. As part of JAG monitoring the hospital demonstrated good audit practice in the department for example, patient sedation levels, consent and note audit, biopsies quality and perforations.

Pain relief

- We saw pain control was an integral part of the delivery of effective care and the specialist palliative care team, the acute pain team and the pharmacy team supported staff. All medications given to patients on discharge were communicated to the patients GP in the discharge letter.
- The trust had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). There were guidelines for prescribing using NICE guidance, for example opioids (a strong pain killer).
- Patient pain scores were completed as part of routine observations and we saw these were completed. A system of scoring 1-10 was in use and this was used to evaluate the effectiveness of pain relief given. We tracked the notes of two patients who had been given 'as required' pain relief. We noted the pain scores were routinely assessed and there was an evaluation recorded of the effectiveness of the pain control given. This meant staff could be sure pain relief prescribed was appropriate to meet patient's needs. This represented an improvement in the recording of the evaluation of as required pain relief since our last inspection.
- Patients we spoke with told us they received adequate pain relief and it was administered promptly when requested.

Nutrition and hydration

- We saw risk assessments were completed by a qualified nurse when patients were admitted to hospital. This included a malnutrition universal screening tool (MUST) which identified patients who were at risk of poor nutrition or dehydration. It included actions to be taken following the nutrition assessment scoring and weight recording. If a patient scored two due to a low BMI, 10% weight loss in six months or had little or no food in the previous five days or more, they were referred to the dietician.

- All records we checked showed MUST scores had been recorded. We noted patients who were identified as at risk, had appropriate nutrition care plans in place.
- We were shown an audit performed to assess whether changes in documentation and increased education had improved compliance with the MUST assessment for inpatients of 48 hours or more. In May 2015 an overall score was 57%, September 58% and February 2016, 63%. This demonstrated the trust policy in the management of patients at risk of malnutrition was not meeting the trust standards which were based on British Association of Parenteral and Enteral Nutrition (BPAEN) guidance. The audit highlighted staff required further education and training to improve areas of concern which were the recording of weight within 48 hours of admission, appropriate intervention (for example red trays, food diary) and appropriate referrals to a dietician. The trust launched a training programme in May 2016 and a specialist nutrition nurse was employed by the trust in September 2016. At the time of inspection the specialist nutrition nurse had completed a trust wide MUST audit (November 2016) and was in the process of submitting the results to the board.
- We saw patients had drinks left within reach and all wards had protected mealtimes. These are periods on a hospital ward when all non-urgent clinical activity stops. During these times patients were able to eat without being interrupted and staff offered assistance.
- We saw food and fluid intake was monitored using food charts and fluid balance charts. There was a 'red-tray' and 'red-jug' system in operation so all staff could identify patients who needed help eating and encouragement to drink. We saw signs were above patients beds indicating when a patient required assistance with eating and drinking and were seen to be unobtrusive and non-judgemental.
- We saw on Bronte ward red trays were used for supporting with feeding and nurses wrote a daily sheet for ward hostesses regarding the trays. The menu consisted of a halal option, soft, vegan, vegetarian, restricted fat and fibre, gluten free, low fat and high energy. The ward hostess kept track of food intake and advised nurses. Additionally they notified the catering manager if they were regularly disposing of a certain type of meal.
- We saw patients who were unable to feed themselves were assisted by the nurses and clinical support workers. On Byron ward we observed staff feeding patients in an appropriate manner. The staff sat at patient level, talked to patients and asked what part of the dinner they wanted to eat. However we saw one patient with a red tray with no one to assist and the patient was visibly frustrated at not having assistance. We asked staff why they were not helping this patient and we were told they were trying to promote independence in the patient and encouraging them to self-feed. We checked the patient's notes and saw there was no written evidence of the patient being independent in either the patient notes or food charts. We spoke with a senior staff member who confirmed staff should be documenting this and the dietician should have updated the care plan.
- On the stroke ward (Harvey) we saw some patients who could not swallow were fed using a PEG (Percutaneous Endoscopic Gastroscopy) feeding tube. We saw these patients had their nutritional needs assessed and monitored by a dietician. The trust had a policy to guide staff and staff we spoke with demonstrated a sound knowledge of the risks of feeding tubes and the care patients with such feeding tubes required.
- We were shown the results of the August 2016 quality and safety of PEG tube insertions for inpatients. The audit showed there were inconsistencies in the documentation of sedation medicines used. Additionally the audit highlighted the trust did not have access to a specialist nurse to review all PEG tubes post insertion. The trust had employed a specialist nutrition nurse in September 2016 in response to the audit. At the time of inspection the specialist nutrition nurse had not completed a re-audit.

Patient outcomes

- The Hospital Standardised Mortality Ratio (HSMR) is a calculation used to monitor death rates in a trust and based on a subset of diagnoses which give rise to around 80% of in-hospital deaths. The national average score is 100 and above that means the trust is worse than the national average. From September 2015 to September 2016 the HSMR showed a reducing

trend although the last two data points had increased. The rate was 100.19 and the hospital was no longer considered an outlier. There was a one point difference between weekdays and weekends.

- Medway Maritime Hospital took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the site achieved grade D in the latest audit, April 2016 and June 2016. Since the previous results (January 2016 to March 2016 the site has improved in one of the team-centred indicators (discharge processes improved from B to A) and deteriorated in two indicators (the stroke unit reduced from D to E and physiotherapy deteriorated from D to E).
- Medway Maritime Hospital results in the 2015 Heart Failure Audit were better than the national average for two of the four of the standards relating to in-hospital care. The hospital scored particularly well for patients having specialist input during their inpatient stay (99% compared to the national average of 80%). However the hospital scored low for being an inpatient on a cardiology ward (33% compared to the national average of 48%). Medway Maritime Hospital results were better than the national average for seven of the nine standards relating to discharge. The hospital scored particularly well for prescribing medicines used to treat high blood pressure on discharge and for being referred to a heart failure nurse for follow up (80% compared to the national average of 70%).
- The 2015 National Diabetes Inpatient Audit showed out of 21 indicators the trust was better than the national average in seven indicators and worse than the England average in ten indicators. There was a large variance for the percentage of patients seen by the trust within 24 hours with none recorded for the trust compared to a national average of 58%. We were told this was due to most of the standards needing to take place in the community and the data could not be split between the community and hospital. This meant the trust was not able to provide the information to demonstrate their performance against the audit standards.
- The last available data for Acute Myocardial Infarction audit (MINAP) was 2013/14 and was reported in our last report.
- The 2015 Lung Cancer Audit showed the proportion of patients seen by a cancer nurse specialist was 95%, which was better than the audit minimum standard of 80% and better than the hospitals 2014 figure which was 93%. The proportion of patients with a group of lung cancers diagnosed histologically called Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 13%, similar to the national level. The proportion of fit patients with advanced NSCLC receiving chemotherapy was 40%; this was significantly worse than the national average (57%). However in 2014 the trust scored 32% for the same standard. The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 59% and similar to the national level.
- Patients in medical care services had a higher than expected risk of readmission for non-elective and elective admissions between March 2015 and February 2016. The overall standardised relative risk for medical emergency admissions was worse than the national average at 115 (any score above 100 shows an increase in risk). The relative risk of readmission was particularly high for elective gastroenterology (130). The standardised average was below the average for non-elective general medicine (98).
- The endoscopy service had two official audit days every year where JAG audits were presented and learning discussed. The unit was closed for this event except for emergencies. We saw the JAG audits showed good caecal intubation rate (CIR, defined so that the entirecaecumis visualized) performance. The CIR is an important indicator of colonoscopy quality. There were clear processes in pace to ensure that all operators maintained a CIR of 95% or above. There was an example of one operator falling below the 95% threshold and being supported to improve and the latest audit demonstrated they were now meeting the CIR rates.

Competent staff

- The trust had an appraisal policy to ensure all staff understood their objectives and how they fit within the departmental and hospital objectives and vision. The trust target for completion of staff appraisals was

95%. We saw data which showed as of October 2016, 84% of staff in the medical care services had received an appraisal. Therefore the service had not met its target.

- However, all staff we spoke with told us they had received an annual appraisal. They told us this process was effective in developing their skills and knowledge further. It also contributed to maintaining registration with the Nursing and Midwifery Council (NMC). We were provided with the example of the discharge specialist nurses who had requested to apply for the practice development nurse and independent prescribing courses during their appraisal. This would be beneficial to the hospital and the discharge service.
- There was a system to ensure nurses remained registered with the NMC which was necessary for them to practice. A ward manager explained and showed us they received an email from the human resources department when a nurse's registration was due to expire. They then checked the NMC website to ensure the nurse had re-registered and kept evidence of this on their ward based personal file.
- We saw posters displayed informing registered nurses of the revalidation requirements introduced by the NMC in April 2016. These included key headlines and sources of further information so nurses could maintain their registration. Staff we spoke with who had already been through the process told us they were fully supported by the hospital and their managers.
- The hospital provided an induction for all agency staff and we saw examples of the induction pack used for agency staff on Keats ward. The hospital worked closely with agencies to ensure competencies were met and provided immediate feedback on areas of concern at individual levels. We spoke with agency staff on the Lister Ambulatory Assessment Centre (AAC) who confirmed their training was completed and checked by the agencies. They had received a local induction and worked as part of the team.
- A student nurse told us there was good mentorship and learning for students. They enjoyed their placements at the hospital and were looking forward to being employed by the trust upon qualifying.
- Newly qualified staff showed us the six month preceptorship programme for newly qualified nurses and also those who had transferred from abroad provided by the trust. We saw the competency and training folders for staff on Keats and Dickens wards. We saw there was a good induction for staff and the practice nurse educator supported staff.
- We saw there was a wide range of specialist nurses, for example palliative care team and discharge co-ordinators, and noted their presence on the wards. Staff told us they felt supported by these specialists and valued their input in ensuring they were delivering competent care.
- Staff told us the trust had launched a transforming care programme in September 2016. This was designed to improve the fundamental aspects of nursing care throughout the trust. This was a matron led programme to help keep patients safe and comfortable. Part of the programme was a 'deteriorating patient' week in October 2016. It provided an opportunity for nursing staff to learn about the many aspects of the programme and what they needed to be doing to ensure they met the fundamental standards of care. The standards were in line with the '3R's' approach: recognising, responding and reporting deteriorating patients or patients of concern. Staff told us they had attended the programme and their awareness had significantly improved as they considered they were now better trained and able to respond to the needs of a deteriorating patient.
- In addition the trust had launched a programme to support and develop junior doctors. The aim of the programme was to empower doctors who were new to the trust to discuss their ideas with colleagues to help create a professional culture where robust challenge and open discussion was valued. Senior clinical staff supported h junior doctors' project work, which focused on patient safety and delivery of efficient services. The doctors were encouraged to submit their work to national conferences and meetings to share learning with other NHS organisations. Junior doctors confirmed they had attended the programme.
- Junior doctors told us they received adequate teaching and supervision. They received two days

induction training and had a named clinical supervisor. There was scheduled weekly teaching sessions on ACC. This included discussion of the case of the week and a journal review.

- Several wards we visited had link persons who were central to disseminating education and support to their local multidisciplinary team. We saw Byron ward had separate link persons for glucose, pressure care, dementia and safeguarding.
- Nursing staff told us they could access training for higher and further education qualifications. For example, the trust supported and funded a nurse on Bronte ward to complete a teaching assignment at the university. However, staff in the admission and discharge lounge and Keats ward told us there was not a clear development programme for band 6 progressions specifically in developing management skills.

Multidisciplinary working

- Part of the medical model was the use of board rounds which involved teams of clinicians working together on behalf of the patient. The relevant consultant and clinical team, including other health care professionals and social care staff discussed each patient on a daily basis. The board round focussed on promoting and ensuring safety as well as working towards an agreed expected discharge date.
- Staff reviewed all patients during board rounds. On the admission wards, these occurred daily at 11.30am on Dickens ward, midday on Wakeley ward and at 9.30am on Byron ward. These were attended by the acute medicine consultant, general medicine consultant, frailty consultant, occupational therapists, physiotherapists, matron and nursing staff. We attended the board round on Dickens ward during the inspection and saw staff discussed risk factors (falls, dementia and diabetes) as well as the plan of discharge. We saw nurses documented the discussions in the patient's notes.
- An emergency medicine physician, duty general medicine physician and representatives from respiratory, cardiology, gastroenterology and frailty medicine attended the daily handover at 8am and a board round at midday, on the ACC.
- The discharge specialist nurses were responsible for all aspects of the discharge process and were allocated specific wards and attended the board rounds and bed meetings. This enabled them to pick up any issues, identify deteriorating patients and patients ready for discharge, chase interventions and highlight if continuing healthcare paperwork was required.
- The integrated discharge team for the hospital worked cohesively with the social teams for Medway and Kent County Councils, continuing healthcare team and care home placement team. There was a multidisciplinary delayed transfer of care meeting weekly and the discharge specialist nurses monitored this daily.
- The hospital respiratory team had regular meetings with community teams and the hospital at home team would support patients with nebulizers to go home early.
- We spoke with staff on Keats ward who told us they had good support from the psychiatry team. They were able to give us examples of the team supporting them with patients who have drug, alcohol and mental health issues.
- Staff on Harvey Ward and Galton Day Unit told us they were happy with pharmacy support available.

Seven-day services

- Staff arranged for patients to be seen daily during a ward round, this included weekends. Medical records we saw confirmed this.
- The endoscopy service provided a service six days a week, Monday to Saturday. The unit was occasionally open on a Sunday to reduce waiting lists.
- The Lister and Ambulatory Care Unit (ACC) was open 8am to 9pm Monday to Friday and 10am to 6pm Saturday and Sundays. Patients on the ACC received a consultant review daily and we saw records to confirm this.
- The integrated discharge team provided a service seven days a week 8am to 8pm.
- The pharmacy was open seven days a week and an emergency drug cupboard provided out of hours use for authorised staff. All nursing staff we spoke with knew about the facility and how to access it. There

was an on-call pharmacy service which staff told us was effective at providing service when required. Pharmacists provided a ward service at the weekends. This meant discharge medicines could be authorised at ward level decreasing dispensing times and waits for patients.

- We saw there were arrangements to ensure key diagnostic services, for example imaging and computed tomography (CT) scanning were available at all times. Medical staff told us they could access services when they needed them.

Access to information

- We saw there were ward based handover sheets for staff to reference. Staff regularly updated these, which contained current and accurate information about patients' needs, treatment plans, risks and their management.
- We attended handover meetings and operational meetings and found there was adequate communication of patient's on-going needs and of any risks to their well-being. Operational issues relevant to the immediate running of the hospital were also discussed.
- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system (PACS). This is medical imaging technology which provides economical storage and convenient access to diagnostic images from multiple machine types.
- Staff sent discharge summaries to GPs on discharge from hospital which we observed.
- Endoscopy patients received a letter on discharge. This included the reason for the procedure, findings, medication and any changes, potential concerns and what to do and details of any follow up. A copy of this letter was send to the patients GP and a copy was kept at the hospital in the patients' medical records. This meant there was a continuity of service and all medical teams were kept informed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All Mental Capacity Act (MCA) training at the trust was delivered under the mandatory adult safeguarding modules. We saw 73% of staff in the medical care service had completed the training by November 2016. This was worse than the trust's target of 80%.
- Staff were generally able to demonstrate an understanding of the MCA such as the need for assessments of capacity, how the assessment should be performed and understanding of best interests.
- We saw assessments of capacity were carried out using a standardised template that ensured the requirements of the MCA Code of Practice issued by the Department of Health were met.
- Staff used a specific consent form for patients undergoing major procedures that lacked the capacity to consent. We checked three of these consent forms and found they demonstrated the reason for the treatment, why it was in the patient's best interests and was the least restrictive option.
- All Deprivation of Liberty Safeguards (DoLS) training at the trust was delivered under the mandatory adult safeguarding modules. We saw 73% of staff in the medical care service had completed the training by October 2016. This was worse than the trust's target of 80%.
- The trust had guidance for staff on the implementation of DoLS which directed staff on the practice and procedures that should be followed when an individual who lacked mental capacity in their best interest, may have to be temporarily or permanently deprived of their liberty. This was to ensure that staff were at all times able to work within the parameters of the MCA. We spoke with staff about their understanding of the appropriate assessment and documentation for DoLS. We found there was an improvement since our last inspection. Staff were able to explain the process and had an understanding of the rationale. Staff on Byron ward told us they completed DoLS assessments when required and sought assistance from the safeguarding lead if required. The safeguarding lead visited the ward weekly to support staff with their understanding and completion of applications.
- We saw the hospital had updated the system for reporting DoLS applications. Staff recorded all DoLS

on the electronic incident reporting system. There were 164 DoLS raised between January and November 2016 on the medical care wards. The hospital had a generic email for staff to use to send DoLS applications and these were all reviewed by the safeguarding team.

- During our unannounced inspection we visited Bronte ward and saw two patients had DoLS and we saw in the patients notes all the relevant assessments and authorisations were in date. This meant staff lawfully deprived patients of their liberty.

Are medical care services caring?

Good

At our previous inspection we rated caring as good for medical care. We have maintained this rating because we observed staff interactions and relationships with patients and those close to them as caring and supportive.We rated the service as good for caring.

We rated caring as good because:

- Staff provided sensitive, caring and individualised personal care to patients. Staff supported patients to cope emotionally with their care and treatment as needed.
- Patients commented positively about the care provided from all staff they interacted with. Staff treated patients courteously and with respect.
- Patients felt well informed and involved in their procedures and care, including their care after discharge.
- Patient's surveys and assessments reflected the friendly, kind and caring patient centred ethos. Our observations of care confirmed this.

Compassionate care

- Medical care services participated in the national Friends and Family Test scheme to gather patient feedback. For the period November 2015 to October 2016 the response rate was worse than the national average at 24%. The percentage of patients that would recommend the trust varied across the wards and on a monthly basis. The lowest recommend rates were recorded on Will Adams Ward (ranging from 8% to 88%) and Keats Ward (54% to 79%). Better recommend rates were recorded on Bronte Ward (68% to 100%), Harvey Ward (50% to 100%), Lawrence Ward (84% to 100%) and Nelson Ward (79% to 97%). We saw wards displayed the results on information boards for all to see. We saw the latest score recorded for the Lister and Ambulatory Care Unit (ACC) Friends and Family Test was 90%.
- We saw the results of the endoscopy unit annual survey that monitored patient's experiences. Staff provided patients with a leaflet and freepost returns envelope during a four-week period in February. The department issued 150 forms and 103 were returned. The 2016 survey asked "were you treated with respect?" (99% positive), "your privacy and dignity respected?" (98% positive), "was the unit pleasant and comfortable?" (94% positive) and "how clean was the unit?" (94% positive). Patients comments included "Staff really kind and patient. I was very nervous, they all put me at ease" and "The service provided was 100%".
- During our inspection we observed staff providing care that was sensitive and compassionate. Staff maintained patients' privacy and dignity. For example, we saw care interventions were carried out behind closed doors or curtains and staff asked before they entered. We observed staff were kind and patient in their approach and we saw numerous examples of difficult situations being sensitively managed.
- We observed the caring nature and enthusiasm of the consultants on the Lister and Ambulatory Care Unit (ACC) who were passionate about the service they were providing.
- Patients told us, and we observed, call-bells were left within reach of patients and were answered promptly. In addition we saw staff respond promptly to requests for assistance.
- We spoke with 13 patients receiving medical care and five of their friends and family who were positive about the care received. Comments included "I feel very safe here as staff constantly check on me and give me reassurance" and "the ward is clean and staff use

hand gel". A patient who had several admissions told us the care received had improved over the last 12 months. They told us "nurses are more friendly, cheerful and responsive".

- We saw thank you cards displayed on Byron and Wakeley wards. Comments included "Just like to thank you for all doing a truly good job", "Your support was needed and much appreciated" and "Thank you for all your care and support it was much appreciated".
- During our unannounced visit we visited three wards early in the morning. All three wards were busy and at full capacity with many challenging patients. However the atmosphere was calm, quiet and patients were receiving the appropriate dignified care.

Understanding and involvement of patients and those close to

- The patients and their relatives we spoke with told us staff were caring and professional. They felt involved in their care and were given adequate information about their diagnosis and treatment. They felt they had time to ask questions and that their questions were answered in a way they could understand.
- We observed staff introducing themselves to patients and their relatives.
- Relatives were encouraged to participate in the care of patients when this was appropriate. For example, we observed relatives assisting with personal care and supporting patients to eat at meal times.

Emotional support

- Patients reported they felt able to discuss their emotional state with staff if required.
- We saw the chaplaincy service visiting the wards and providing emotional support and spiritual care to those patients who wanted it.
- There was a 'dementia buddy' scheme where volunteers came to the wards to carry out activities such as hand massage or listening to music. We saw posters advertising the scheme and the volunteers who provided the service. Staff on the wards who had used the service told us it provided welcome support to those living with dementia.

Are medical care services responsive?

Requires improvement

At our previous inspection in 2015, we rated the service as inadequate for responsive. On this inspection, we have changed the rating to requires improvement because we have seen significant changes in key areas such as discharge planning, managing the demand and flow through the service, responding to individual needs and complaints.Although there were many good things about the service, it breached a regulation relating to same sex accommodation and there were also issues regarding out of hours bed moves and outliers, which meant we cannot give a rating higher than requires improvement.

We rated responsive as Requires Improvement because:

- Patients were frequently treated in mixed sex wards and there was a lack of understanding by staff of the regulations regarding same sex accommodation.
- Medical care services were not meeting national standards for referral to treatment times (RTT).
- The average length of stay (AVLOS) of medical care patients was worse than the national average. However, the trust had reduced the AVLOS since the last inspection which represents an improvement in performance.

However:

- The service delivery was planned to meet the needs of local people with the introduction of a medical model to improve the care and safety of patients while they were in hospital. The Lister Ambulatory Assessment Centre (AAC) was a key part in supporting the model providing rapid access clinics avoiding the need for attendance at the emergency department and unnecessary admissions.
- The average length of stay in the wards had reduced and the hospital had decreased the length of stay over seven days.
- The introduction of the seven day frailty pathway enabled staff to treat the patient quickly to avoid the need for the patient to be admitted to hospital.

- The trust had improved their discharge planning for medically fit patients. The hospitals delayed transfer of care data was one of the lowest in England.
- Medical outliers occurred as patients were cared for in non-speciality areas. However we saw there was no adverse effect on patients.
- The trust's RTT within 18 weeks for admitted pathways for endoscopy services was better than the national overall performance and was being met within three weeks. There were no waiting lists for two weeks wait.
- The service was responsive to the needs of patients living with dementia or learning disabilities with appropriate environments, recognised initiatives and individualised support.
- There were systems to ensure that patient complaints and other feedback was investigated, reviewed and appropriate changes made to improve treatment care and the experience of patients and their supporters.

Service planning and delivery to meet the needs of local people

- Since the last inspection, the hospital had closed 49 medical care inpatient beds and a new medical model had been introduced. The aim of the medical model was to improve the care and safety of patients while they were in hospital as no more than two consultants managed the care of an individual patient. Additionally this would enable the reduction in mortality rates and improving discharge planning. The Lister Ambulatory Assessment Centre (AAC) was a key part in supporting the model. Patients were treated in AAC for many conditions, such as deep vein thrombosis or chronic obstructive pulmonary disorder and were to be discharged the same day. This was to avoid unnecessary admissions and to make better use of hospital beds.
- A part of the AAC was rapid access clinics where GP's could refer patients for urgent consultation opinion. For example, rapid access cardiac clinics or endoscopy appointments. This enabled patients to access specialist care quickly and avoided the need for attendance at the emergency department.
- We saw the AAC worked closely with the local community nursing service 'Hospital at Home' scheme to enable care to be delivered as close to home as possible whenever it was clinically safe to do so. GP's could contact the consultants at the unit for immediate advice to prevent unnecessary admission.
- The hospital had introduced a seven day frailty pathway which worked across primary, community and secondary boundaries. The acute frailty pathway ensured patients with acute frailty were seen at the 'front door' by a specialist multidisciplinary team including a consultant geriatrician and specialist nurse. The team also had access to a range of other specialists including physiotherapy, occupational therapy, dietician and integrated discharge team. The use of the 'FRAIL' tool (Falls, Reduced mobility, Acute confusion, Incontinence and Lots of medications) helped staff to identify frailty. This enabled staff to treat the patient quickly and avoid the need for the patient to be admitted to hospital. The number of patients on the pathway had increased by 86% at the time of inspection.
- Medway is an area with above the national average number of smokers. Since October 2016, senior managers declared Medway NHS Foundation Trust a smoke-free site. The decision to become smoke-free had been taken because the trust recognised smoking had a significant negative impact on people's health, both those people who smoke and who are passive smokers. Becoming smoke-free meant a better environment for all users of the site including patients, visitors and staff. We saw there was a service provided by the trust to assist and support this and was advertised in the main reception and refreshment areas. The trust provided free nicotine replacement therapy to patients on the wards and on-site support staff. We were told a member of staff had thanked the medical director for making the trust smoke free as this had prompted them to give up.

Access and flow

- At our last inspection we found the average length of stay (AVLOS) for emergency admissions to medical care services was eight days. The trust had slightly reduced this figure and we saw that between April 2015 and March 2016 the AVLOS for emergency admissions was 7.9 days. However, this was longer

than the national average of 6.6 days. The trust had reduced the AVLOS for medical elective patients to 4.9 days, which was worse than the national average of 3.9 days.

- Medical care services were not meeting national standards for referral to treatment times (RTT) in some of the smaller areas of the medical service. Between November 2015 and September 2016 no data was submitted to NHS England. Information regarding the non-submission of data and any internal monitoring was not provided by the trust. Data showed in October 2016 the trust's RTT within 18 weeks for admitted pathways for medical care services (78%) was worse than the national overall performance (90%). Data provided for medical specialities RTT within 18 weeks showed cardiology achieved 78% and was worse than the national average (85%).
- The acute admission wards turnover had increased from 50 to 220 admissions per week. The average length of stay in the wards had reduced from five days to two days. The hospital had decreased the length of stay over seven days by 12%.
- Part of the medical model was the use of board rounds which managed the flow of patients coming in and out of the hospital by identifying those patients that were ready for discharge in a timely manner. Board rounds determined which patients were to be discharged that day and these were transferred to the discharge lounge to free up beds. Additionally the use of the medical model was to help in the prevention of unnecessary admission and avoid overnight stays in a significant proportion of people who previously would have been admitted due to a lack of available care in the community.
- There were three bed meetings every day to assist in the effective operational management of the hospital. We attended one meeting. We saw all the relevant stakeholders attended and we considered them well run and focussed.
- We spoke with staff on the AAC. They told us the aim was for patients to receive a rapid review of their condition, to have any diagnostic tests and to commence treatment. If indicated, they were transferred to relevant speciality wards for on-going care otherwise they would be discharged. We were told the aim was for all patients entering the centre to be discharged within a four hour period and those with specific conditions that may require longer period of intensive medical input may remain in the unit for up to eight hours. All patients were to be discharged either home or admitted to a ward within a 12 hour period of time the unit was open. We were shown data between March and November 2016, which showed 5,562 patients, had attended the AAC. Of these 29% had been admitted and 71% had been discharged within the 12 hour period. Of the total, 207 patients were seen at the weekend and 83% had been discharged and 17% admitted.
- We saw a survey of 96 staff members was completed following the implementation the new medical model. In general, the introduction of the model was perceived to have been a success by the majority of medical and nursing staff. Over 71% felt that quality of care had improved and 65% felt safety had improved. Over 80% of staff felt that the effort involved in introducing the Lister Ambulatory Assessment Centre (AAC) and the acute admissions wards (AAW) was clinically worthwhile. However, in relation to the AAW there was a difference in opinion between medical and nursing staff with 93% doctors (96% of consultants) compared to 49% nurses rating the change as worthwhile. The survey noted this difference probably reflected the staffing pressures and stress experienced by nursing staff on the AAWs.
- However the AAC unit was not specifically operating as an ambulatory care ward as it was being used as an escalation ward with patients staying overnight and for longer periods. Between December 2015 and November 2016, 3,995 patients had stayed in the unit overnight. This happened most nights with an average of 25 days a month. On the day of our inspection seven out of the 15 beds were occupied by patients who had stayed on the ward the previous night. We visited the unit on our unannounced visit and saw the ward was at full capacity with 15 patients present. This impeded the ability of the unit to respond promptly to patients needs and to streamline flow through medical care services.

Medical care (including older people's care)

- On this inspection data showed between September 2015 and August 2016, 78% of individuals did not move wards during their admission, and 22% moved once or more. This is an improvement since our last inspection when 62% were not moved at all.
- Our last report showed there were on 14 bed moves out of hours (10pm to 6am) reported in a six month period. There were 1,022 bed moves for patients occurring out of hours between March and August 2016. Wakeley ward had the highest moves with 310. The reason for all bed moves was recorded as clinical need. We asked the directorate managers regarding the vastly increased number of bed moves. They confirmed there was an increase in the data as it had not been accurately collected in the past.
- Due to the lack of beds in medical wards, patients may be placed in other departments' wards (usually in surgical wards) and these patients are called medical outliers. On the day of inspection there were 30 medical outliers across the hospital. We visited a surgical ward, Kingfisher which had two (in a 14 bedded ward) and the surgical assessment unit which had four (in an eight bedded unit). We reviewed the care of these medical patients and we saw there was not an adverse effect on the quality of care for the medical patients. Staff told us and records confirmed there was a designated consultant and their team for each outlier patient who visited each patient everyday by midday.
- Cancer services had improved with an established clinically led service with active and full representation on the cancer board and service multidisciplinary teams. All clinical leads had taken ownership and oversaw the patient experience through multidisciplinary teams and weekly patient tracking list sign off processes. The 62-day GP referral exceeded the target and the national standard in August and was above the national average in August and September 2016. The two-week wait had improved and was compliant in all areas, except dermatology. This was due to rising demand and lack of capacity.
- The endoscopy service was meeting national standards for referral to treatment times (RTT). Data showed in September 2016 the trust's RTT within 18 weeks for admitted pathways for endoscopy services was better than the national overall performance and was being met within three weeks. There were no waiting lists for two weeks wait. Patients who required general anaesthetic were appropriately managed and added to the theatre list when capacity had been identified. We saw only one patient had been on the waiting list for eight weeks due to their co-morbidities and this was better than the national average.
- We saw the trust was not meeting its target of 25% per month of patients to be discharged before 12 noon. Between January and August 2016, 14% of patients were discharged. We saw this was an item agenda on the directorates performance review meeting exception report. The directorate acknowledged the target was affected by the admission and discharge lounge being used as an escalation area which affected the ability to transfer patients waiting for transport.
- Medway Community Health Trust funded and employed an Integrated Discharge Team (IDT) that included nurses, therapists and social care staff. They supported medical care services in the management of patient discharge, especially those with complex needs. They visited the wards daily and attended board rounds to discuss the discharge plans for individual patients.
- The medical model determined all patients were to be given an expected date of discharge (EDD) within 24 hours of admission. The consultant and the medical team agreed any changes to the EDD. At the wards board rounds each patient would be assumed to be having a 'red day' (fit for discharge). Patients were considered to be having a 'green day' only when they were receiving an intervention that could only be done as an inpatient which supported their journey through to discharge.
- Staff told us the trust had undertaken three multi agency discharge events since January 2016 that was supported by the emergency care improvement programme. This was well attended by external partners and commissioners. There had been trust wide training for all ward staff in the completion of continuing healthcare paperwork and these staff were supported by the IDT. This had resulted in the trust being able to discharge medically fit patients more quickly. The hospitals delayed transfer of care for patients medically fit for discharge had reduced from

an average above 110 to an average of 80, which was one of the lowest in England per population. On the day of inspection we saw there were 35 patients medically fit who were waiting for discharge. Of these 26 were waiting for a care package and six were waiting for a nursing home placement.

- The trust had introduced 'home first' for patients who were medically fit but still required additional support at home. Each patient was given a home assessment within two hours of their discharge. This included a personal care plan for their therapy, goals, carer provision and any equipment they required. The 'home first' approach not only ensured patients had a smoother journey on discharge from hospital, it also helped to ease the demand on hospital beds and staff and made better use of community services.
- We saw therapy teams submitted response times for seeing new and existing patients. This was started in August 2016 to enable the teams to monitor their response to referrals as part of the multidisciplinary approach for patient care. We saw the data up to week commencing 21 November 2016. The physiotherapy team saw 98% of new patients on the day of referral and 86% of existing patients seen on expected day excluding agreed exceptions, for example, the patient was unwell. The occupational therapists saw 76% new patients and 82% existing patients. The speech and language therapists saw 77% of patients within two working days and 100% of patients on their routine five-day appointment. The dietetics team saw 100% of patients within two working days and 71% of patients on their routine five-day appointment.

Meeting people's individual needs

- The hospital had multiple breaches of mixed sex accommodation (MSA) rules on a daily basis. The local clinical commissioning group (CCG) had retracted a contract performance notice against the trust in August 2016 in response to the trust taking clear ownership of the issue and having a plan in place to continue to address it including senior nursing leadership of the issue. However, the CCG continued to monitor the trust and a spot check of five wards was undertaken and found two of the wards were breeching the MSA rules.
- We noted on the directorate risk register (October 2016) the trust acknowledged it was unable to deliver efficient and safe patient care due to capacity issues and they were unable to place patients into the right beds in a timely fashion. We saw the register had been updated commenting the use of the medical model was showing improvements to patient flow. However there was no further data to corroborate this.
- The hospital reported 93 MSA breaches in October 2016 for medical care services and all were reported as clinical need. During the unannounced inspection we saw there were MSA breeches in the ACC, which was operating as a medical ward with patients staying overnight. During our announced inspection we found breaches of MSA in Nelson and Wakeley wards and the ACC. Three bays in the ACC were clearly labelled 'same sex bay' and we saw both male and females, with curtains drawn, in the bays.
- Staff in the ACC told us "MSA is allowed because it is an assessment unit". When questioned, the staff were not aware they were still required to make reasonable adjustments to segregate male and females. Additionally, the staff on Nelson and Wakeley wards told us the MSA was for a "clinical decision". Therefore, staff were unable to fully explain the reasons for the MSA breaches and we found they did not have a full understanding of the regulation.
- We observed clinical 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.
- We saw on Wakeley ward staff did daily care rounds every two hours between 8am and 10pm. They asked five questions "do you need anything", "do you have any pain", "would you like a drink?", "would you like something to eat?" and "can you reach your call bell?" We saw the completed checklist was displayed on the door of bay 2 in the ambulatory care unit. However, this was last completed four days previously.
- We saw mandatory training records which showed as of October 2016, 91% staff in the directorate had completed ethnicity and diversity training, which was better than the trust target of 80%.

- The hospital had access to translation services for face to face and telephone interpreting. This could be booked through a centralised booking system.
- Patients living with dementia were supported by the hospital. A butterfly flagging system on the notes identified the patients who required extra assistance. This is a commercial scheme used nationally for this purpose. We saw patients living with dementia had a picture of a butterfly placed on their notes. This helped ward teams to identify patients and provide the appropriate care and support. Staff showed us a leaflet giving advice to people living with dementia and their carers when coming into hospital. In addition, patients living with dementia had a 'This is me' booklet. This is a document designed by the Alzheimer's Society that documents key personnel, biographical information and care preferences for staff to reference.
- The trust had a Dementia and Delirium Team who provided support to ward teams, patients and carers in all areas of the hospital. Improved training and induction programmes provided staff with the knowledge and skills needed to care for people living with dementia more effectively. Several wards we visited had link persons for dementia who were central to disseminating education and support to their local multidisciplinary team. In addition, volunteers supported staff and patients who were living with dementia. Wakeley ward had a dementia resource folder that included examples of completed dementia assessments and information about the services of the Alzheimer's Society and the butterfly system.
- The trust was responsive to the needs of patients who were living with dementia and may have a Deprivation of Liberties Safeguards (DoLS) in place. There were arrangements to ensure when patient's required one-to-one care this was provided and additional staff were hired to provide this. Staff on Will Adams ward told us they had been able to provide one-to-one support for a patent living with dementia by contacting the matron.
- We saw on Keats ward, agency mental health nurses, (five on the day of our inspection) specifically employed to support these patients. We were told the ward used the same agency staff to provide continuity. On our unannounced visit we saw on Bronte ward two patients subject to DoLS had registered mental health nurses with them at all times.
- In Tennyson and Milton wards there were sensory rooms for people living with dementia. A sensory room is a special room designed to develop a person's sense, through special lighting, music, and objects. Staff used the room as therapy for patients living with dementia or learning difficulties. However, staff told us these were underused, as they were too busy to assist patients to use the facility.
- Wakeley ward had suitable equipment for patients living with dementia, for example falls alarms and mattresses. Staff told us they would aim to site patients living with dementia or learning disabilities in the front bays, which were closer to the nurse's station.
- Patients living with a learning disability were supported during their care and treatment. We saw a learning disability resource folder on Wakeley ward which included picture charts for food and drink, body parts, personal care and included the trust Mental Capacity Act policy. Staff told us they could contact the learning disabilities team for support and advice regarding the care of any patient living with a learning disability. They told us how they had been supported to care for a patient by the use of an individual communication folder.
- We saw bathrooms and toilets were suitable for those with limited mobility. There were adequate supplies of mobility aids and lifting equipment such as hoists to enable staff to care for patients.
- Ward areas displayed photo-boards of staff so patients and their relatives could identify them and their job role. We noted these were generally kept up to date.

Learning from complaints and concerns

- Patients we spoke with were aware of how to raise a concern or complaint, including the role of the Patient Advice and Liaison Service (PALS). We found the PALS office was clearly signposted. We saw information on how to raise complaints and concerns were displayed in ward areas.

Medical care (including older people's care)

- Nursing staff we spoke with demonstrated understanding of the complaints process and were able to discuss how they dealt with complaints. They were aware of the role of PALS and how to contact them.
- We saw the wards displayed 'you said, we did' posters on noticeboards. This detailed how they had responded to both positive and negative feedback.
- We saw the directorate had a clear process for the management of complaints. Following executive sign-off, the directorate management team were made aware of all complaints that were up-held. The management team wrote to the relevant ward and medical staff to ensure they were aware of the outcome and lessons to be learnt. Further discussion then took place at departmental level. Staff we spoke with told us complaints were discussed in ward safety huddles and at ward meetings. We saw records to confirm this.
- During the period between August 2015 and July 2016 the trust received 116 complaints about medical care services. The most frequently complained about specialty was general medicine with 73 complaints and the most frequently complained about ward was Keats Ward with 16 complaints. The most frequently occurring themes for complaints were lack of care/ attention and treatment (mentioned in 49 complaints) and lack of communication to family members (mentioned in 22 complaints).
- Since our last inspection the trust had made significant efforts in responding to complaints and to reduce the back log. The target response time had been increased to accommodate this. However, we saw the trust took an average of 80 days to investigate and close complaints. This was not in line with the trust's complaints policy which stated the target response time was 30 days, unless the complainant agreed to a longer period in which case the response should be sent.

Are medical care services well-led?

Good

At our previous inspection in 2015, we rated the service as inadequate for well-led. On this inspection, we have changed the rating to good because we have seen significant changes in key areas such as developing a clear leadership strategy, involving staff in the vision of the service and change in the bullying culture. We rated well-led as Good because:

- There was a clear statement of vision and values of the service that was well developed and understood by staff. Across the directorate staff and managers told us they felt the current system of leadership had provided continuity and direction for the service.
- Staff spoke highly about their departmental managers and the support they provided to them and patients. All staff said managers supported them to report concerns and their managers would act on them. They told us their managers regularly updated them on issues that affected the separate departments and the whole hospital.
- Governance processes were evident at ward, divisional, hospital and corporate level. This allowed for monitoring of the service and learning from incidents, complaints and results of audits. The hospital had a risk register and was reviewed at the governance committee meetings.
- Staff asked patients to complete satisfaction surveys on the quality of care and service provided. Departments used the results of the survey to improve services.
- Staff were positive about working for the trust and spoke with pride about how far the trust had come in such a short time. They told us they now felt valued and that their opinion mattered.
- We saw some examples of innovative practice had been introduced.

Vision and strategy for this service

- The strategy of the directorate was to focus on the recovery plan over 2016/17. This would be achieved in

improving the quality, timeliness and efficiency of care, through emergency and planned pathways, and in finances. Staff we spoke with at all levels were able to describe the progress that had been achieved and the areas of improvement still required. At our last inspection we noted that staff were not fully aware of the directorate plans so this shows an improvement in staff engagement with the vision and actions.

- The directorate recognised there was a shortage in a number of different staffing groups, in particular permanent nursing staffing. Recruiting permanent nurses, achieving safer staffing levels and reducing the dependency on agency staff was a leading priority. A new recruitment campaign was launched in the United Kingdom in October 2016 and the trust continued to search for suitable candidates from abroad.
- We were told the directorate would continue to develop the frailty model in partnership with the clinical commissioning group (CCG) by introducing community geriatricians and nurses. This would assist in reducing admissions and increasing discharges.

Governance, risk management and quality measurement

- There was a governance framework in place with responsibilities defined which monitored the outcome of audits, complaints and incidents. Staff understood and could explain the system. There was a monthly acute and continuing care directorate governance group meeting. We looked at the minutes of the meetings held in June, July and August 2016. We saw key staff attended and the agenda items covered all the main areas of concerns and actions were identified to individuals. We saw the meetings followed a standard template with standing items to be discussed at every meeting, for example audit results and findings from mortality and morbidity meetings. This was an improvement as at our last inspection we found meetings were not always held as they were not quorate (having the necessary number of people present for decisions to be allowed to be made).
- We saw minutes of the monthly acute specialist medicine programme board meeting. These showed there was discussion about performance, incident trends, reviews of progress of incidents under investigation and an analysis of overdue incidents.
- The divisional dashboards provided clear indicators for quality measurement in the trust. This also contained performance information at ward level. This meant departmental managers were able to identify emerging concerns as well as giving them and their staff assurance they were performing well or improving. We saw the directorate performance review meeting exception report where indicators were discussed, the corrective actions taken, their target, actual score and rating. Indicators included incidents, infection control, referral to treatment and staffing levels.
- We saw the directorate maintained a risk register that was based on common themes and elevated risks throughout the departments. The directorate register informed the corporate risk register. We saw the risks were clearly identified and mitigating actions were related.
- The medicines management committee had been strengthened and was led by the medical director. This meant a coherent and unified approach in providing a safe delivery of medicines.
- Managers, clinical staff, schedulers and consultants attended the monthly endoscopy user group meeting. We saw the minutes for April 2016. The minutes showed the group reviewed and updated outstanding actions, service delivery and discussed incidents, equipment and staff development.
- We saw the minutes of the meetings for staff in the endoscopy unit. These were documented in a diary and handwritten. We saw meetings happened regularly and concerns were discussed. However there was not a standard agenda to ensure routine information flow about learning from complaints or incidents.
- All wards had senior sisters and they attended a senior nurse's forum on alternate months. Monthly ward audits were performed to inform clinical standards. The matrons and general managers undertook 'perfect ward' audits (an electronic programme that

involves a series of ward inspections to recognise high achieving wards and those that require improvement). We saw the results of the 'perfect ward' audits informed team meetings. This represented an improvement since our last inspection.

Leadership of service

- Since our last inspection the leadership strategy had been simplified to provide staff with clarity. Trust wide there were three directorates who reported to the board. The medical care service was in the acute and continuing care directorate and was led by the director of clinical operations who reported directly to the chief executive. The directorate had a director of clinical operations, deputy medical director and deputy director of nursing. The directorate was divided into four programmes and each was led by a clinical director who was supported by a senior nurse and a general manager.
- Across the directorate staff and managers told us that they needed a period of stability as they had been in constant reorganisation and change for many years. They felt the current system of leadership had provided continuity and direction for the service.
- Staff across the directorate reported leadership up to matron level was clear and supportive. Staff knew their managers and felt free to contact them. They felt valued and that their opinions counted. All the ward managers we spoke with knew what their wards were doing well and could clearly articulate the challenges and risks their ward faced in delivering good care.

Culture within the service

- We heard from all staff groups throughout the hospital that the trust was "On a journey". Staff were positive about working for the trust, and spoke with pride about how far the trust had come in such a short time. They told us they now felt valued and that their opinion mattered. Although they acknowledged there was still a lot of work to do they felt part of the plan to put things right. For example, staff remained under pressure to deliver high quality care with an increasing workload and low staffing levels. The change in culture meant they now felt able to escalate staffing issues and senior managers worked together to find solutions. The directorate managers acknowledged they were aware of pockets of cultural issues with staff in the lower bands as this was the first time they have been asked their opinion.
- The trust had raised the profile of appropriate behaviour and a historic culture of bullying had significantly improved. Both nursing and medical staff told us the trust had addressed bullying and dignity in the workplace. Staff who previously felt bullied were able to challenge that behaviour by making a complaint, confident the trust would take action.
- We saw the endoscopy unit had a calm atmosphere. We observed working relationships between staff and consultants. Staff were very complimentary about their team and the support from the sister.
- Staff on Nelson ward told us the culture of the hospital was improving and part of this was senior staff were more approachable. Staff on Wakeley ward told us they were proud of how the ward had changed for the better since the last inspection. Bronte ward told us local managers were now noticeable however they rarely saw senior managers.
- Keats ward displayed a 'praise board', which gave staff the opportunity to praise each other. For example, a member of staff who had no sickness absence in the last 12 months.
- The trust monitored workforce performance indicators in order to plan recruitment and monitor trends. We saw the trust had worked towards reducing vacancy rates across all departments. Staff on Dickens ward told us the vacancy rate, in their ward, was still high but had reduced from 100% (6 months ago) to 49%. The trust's target rates for vacancies and turnover was 8%. In July 2016, both nursing (31%) and medical staff (15%) were higher than the target. Turnover rates between 2015 and September 2016 was 14% for nursing staff and 7% for medical staff. Both nursing (3.6%) and medical staff (0.7%) in medical care service were below the trust target of 4% for sickness absence.

Public engagement

- At our last inspection we found there were no plans to engage the public in service developments or re-design. At this inspection we saw the hospital had

responded to this and had regular listening events with the public. Additionally the trust provided a newspaper every other month updating the public on developments at the hospital.

- On each ward we visited, we saw information displaying the results of patient surveys and what patients thought about the care they received on the ward. The information was updated each month with patients' comments about their experience in hospital which included what the hospital was doing well and where they could do better, under the title 'you said, we did'. This meant the trust was making an effort to listen to patient feedback and act on suggestions and concerns to improve services. We saw changes that had happened because of this system, for example improving the standard of food and a process was in place to change bedside tables, which were difficult to move.

Staff engagement

- We saw there was an increase in the number of staff completing the staff survey for 2016 compared to previous years. In the acute and continuing care directorate 42% of staff had completed the survey. Of these 55% would recommend the organisation as a place to work. Additionally, if a friend or relative needed treatment, 57% would be happy with standard of care provided by the organisation. The survey showed 69% were positive about their immediate managers and 44% regarding senior managers. This was better than the trust wide results in the 2015 survey for the same questions.
- Senior managers published newsletters such as the weekly 'aiming for the best' and the monthly 'improving safety'. The weekly newsletter advertised training, conferences and updated staff with changes in specific areas of the hospital. Additionally the monthly newsletter discussed incidents reported and key learning required.
- The trust had introduced a magazine designed to ensure all staff and the wider community had the opportunity of reading about the trust's achievements and the work being done throughout the hospital. Staff were encouraged to share similar stories for future publications.

Innovation, improvement and sustainability

- We saw examples of initiatives designed to improve the medical service in a sustainable manner. These included the deteriorating patient programme, discharge processes and recruitment.
- The directorate was working to recruit, attract and retain staff. There were local recruitment plans which were aligned to the trust wide plans learning from the success of the emergency department recruitment process. The directorate had received 16 applications for medical training initiative posts from Nigeria, staff had attended medical conferences and the trust had invested in senior registrars with attractive rotational posts.
- As part of the trust recovery plan, the deteriorating patient programme launched professional standards for recognising and responding to unwell patients to ensure clinicians were better equipped and trained to manage these patients.
- The trust had provided increased training opportunities for managing the deteriorating patient, safeguarding and continuing healthcare. There were trust wide improvement programmes established to increase the clinical skills and confidence of staff and provide a framework for sustainability. For example transforming care (a programme of work focusing on the fundamentals of nursing care), deteriorating patient programme and end of life care.
- The integrated discharge team invited representatives from local nursing homes to attend a tea party as a meet and greet and explain the new developments the trust was launching regarding discharge planning. This enabled all to work together in the role of discharging patients in a more streamlined and effective manner. The tea party took place in May 2016 and was well attended. We saw the invites for the next planned event due to take place in January 2017.

Surgery

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

Information about the service

Medway NHS Foundation Trust provides a range of surgical services to a population of over 400,000. The trust had 22,265 surgical admissions from April 2015 - March 2016. Emergency surgery accounted for 39.4% of activity during this period. Elective surgery accounted for 26.1% and day case surgery (where patients go home on the same day of their operation) 34.5%.

Medway NHS Foundation Trust has 19 day case and 164 inpatient surgical beds. The service has 14 operating theatres covering general surgery, anaesthetics, urology, ear, nose and throat (ENT), orthodontics (teeth), vascular (blood vessels) and orthopaedics (bones and joints). Four of the 14 theatres are for day surgery. These form part of the Sunderland Day Case Centre. The trust has seven surgical wards: Pembroke, Arethusa, Kingfisher, Victory, McCulloch, Phoenix and Sunderland.

The trust has a pre-operative care unit (POCU), where patients change, prepare and have admission checks before going to theatre for elective surgery. POCU has 12 small cubicles, with seating for patients and their relatives and four consultation rooms. For emergency admissions, the hospital has an eight-bedded surgical assessment unit (SAU) adjacent to Kingfisher Ward. The hospital's emergency department can refer patients to the SAU for assessment pending emergency surgery. The SAU also has a triage room, a seated waiting area and a clinic room.

This inspection was a follow-up to our last visit in August 2015, when we rated the service as inadequate. At our previous inspection, we found staffing levels throughout the department were insufficient to meet people's needs. There was a lack of learning from complaints and concerns. Staff morale was poor because of ineffective engagement, management and constant changes to directorate teams.

During our inspection, we spoke to 71 members of staff, including nurses, doctors, operating department practitioners (ODPs) and administrative staff. We spoke to 16 patients and seven patients' relatives. We reviewed 11 sets of patient records as well as a variety of trust data including meeting minutes, policies and performance data.

Surgery

Summary of findings

At our previous inspection in 2015, we rated the service overall as inadequate. Following significant improvements in key areas including incident reporting and learning, assessing and responding to patient risk, complaints, leadership, culture and staff engagement, we now rate the service as requires improvement.

We rated this service as requires improvement because:

- The service did not always use facilities and premises appropriately due to a lack of available beds. There were inappropriate ward placements, patients staying overnight in the recovery areas in main theatres and mixed-sex accommodation breaches. Patients also had bed moves at inappropriate times such as during the night.
- Problems with access and flow meant operating lists rarely ran on time.
- Medicines storage and management arrangements were not always sufficiently robust. We found out-of-date emergency drugs in main theatres and an unlocked drugs cupboard containing medicines to take out on Phoenix Ward. We also saw evidence of intravenous drug administration on Phoenix Ward that was not in line with Nursing and Midwifery Council (NMC) Standards for Medicines Management.
- The shortage of permanent nursing staff may have left the service vulnerable to spells of understaffing. However, in most areas, we saw the service used agency staff appropriately to fill the gaps.
- Staff did not receive mandatory training in identifying and reporting female genital mutilation (FGM). As a result, some clinical staff lacked awareness of FGM and their legal duty to report it.
- The trust failed to meet the national specifications for cleanliness in the NHS (NSC) regarding the frequency of audits in theatres. Infection prevention and control measures were not effective in some areas. For example, there were repeated infections on Phoenix Ward.
- Bedside handovers on the surgical wards did not always maintain patients' privacy and confidentiality.
- Not all leaders had the necessary experience, knowledge, capacity or capability to lead effectively. However, the trust recognised this and had introduced training to support and develop leaders, such as matron development days.

However:

- The service encouraged openness and transparency about safety. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. We saw evidence of learning from incidents and a positive culture of incident reporting and learning.
- The service assessed, monitored and managed risks to patients. This included daily checking of signs of deteriorating health, medical emergencies or behaviour that challenged.
- The service planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Regular monitoring and audit ensured consistency of practice.
- The service routinely monitored and collected information about patient outcomes. The service used this information to improve care. Benchmarking data showed patient outcomes were similar to national averages. The trust's performance had improved in some areas since the previous year.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.
- The trust had cleared its backlog of complaints and complaint response times were beginning to meet trust targets. We also saw evidence of learning from complaints.
- The service made reasonable adjustments and took action to remove barriers for patients who found it hard to use or access services. This included translation services, services for patients living with dementia and facilities for bariatric patients.
- Staff in all areas knew and understood the trust's vision and values.

Surgery

Are surgery services safe?

Requires improvement

At our last inspection in 2015, we rated safe as inadequate. However, following significant improvements in key areas, such as incident reporting and learning, where we saw evidence of learning from incidents and a positive change in culture in this area since our last inspection, we now rate safe as requires improvement. We also saw significant improvements in recognising and responding to deteriorating patients through improved staff training in this area and the introduction of "safety huddles" on the surgical wards.

We rated safe as requires improvement because:

- Medicines storage and management arrangements were not always sufficiently robust. We found out-of-date emergency drugs in main theatres and an unlocked drugs cupboard containing medicines to take out on Phoenix Ward. We also saw evidence of intravenous drug administration on Phoenix Ward that was not in line with Nursing and Midwifery Council (NMC) Standards for Medicines Management.
- The service failed to meet the national specifications for cleanliness in the NHS (NSC) regarding the frequency of audits in theatres. Infection prevention and control measures were not robust in some areas. For example, there were repeated infections on Phoenix Ward.
- The shortage of permanent nursing staff may have left the service vulnerable to spells of understaffing. However, in most areas, we saw the service used agency staff to fill the gaps.
- Staff did not receive mandatory training in identifying and reporting female genital mutilation (FGM). As a result, some clinical staff lacked awareness of FGM and their legal duty to report it.
- Confidential patient information, including drug charts, was not always stored securely on the surgical wards.

However:

- The service encouraged openness and transparency about safety. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. We saw evidence of learning from incidents and a positive culture around incident reporting and learning.
- The service assessed, monitored and managed risks to patients who use services on a day-to-day basis. This included daily checking of signs of deteriorating health, medical emergencies or behaviour that challenged.

Incidents

- From September 2015 - August 2016, the trust did not report any never events for Surgery. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The trust reported five serious incidents (SIs) from September 2015 - August 2016 related to surgery that met the SI reporting criteria set by NHS England. Two of these incidents were treatment delay meeting SI criteria. There was one health care associated infection/ infection control incident, one pressure ulcer and one slip/trip/fall, which all met SI criteria.
- Data from a one-year period from May 2014 - April 2015 showed the trust reported 13 SIs. Therefore, the five SIs reported from September 2015 - August 2016 meant the rate of SIs had reduced by more than half.
- The overall number of incidents also reduced since our last visit. From September 2014 – August 2015, surgical services reported 1,794 incidents. The number of incidents reported from September 2015 – August 2016 was 1,057. This meant there were 737 fewer incidents than in the previous year.
- We reviewed incidents involving surgical patients reported from September 2015 - August 2016. Surgical services reported 1,057 incidents during this period. We saw the trust graded the vast majority of incidents (95.5%) as either “no injury or harm” or “low harm”. This demonstrated a positive culture of reporting incidents because it showed staff reported “near misses” when there was no harm to patients. The proportion of no

harm and low harm incidents was similar to the previous year. From September 2014 – August 2015, the service graded 95.1% of incidents as either "no injury or harm" or "low harm".

- The service used an online software system for reporting incidents. Staff we spoke to could describe the process for reporting incidents and gave examples of times they had done this. Staff told us their managers encouraged them to report incidents and supported them with this process.
- Matrons or senior sisters investigated incidents with oversight by the surgical directorate governance manager. Matrons and senior sisters attended weekly incident meetings led by the surgical directorate governance manager. This enabled the sharing of incident learning between different clinical areas related to surgery.
- Staff told us the relevant senior sister subsequently fed back to the team with learning from incidents at monthly ward or theatre team meetings. We saw copies of various ward meeting minutes that showed evidence of feedback following incident learning. Staff gave us examples of learning from incidents, such as a medication incident on McCulloch Ward where staff administered Midazolam (a sedative) by the wrong route. This resulted in staff no longer storing Midazolam on the ward unless they had a patient receiving end of life care. Staff also attended refresher training to update their competencies in this area and prevent a recurrence. Staff we spoke with felt that incident reporting and learning had improved since our last inspection.
- We also saw 'governance boards' in staffrooms. The governance boards displayed details of incident investigations and learning from all surgical wards. A senior sister told us the service introduced the governance boards approximately two months before our visit. Most staff said they read the information on the boards and felt they were useful. One nurse on McCulloch Ward told us the boards enabled better sharing of incident learning with other wards. Before this, staff did not always know about incidents on other wards until the governance board. The new system enabled more transparency and shared learning to help prevent incidents recurring.
- All staff we spoke with were aware of the Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Staff provided examples of times the service had discharged DoC, for example, when a patient was injured following a fall. We saw evidence from root cause analysis (RCA) investigations that the service applied DoC following serious incidents. We saw guidance on DoC available in staff areas.
- Different surgical disciplines held regular mortality and morbidity (M&M) meetings. However, these meetings did not always happen every month as the trust told us there were no M&M meetings scheduled in August 2016. The purpose of M&M meetings was to allow clinicians to discuss patient deaths and other adverse events in an open manner, review care standards and make changes if needed.
- We saw M&M meeting minutes from July 2016 for urology, trauma and orthopaedics, and general surgery. Consultants discussed areas of good practice, as well as areas for improvements. However, the minutes we viewed lacked recorded actions, records of learning and actions to prevent recurrence. There was no evidence that staff completed or discussed learning actions from previous meetings. This meant the department might have missed opportunities to effectively share and learn from complications and errors, as well as prevent future recurrences and improve standards.

Safety thermometer

- The safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to hospital inpatients. These include falls, new pressure ulcers, catheter and urinary tract infections (UTIs) and venous thromboembolism (VTE), which are blood clots in veins.
- Data showed the trust reported 24 pressure ulcers related to surgical inpatients from September 2015 – August 2016. We saw that there was a peak in the number of pressure ulcers reported from November – December 2015. In these months, the trust reported four and five pressure ulcers respectively. Since then, the number of pressure ulcers reduced, with no incidents of

pressure ulcers in August 2016. Pembroke and Arethusa Wards displayed certificates commending them for achieving 200 and 300 days, respectively, without any pressure ulcers in 2016.

- The trust reported 10 catheter-acquired urinary tract infections (UTIs) from September 2015 – August 2016. Four UTIs took place in April 2016. The trust had an outbreak of MRSA on Phoenix Ward in the same month, and we saw that one of the action plans relating to this incident was to improve catheter care. The rate of catheter-acquired UTIs subsequently improved, with only two UTIs reported in the last four months of the reporting period.
- The trust reported two falls with harm from September 2015 – August 2016. We saw falls data, along with the other safety thermometer data, displayed publically on Arethusa and Pembroke Wards. This showed these wards monitored and recorded the number of falls on a daily basis.
- Data showed there were 12 cases of VTE for surgical patients across the trust from December 2015 – November 2016. Of these, there were three cases each from March 2016 and May 2016, one case each in February, March, April and June 2016, and two cases in July 2016. The trust had not reported any VTEs from August 2016 until the time of our inspection. The harm-free care rate relating to VTEs ranged from 98% to 100% during the reporting period.

Cleanliness, infection control and hygiene

- The trust did not meet the national specifications for cleanliness in the NHS (NSC) regarding the frequency of audits in theatres. The NSC states that all very high-risk areas should have weekly audits. The frequency of audits can drop to monthly if they pass the required percentage on a regular basis and management are confident they can maintain the scores. The trust routinely monitored very high-risk areas such as theatres on a monthly basis. This was not in line with the NSC or the trust's operational cleaning plan, which stated, "The pass rate for this category is 98% and [very high risk areas] are audited weekly".
- Data showed Sunderland Day Case Centre theatres achieved the 98% pass rate for 75% of their cleaning audits from April – November 2016. In the same period, main theatres passed only 25% of their audits. This meant theatres needed weekly cleaning audits in order to comply with the NSC and trust policy. At the time of inspection, the trust was not doing this. The consequences of not monitoring very high risk areas weekly is that an area may fall below the required standard for up to four weeks before any action is taken. This may increase the risk of hospital acquired infections
- Trust data showed surgical services reported 15 cases of MRSA from April - August 2016. Of these, there were 10 cases on Phoenix Ward. There were two cases each on McCulloch Ward and Kingfisher Ward/Surgical Assessment Unit (SAU) and one case on Arethusa Ward. All 15 patients tested positive for MRSA post-48 hours of hospital admission. This meant it was likely they had picked up MRSA during their hospital stay.
- During the same period, there was one case of MRSA colonisation on Victory Ward. This meant the infection entered the patient's bloodstream. MRSA colonisation can result in complications such as sepsis if left untreated.
- The 10 cases of MRSA on Phoenix Ward happened within a three-month period between April and June 2016. The trust declared the MRSA outbreak on Phoenix Ward as a serious incident. We saw a copy of the root cause analysis (RCA) investigation relating to the outbreak. The service vacated a six-bedded bay and a side room, and performed a deep clean using hydrogen peroxide. The RCA identified dirty ventilation shafts as a possible cause of the outbreak. The service cleaned the ventilation shafts as part of the deep clean to remove MRSA.
- The RCA investigation also identified poor staff compliance with infection prevention and control (IPC) policies as a root cause of the outbreak. The RCA stated that staffing shortages on the ward, along with high use of agency nurses who did not have adequate training, also contributed to the outbreak.
- We saw the service took action to address the root causes of infection and help prevent a recurrence. We saw a 13-point action plan following the RCA. Some actions were complete, such as the deep clean of the ward. Others were ongoing at the time of our visit. We saw actions to address staff competencies around IPC. These included staff updating their mandatory IPC

training. The RCA report showed 100% of staff had up-to-date training following the recommendation. The ward manager also assessed the competencies of staff in this area. Trust data showed Phoenix Ward had no further cases of MRSA in the final two months of the reporting period. During our visit, we saw compliance with IPC policies, including "bare below the elbows" to enable effective hand washing.

- However, trust data showed Phoenix Ward had one case of methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia in August 2016. There were also six cases of E. coli on Phoenix Ward in April – September 2016. This accounted for 33% of the total E. coli cases related to surgery (18 cases) during this period. Four of the six patients tested positive for E. coli post-48 hours following admission. This meant they contracted the infection while on the ward. Two of the four attributable cases happened in July 2016 after staff had updated their training. This may have meant the additional IPC training and monitoring was not robust enough to prevent further infections.
- We saw there was one other case of MSSA bacteraemia from April – September 2016. This happened in May 2016 on Pembroke Ward. However, in this case, the patient tested positive for MSSA bacteraemia less than 48 hours following admission. This meant the patient did not contract MSSA from the ward.
- The trust's policy was to screen patients having elective surgery for MRSA at their pre-operative assessment. The service screened patients who had emergency surgery on the day of admission. Patients who stayed in hospital longer than one week had a further weekly screen. The trust measured compliance with the MRSA screening policy. Data from April - August 2016 showed variable screening rates for surgery, which ranged from 87% to 100% for admission screening. The rates for weekly screening ranged from 85% to 96% in the same period. This meant the service might not have identified all patients carrying MRSA.
- Surgical services reported three cases of Clostridium difficile (C. diff) between April - September 2016. Two cases occurred on Kingfisher Ward/SAU and one case on Sunderland Day Unit. However, only one of the three cases developed C. diff after 72 hours post-admission. This case happened on Kingfisher Ward/SAU in September 2016. This meant two of the three patients did not contract C. diff from the hospital.
- The trust took part in the Public Health England (PHE) surgical site infection surveillance service (SSISS). This allowed the trust to benchmark its infection rates against other trusts and identify areas for improvement. The trust supplied surgical site infection (SSI) data to PHE on hip replacements, knee replacements and repair of neck of femur (surgery to repair hip fractures).
- As part of the SSISS, the trust sent out post-operative questionnaires to patients. This helped them identify more patients who developed a SSI after discharge but did not receive further treatment at the trust.
- The trust's SSI report for January – June 2016 showed 2.4% of patients developed an SSI following knee replacements during this period. This was worse than the average infection rate of 1.9% for other hospitals that sent patient questionnaires during the same period.
- The report showed 0.6% of patients developed an SSI following repair of neck of femur in January – June 2016. This was better than the average infection rate of 1.4% for other hospitals that sent patients questionnaires during the same period.
- The data showed 0% of patients developed a SSI following hip replacement during this period. This was better than the average infection rate of 1.2% for other hospitals that sent patients questionnaires during the same period.
- The trust carried out monthly hand hygiene audits. The audits measured staff compliance with hand hygiene policies, such as hand washing and "bare below the elbows". Audit data from April – August 2016 showed surgical directorate compliance ranged from 94% to 99%. This was worse than the trust target of 100%. The service missed some audits, for example; we saw there was no data reported for the Day Surgery Procedure Suite for five out of the six months during this period. This meant the trust might not have had assurances staff in this area were complaint with IPC policies and practices.

- However, in all clinical areas we visited, we saw a high level of staff compliance with IPC practices such as hand washing, use of alcohol hand gel and bare below the elbows. We saw staff cleaned their hands appropriately before and after patient contact. This was in line with the National Institute for Health and Clinical Excellence (NICE) QS61, quality statement three: hand decontamination. We also saw staff used personal protective equipment (PPE) such as gloves and aprons appropriately.
- Clinical areas we visited were visibly clean and tidy. We saw comprehensive cleaning schedules displayed at the entrances to wards and theatres. We saw cleaning checklists in main theatres, which provided evidence of daily cleaning and monthly deep cleans. The service performed monthly cleaning audits and displayed the results in each area. We spoke to housekeepers, who were able to describe the colour coding system they used for cleaning equipment in line with the National Specifications for Cleanliness in the NHS. The use of specific coloured reusable cleaning equipment such as mops and cloths in different clinical and non-clinical areas helps minimise the spread of infections. We also saw details of the National Specifications for Cleanliness colour coding displayed in the sluice on Pembroke Ward to remind staff.
- We saw isolation of a patient with suspected measles in a side room on Kingfisher Ward. There was a clear sign on the patient's door to alert staff to take additional IPC precautions. Staff discussed the need for additional PPE precautions during a ward round. We saw the senior sister ensured only vaccinated staff treated the isolated patient. The senior sister advised staff to check their immune status with occupational health. Staff also checked the patient's visitors were immune before allowing them into the patient's room. This helped minimise the risk of infection spreading to staff and visitors.
- However, we saw a clinical waste bin outside the side room used to isolate a patient with suspected measles on Kingfisher Ward. The placement of the clinical waste bin in the corridor meant staff took potentially contaminated personal protective equipment (PPE) such as gloves and aprons into the corridor to dispose of them. We saw the bin was full and the strings of a used apron stuck out over the edge. This risked the spread of infection, particularly if someone accidently knocked over the unsecured bin in the corridor.
- In all clinical areas we visited, we saw the correct segregation of clinical and non-clinical waste into different coloured bags. This was in line with HTM 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. We saw that staff had labelled sharps bins and that no sharps bins were overfull. This was important to prevent injury to staff and patients from sharp objects such as needle sticks.
- The service sent surgical instruments off-site for sterilisation. The trust told us the agreed turnaround time was 18 hours. Theatre staff sent items for sterilisation three times a day. This ensured there were sufficient sterile instruments available for surgery. However, theatre staff told us they could obtain sterile instruments within six hours if necessary.

Environment and equipment

- We saw that the corridor flooring in theatres had worn away. Staff had covered the worn areas with tape. This was contrary to the Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment HBN 00-09, which states, "Flooring should be seamless and smooth, easily cleaned and appropriately wear-resistant". Damaged flooring can harbour dirt and dust and make cleaning difficult.
- Pembroke Ward and Arethusa Ward mostly cared for trauma and orthopaedics patients. As this group of patients had surgery to their bones and joints, it meant they were often not fully mobile after surgery. The two wards shared a standing hoist, which staff felt was sufficient to meet patients' needs. Each ward had their own sling hoist to transfer patients, for example, from bed to chair. However, during our unannounced visit, we saw there was no sling hoist on Pembroke Ward. Staff told us Arethusa Ward had borrowed it, as their sling hoist was awaiting repair.
- Staff on Pembroke Ward told us there were no patients who needed a sling hoist at the time of our visit. They told us that if they admitted a patient who needed to use it, then they would share the one functioning sling hoist with Arethusa Ward. Staff told us they had done this in the past when necessary. Sharing a single sling

hoist would involve staff leaving the ward and taking the lift down to Arethusa Ward every time a patient needed the sling hoist. This may cause staff to spend excessive time away from the ward each day. This meant there were sometimes not enough sling hoists to meet patients' needs.

- On Arethusa Ward, staff were unable to provide us with any evidence of a return date for their sling hoist. A senior sister told us the ward sent the hoist to the hospital's equipment team for repair four weeks before our visit. However, we spoke to a member of the trust's equipment team who was unsure of the hoist's whereabouts. He confirmed the hoist was not in the trust's repair workshop. Before our visit ended, we saw a senior sister speaking to a member of the equipment team to follow-up the issue of the broken/missing hoist.
- We checked six adult resuscitation trolleys in the following areas: Kingfisher Ward/SAU, Arethusa Ward, Pembroke Ward, Phoenix Ward, Sunderland Day Surgery Unit and one trolley in main theatres. All equipment and drugs were within their use-by dates. We also saw checklists for all six trolleys showing evidence staff checked the trolleys daily. This provided assurances emergency equipment was safe and fit for purpose.
- We saw 'sepsis six' boxes available on the surgical wards. The boxes, produced by the UK Sepsis Trust, contained all the equipment staff needed to treat patients with sepsis. We checked the boxes on Arethusa, Pembroke and Phoenix Wards and saw the boxes were complete, with all items within their recommended use-by dates. On all three wards, we saw records providing evidence staff checked the boxes daily. This provided assurances the wards had appropriate equipment for the treatment of sepsis readily available.
- We checked the anaesthetic machines in main theatres and saw log books showing evidence of daily checking with no gaps. This was in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. We also saw maintenance records showing evidence of six-monthly maintenance checks. This provided assurances the anaesthetic machines worked safely.
- We saw equipment maintenance schedules in main theatres. This provided assurances the service maintained theatre equipment so that it was safe and fit for purpose. The service scheduled equipment maintenance and servicing at weekends. There were fewer operations at weekends so this helped minimise service disruption. The maintenance schedule included equipment for bariatric patients.

Medicines

- We checked the local anaesthetic toxicity trolley in main theatres and found 11 vials of out-of-date Dantrolene. The vials had expired almost one month before our visit. Dantrolene is a muscle relaxant used to treat malignant hyperthermia- a rare and life-threatening disorder triggered by general anaesthesia. Keeping medicines beyond their expiry dates may compromise their function and safety.
- On the same trolley, we saw three vials of water for injection that had expired the month before our visit. Staff had identified this and written a note on the whiteboard next to the trolley stating "limited water for injection available in trolley- pharmacy aware". Staff dated the note 2 November 2016, which was 27 days before our visit. This meant pharmacy staff had failed to supply more water for injection, and theatre staff had not followed this up for 27 days. We highlighted the issue of the out of date drugs to theatre staff, who arranged replacement.
- During our unannounced visit, we saw an unlocked cupboard full of to take out (TTO) medicines ready for patients to take home on Phoenix Ward. This meant there was the potential for unauthorised access to TTO medicines. We reported this to staff immediately and saw a member of staff lock the cupboard.
- We checked controlled drugs (CDs) in main theatres, Pembroke Ward, Arethusa Ward and Sunderland Ward. Controlled drugs are medicines liable for misuse that require special management. We saw the CD cupboards were locked in all three areas. Only authorised staff could access CDs by asking the nurse in charge for the keys to the cupboard. We checked the CD registers in all three areas and found two members of staff had signed for all controlled drugs. This was in line with national standards for medicines management. We randomly checked the stock level of CDs on Arethusa Ward and Pembroke Ward. We saw the correct quantities in stock according to the stock list, and that all were in-date.

- We checked the drugs fridges on Arethusa and Pembroke Wards. We saw that fridge temperatures on both wards were within the expected ranges. We saw records on both wards, which showed staff, had checked the fridge temperatures daily. All temperatures recorded were within the expected ranges, and there were no gaps on the checklist. This provided assurances the wards stored refrigerated medicines within the recommended temperature range to maintain their function and safety.
- We observed a drugs round on Phoenix Ward. We saw the nurse carrying out the drugs round checking the correct drugs and dose against the patient's drug chart. The nurse also checked the expiry date of each drug. We saw that the nurse asked patients to state their name and date of birth and checked this against the chart before giving the medicine to the patient. The nurse also told the patients which medication they were giving them. The nurse stayed with the patient while they took their medicine. These processes ensured the correct patient received the correct medicine at the correct dose. It also ensured there were no unused medicines left on the ward, which may be subject to misuse.
- We observed a discharge on Pembroke Ward. We saw the nurse gave the patient instructions for new medicines that she had not brought in with her. However, the discharge took place near to the nurses' station rather than at the patient's bedside. Discharging patients in communal areas is not best practice. The handover was rushed, as a member of private ambulance crew was eager to transport the patient home. This meant the patient might not have had enough time or privacy to ask any questions they wanted to.
- We reviewed eight medication administration records (MAR). On all eight MAR charts, we saw staff had recorded patient allergies. Medication reflected patients' care plans. For example, we saw staff had not given a patient any sedatives after an entry in the care plan stated, "Do not give sedatives". We saw evidence of pharmacy oversight in all records.
- However, we saw evidence of one missed dose, which was on Arethusa Ward. On two other MAR charts on Arethusa Ward, we saw that staff had not signed to confirm they had set up and checked the administration of an intravenous (IV) drug. This was not in line with Nursing and Midwifery Council (NMC) Standards for Medicines Management.
- Staff checked relevant patients had appropriate antibiotic cover during a trauma team briefing in main theatres. Patient records showed evidence of antibiotic prescription where clinically indicated.

Records

- We saw that patient records were not always stored appropriately. We also saw the drug chart for a patient staying in a side room on Phoenix Ward stored in the corridor. The chart was in an unattended area, which created a risk of personal and confidential data loss. We also found patient drug charts awaiting medical review stored in a tray in the corridor on Pembroke Ward. Although staff could see the tray from the nurse's station, there might be unattended personal and confidential information if staff left the nurses' station. On Arethusa Ward, we saw a letter containing personal information stored in a tray at the nurses' station. Information was clearly visible to patients and visitors who presented at the desk.
- We reviewed the records for 11 surgical patients. Overall, we saw an appropriate standard of documentation. We saw staff had signed and dated all entries in line with best practice guidance. However, we also saw loose documents inside patient files. Failure to effectively file paperwork risked confidential patient data falling out. This risked unauthorised access to confidential data and accidental loss of essential medical information.
- Patients had care plans that identified all their care needs. We saw staff had fully completed the care plans in the records we reviewed. We also saw evidence of pre-operative assessment in all sets of notes we reviewed.

Safeguarding

- Safeguarding training rates were variable. Trust data from October 2016 showed 77.0% of staff had completed annual safeguarding vulnerable adults' level one training. This was worse than the trust target of 80%. However, 80.4% of relevant staff had completed annual safeguarding vulnerable adults level two training, which was in line with the trust target.

- Data showed 86.5% of staff had completed annual safeguarding children level one training, which was better than the 80% target. However, 78.1% of staff had completed safeguarding children level two training. Only 50.0% of relevant staff had completed safeguarding children level three training. Completion rates for safeguarding children levels two and three were below the trust target. This meant that not all staff had the correct level of training in line with the national intercollegiate guidance, "Working together to safeguard children" (March 2015). Not having a sufficient level of safeguarding training may prevent all staff from correctly identifying safeguarding concerns.
- However, staff we spoke with were able to describe the correct processes for reporting safeguarding concerns. Staff provided examples of times they had appropriately raised vulnerable adult and child safeguarding concerns. We saw a safeguarding folder available to staff on McCulloch Ward with contact details for the trust's safeguarding team and details of how to raise a concern.
- Staff did not receive mandatory training in identifying and reporting female genital mutilation (FGM). As a result, some staff lacked awareness of FGM and the mandatory reporting requirements for healthcare professionals.
- In other areas of the service, there was greater awareness of FGM. On Sunderland Day Unit, we saw the staff training calendar, which showed FGM training, was booked for the day of our unannounced visit. The senior sister told us the session had been cancelled; however, she planned to reschedule the training for another day. Two members of nursing staff on Sunderland Day Unit demonstrated awareness of FGM and the trust's policy, despite not having attended the training. We saw the FGM policy, which the hospital reviewed in January 2016.

Mandatory training

- Trust data from October 2016 showed the overall mandatory training rate for surgery was 80.7%. This was about the same as the trust target of 80.0%. However, completion of eight out of 17 modules was worse than the 80% trust target. These modules included adult life support (59.1%), infection control level two (78.1%), information governance (77.2%), manual handling (73.2%), and paediatric life support (55.9%). This meant staff may have not had an appropriate level of training in all areas. For example, poor rates of infection control training may have contributed to the hospital-acquired infections discussed in the cleanliness, infection control and hygiene section of this report.

Assessing and responding to patient risk

- We saw evidence of thorough risk assessment, including falls assessments, in the patient records we reviewed. We saw individual falls management plans for patients identified as being at high risk of falls following assessment. However, in one set of notes, we saw no falls assessment for a patient who met the criteria for assessment. We highlighted this to the Senior Sister on McCulloch Ward, who immediately arranged an assessment for the patient.
- For patients identified at high risk of falls, the trust used a yellow wristband system to enable staff to easily identify these patients and provide them with additional support. We saw patients with high falls risk wearing the yellow wristbands during our visit and staff highlighted these patients during nursing handovers. This ensured staff starting their shift knew to provide extra support to these patients. Staff on McCulloch Ward described safety measures the surgical wards used to help prevent falls in patients with high risk, such as low-lying beds. We saw sensor mats in use on Phoenix Ward. The sensors alerted staff when a patient left their bed so that staff could assist them if necessary.
- We saw evidence of VTE assessment in the notes we reviewed. We saw prescription of VTE prophylaxis, such as anti-clotting drugs and anti-embolism stockings, where clinically indicated. We saw two patients on the Pre-Operative Care Unit (POCU) and one patient on the Surgical Assessment Unit (SAU) wearing prescribed anti-embolism stockings in preparation for surgery. However, during a nursing handover on Phoenix Ward, we saw that a patient did not receive their regular anti-clotting medicine at the recommended time. This was because the ward did not have any in stock. We saw her anti-embolism stockings hanging at the end of her bed rather than on her feet. This meant the ward might not have managed the patient's VTE risk appropriately. However, we saw staff managed the VTE risk appropriately for all other patients on Phoenix Ward.

Surgery

- We saw evidence in patients' notes and during a theatre team briefing that the service routinely checked the pregnancy status of all female patients of childbearing age before elective surgery. Staff checked pregnancy status using a urine pregnancy test with the patient's consent. This was in line with NICE guideline NG45: "Routine preoperative tests for elective surgery".
- The service used the American Society of Anaesthesiologists (ASA) grading system to pre-assess patients' level of risk for general anaesthesia. There were five grades within the ASA system. Grade one patients were normal healthy patients and grade five patients were patients not expected to survive more than 24 hours with or without surgery. The hospital had level two and three critical care facilities for critically ill patients to recover in following surgery. This allowed them to treat patients of all ASA grades safely.
- We observed theatre staff carrying out the World Health Organisation (WHO) Surgical Safety Checklist for two procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre) and debrief. For both procedures, staff fully completed all the required checks.
- The service audited staff compliance with the WHO checklist and calculated the percentage compliance each month. We saw copies of the audits for September 2015 – August 2016. Throughout this period, we saw a high level of compliance, which ranged from 95.2% to 98.3%. During this period, the service audited between 90 and 647 operations each month. Audits provided the trust with assurances staff performed the necessary checks to help keep patients safe during surgery.
- The service used the National Early Warning System (NEWS) track and trigger flow charts. NEWS is a simple scoring system of physiological measurements (for example, blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support.
- Following serious incidents around the time of our 2015 inspection, we found poor practices around staff usage of NEWS. Staff did not complete NEWS charts correctly or escalate patients for timely medical review in line with trust policies. During this inspection, we saw the trust had taken actions to address this. The trust provided NEWS training to staff and we saw written information for staff on 'recognising patients of concern' and 'responding to patients of concern'. The trust asked all relevant staff to sign to confirm that they understood the trust's policy. We reviewed three staff competency folders on McCulloch Ward and saw evidence of recent NEWS competency certificates in all three. The trust introduced monthly NEWS chart audits in February 2016 to assess staff completion of NEWS charts. The most recent results from July 2016 showed that performance varied between wards. The best result was 100% on Victory Ward. Pembroke Ward had the worst result, with 90.6% of charts filled in correctly. However, the audit showed staff on all wards calculated 100% of scores correctly. The July 2016 audit also showed staff escalated 100% of patients for medical review correctly in line with trust policy on five out of the six wards. On the remaining ward, Arethusa, staff escalated 90% of deteriorating patients appropriately. We saw that staff received feedback on the NEWS audits at ward meetings to help improve performance where relevant. The audits helped provide the trust with assurances around the appropriate management of deteriorating patients.
- We reviewed 11 patients' NEWS charts. We saw staff had completed all 11 charts fully and accurately. We saw evidence of increased monitoring and medical review when clinically indicated in line with the NEWS guidance. During patient handovers on Kingfisher Ward/ SAU and Phoenix Ward, we saw further examples where staff had escalated deteriorating patients with a raised NEWS score for medical review.
- Nursing staff on the surgical wards had daily "safety huddles". We observed safety huddles on Kingfisher Ward/SAU and Phoenix Ward. Staff highlighted patients at increased risk for extra monitoring. This included patients with a raised NEWS score, patients with a safeguarding alert, patients with sepsis, patients with communicable infections in isolation and patients at high risks of falls and pressure ulcers. However, we saw that the safety huddle on Phoenix Ward started behind a closed door in the day room. The night staff were leaving the ward to go home while the day staff had the safety huddle. These meant patients on the ward were

unattended and nurses were not able to hear call bells. The inspection team pointed out this risk and the ward sister opened the door so that staff would be able to hear any call bells if patients rang them.

- On Kingfisher Ward, the safety huddle took place at the nurses' station. This meant nursing staff could see the ward and easily hear and respond to call bells if they rang.

Nursing staffing

- Recruitment and retention of staff was a concern at our last inspection and continued to be a problem in some areas. Trust staffing data showed there was a consistent registered nursing vacancy rate in surgery of 36% from May to July 2016. The vacancy rate for unqualified nurses and care support workers (CSWs) ranged from 30% to 32% in the same period. The most recent available staffing figures from July 2016 showed surgical services had 125.8 whole-time equivalent registered nursing vacancies. There were 52.4 vacancies for unqualified nurses and CSWs.
- However, the trust had an active recruitment drive to address the high vacancy rate. This included partnerships with local universities to recruit newly qualified nurses. The trust held nursing open days every other month for nurses considering coming to work for the trust. A senior sister on McCulloch Ward told us she attended the open days to greet prospective staff and talk to them about the trust. She told us this had helped recruit more staff in her area and the ward had recently recruited four new nurses. Nurses we spoke to on McCulloch Ward told us staffing had improved, and said there was now less reliance on agency staff.
- Staffing levels were also improving in theatres. The day surgery unit had 32 WTE members of staff and did not need to use agency staff to maintain safe staffing levels. Main theatres recently recruited 12 new nurses who were awaiting induction. This brought the vacancy rate in main theatres to 14%.
- Staff in the SAU told us it was sometimes difficult to observe patients in the SAU bays and in the waiting room simultaneously. This was because there was routinely only one registered nurse staffing the SAU, with support from two CSWs. We checked the SAU operational policy, which stated the minimum staffing for this area was two registered nurses and two CSWs. This meant nurse staffing levels in the SAU were not in line with the trust's policy.
- Staffing levels in the SAU could compromise safety, especially if the emergency department (ED) brought unstable patients to the SAU waiting room. The SAU operational policy stated, "Unstable patients must remain within ED until they are stabilised". However, staff told us examples of ED staff bringing inappropriate patients to the SAU waiting room when there were no trolleys available. Staff always reported these incidents via the electronic incident reporting system but told us ED never shared the outcomes of these investigations. Incidents included a patient with a bowel perforation and another patient with a pain score of eight out of 10. This meant the patient was in severe pain; therefore, a waiting room would have been an inappropriate environment for them.
- Staff told us they managed these incidents by moving medical outliers to other wards to make SAU beds available for patients in the waiting room. A senior sister told us about an occasion she found a bed on another ward and made it ready to move a medical outlier out of the SAU. The SAU also escalated to senior management when the number or acuity of patients in the SAU waiting room compromised safety. Senior managers then helped find available beds to move medical outliers out of the SAU to free up beds for patients in the waiting room. The SAU kept an escalation folder to document escalation, which we saw during our inspection.
- Surgical services used an evidence-based acuity tool to assess patient acuity and dependency and ensure the nursing establishment reflected patient needs. Planned nursing ratios on the surgical wards were typically one nurse to eight patients. However, the service used a higher nurse to patient ratio where the acuity tool identified the need.
- The service relied on agency staff to fill gaps created by the high nursing vacancy rate. In main theatres, staff told us this sometimes caused problems when agency staff refused to carry out particular work. They felt this created extra pressure on the permanent staff to ensure theatre lists ran safely. Staff told us they found this "exhausting".

Surgery

- On the surgical wards, we saw they tried to use regular agency staff where possible. This meant staff were familiar with the ward environment, policies and ways of working to help ensure consistent care. We spoke to an agency nurse on Kingfisher Ward who said she felt included in the team and said teamwork on the ward was good. However, some staff we spoke to felt that not all agency staff on the wards took as much responsibility for their work as permanent staff. One nurse commented that agency staff were "Not always engaged in the way the ward works". This was sometimes a problem at night, when there was more reliance on agency staff to cover shifts. Staff told us there was usually at least one permanent member of nursing staff on every night shift. However, there were some occasions when only agency nurses staffed the wards. This meant there might have been a lack of leadership on the wards at night on some occasions.
- To ensure safe staffing levels, we saw staff moved between wards to cover vacant shifts. On one shift, we saw a care support worker (CSW) fill the staffing gaps on two different wards that were not her usual ward. However, staff told us they only moved between surgical wards. Medical nurses did not cover vacant shifts on the surgical wards. This ensured an appropriate skill mix and meant only staff that were trained to care for patients post-surgery worked on the surgical wards. Staff understood the reasons for ward moves, even though they sometimes found it frustrating to move to a different area at short-notice.
- Despite the use of agency staff and the movement of nurses between wards, we saw there were still some unfilled shifts. We reviewed the nursing and CSW staffing levels at the time of our visit for 15 different shifts across four surgical wards. These were Arethusa, Pembroke, Kingfisher/SAU and Phoenix Ward. We saw that 11 out of 15 shifts had the planned number of nurses. Four shifts had one nurse less than the planned number (four nurses instead of five). Two of the shifts where staffing fell below the planned level were on Kingfisher Ward/SAU. This was because of staff sickness. The other two were on Pembroke Ward. This meant 26.7% of shifts we reviewed had less than the expected number of nurses to care for patients at the start of the shift. However, on Kingfisher Ward/SAU, we saw the service moved a CSW from another ward to help fill the gap created by staff sickness.
- We saw that 14 out of 15 shifts had the planned number of CSWs. Only one shift did not have the planned number of CSWs (three instead of four). This was on Kingfisher Ward/SAU.
- During our unannounced visit, we saw the staffing board on Phoenix Ward had the incorrect date. Staff had not changed the date for two days before we visited on 8 December 2016. The nurse in charge was not on the ward; therefore, we asked another nurse if the staffing figures were correct. The nurse we asked was unsure of whether the staffing numbers were correct for the day of our visit. Therefore, we were not assured Phoenix Ward displayed the correct staffing numbers.
- In main theatres, we saw that staffing levels during our visit met the Association for Perioperative Practice (AfPP) guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list. We also saw the staffing rota for December 2016, which showed theatres, allocated sufficient staff to cover each list.
- Matrons told us they covered clinical shifts in theatres when necessary, for example to cover staff sickness. This ensured staffing levels met the AfPP guidelines and prevented the cancellation of operations. The theatre matron said there were times in the past when lists had gone ahead without a full complement of staff. However, this no longer happened and the service cancelled lists if staffing levels fell below AfPP guidelines and there were no senior staff available to cover.
- We observed nursing handovers on Kingfisher Ward/SAU and Phoenix Ward. The service carried out bedside handovers. On Kingfisher Ward/SAU, the entire nursing team went to patient's beds to handover each patient. On some of the other wards, nurses spilt into different teams on the ward, which cared for smaller groups of patients. On Phoenix Ward, one registered nurse handed over to another nurse and two CSWs.
- The wards used a standardised trust handover sheet containing information about each patient. Each nursing staff had a copy, which they referred to throughout the handover. We saw that nurses communicated important information about individual

patients to the incoming team. This included NEWS scores, individual needs, mediation and nutritional status. We saw nurses generally handed over important information to enable continuity of care. However, we saw one example on Phoenix Ward where staff did not discuss the NEWS chart for a patient transferred from the high dependency unit (HDU). It is important to closely monitor patients transferred from HDU for any signs of deterioration; however, there was no discussion of this.

Surgical staffing

- Trust data from July 2016 showed a vacancy rate of 16.1% for medical and dental staff in surgery. This was worse than the trust target of 8.0%. However, the trust was working to address this and had bespoke recruitment plans for hard-to-recruit specialties.
- The proportion of consultant staff working for the trust at the time of our visit was 37%. This was worse than the England average of 44%. The service employed a higher proportion of junior staff in foundation years one and two (15%) than the England average (11%). This meant the service had a less experienced skill mix of surgical staff than the England average.
- The service used locum staff to ensure service continuity at times of staff shortages. Locum staff worked at the trust on a long-term basis. This helped ensure the service used locums who were familiar with the trust's policies, environment and ways of working to ensure consistent care for patients.
- Each surgical speciality had at least three tiers of on-call cover, from junior doctors through to consultants, 24 hours a day, seven days a week. Consultants were on site from 8am to 8pm daily and non-resident out of hours. Consultant led ward rounds were standard practice at weekends. On-call consultants attended the hospital out-of-hours when there was an emergency.
- To ensure all specialties had the correct level of cover, the service had seven consultants on call at any one time. The seven on-call consultants covered general surgery, anaesthetics, urology, ear, nose and throat (ENT), orthodontics, vascular and orthopaedics.
- We observed a medical handover in the doctors' office on the SAU. Doctors handed over patients from the night shift to their colleagues starting the day shift. The process was effective and doctors from the night and day shifts attended, as well as a general consultant to provide oversight.

Major incident awareness and training

- Senior staff in different areas of surgery completed emergency preparedness resilience and response (EPPR) training. Trust data from November 2016 showed 75% of required staff had up-to-date training. This was worse than the trust target of 95%. However, we saw that 100% of on-call managers had up-to-date training. This meant there would always be a manager on call who had appropriate training to respond to a major incident.
- The trust had a major incident and business continuity policy, which provided the necessary guidance for staff. Matrons we spoke to demonstrated awareness of the policy and knew how to access it on the trust intranet. The hospital had back-up generators to ensure an uninterrupted power supply if the mains supply failed.
- The floor coordinator had responsibility for directing staff if there was a fire in theatres. However, not all staff we spoke to in theatres knew the correct processes for evacuation if there was a fire. We also spoke to a nurse in charge on Phoenix Ward, who told us they did not know the location of the nearest fire point and had not received fire training. This meant that not all staff might have known how to evacuate clinical areas safely in the event of a fire.

Are surgery services effective?

Good

At our last inspection in 2015, we rated effective as requires improvement. Following improvements in key areas including patient outcomes following surgery and staff competencies on the surgical wards, we have now rated effective as good.

We rated effective as good because:

- The service planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Regular monitoring and audit ensured consistency of practice.

- The service routinely monitored and collected information about patient outcomes. The service used this information to improve care. Benchmarking data showed patient outcomes were similar to national averages. The trust's performance demonstrated continuous improvement in some areas since the previous year.
- The service identified the learning needs of staff and provided training to meet their learning needs. Staff received support to maintain and further develop their professional skills and experience.
- Staff had meaningful and timely supervision and appraisal. Relevant staff received support through the process of revalidation.
- The service obtained consent to care and treatment appropriately in line with legislation and guidance.

However:

- Staff did not always make applications to authorise a deprivation of liberty safeguard in a timely manner.
- Staff used fluid balance charts for patients who needed additional monitoring but did not always complete the charts in full. This meant the service might not have monitored fluid balance effectively for all patients who needed monitoring.

Evidence-based care and treatment

- We reviewed policies and procedures in main theatres. All policies we saw were within their review dates and referenced relevant national guidance. This included NICE and the Royal College of Surgeons (RCS). Staff could access policies and procedures electronically through the trust intranet and knew how to do this.
- The service audited staff compliance with trust policies in several areas and reported the results monthly. For example, we saw monthly WHO surgical safety checklist and NEWS audits. We saw staff meeting minutes, which demonstrated staff received feedback on local audit results and areas for improvement. For example, we saw staff on McCulloch Ward received feedback on completion of NEWS charts at their July 2016 ward meeting.
- Surgical services had a comprehensive local audit programme to measure performance. We saw audits in areas such as anaesthetics and consent. The trust also participated in national audits such as the national prostate cancer audit for patients who had surgery for prostate cancer.
- We reviewed 11 patient records, which all showed, evidence of regular observations, for example, blood pressure and oxygen saturation, to monitor the patient's health post-surgery. Staff had completed all observations in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration.
- We saw the service provided care in line with NICE guideline CG83: Rehabilitation after Critical Illness. For example, we saw a member of staff on Pembroke Ward assessing the ongoing needs of a patient before discharge home and arranging further rehabilitation services for after discharge.

Pain relief

- We saw the use of a pain assessment tool in 11 sets of patient notes we reviewed. During routine observations, staff asked patients to rate their pain between one and 10. One meant no pain and 10 represented extreme pain. We reviewed three patients' medication administration records (MAR) and saw staff prescribed and administered pain relief appropriately.
- During a drugs round on Phoenix Ward, we saw that the nurse asked patients whether they had any pain. A patient we spoke to on Pembroke Ward told us staff responded quickly when patients on the ward were in pain.
- The service had appropriate safety measures for patient controlled analgesia (PCA) and epidurals. For example, the service prescribed anti-emetic medicine to prevent nausea and vomiting. Medical staff also prescribed reversal agents and fluids for use in the unlikely event of an emergency.
- The trust had an acute pain service. An acute pain team provides specialist advice for managing severe short-term pain such as after surgery. This was available Monday to Friday, 9am to 5pm. Outside these hours, staff could access support from the outreach team with assistance from the on-call anaesthetist.

Nutrition and hydration

- The trust used the Malnutrition Universal Screening Tool (MUST) as part of pre-assessment screening. The MUST tool enabled staff to identify patients at risk of malnutrition and make adjustments to ensure they received adequate nutrition and hydration where appropriate. We reviewed five sets of patients notes on McCulloch Ward, which all provided evidence of MUST assessment.
- The trust provided special diets such as gluten-free and diabetic diets for patients who needed them. We saw a patient on Kingfisher Ward who was on a fat-free diet for medical reasons.
- The service had access to dietitians on-site for patients who needed dietician input. The dietetic service was also available to bariatric patients to help them lose weight before surgery.
- The trust told us they did not audit pre-operation fasting times for adult surgery. However, the service was considering introducing adult pre-op fasting audits as part of the enhanced recovery programme. However, there was an effective process to ensure patients fasted for an appropriate period before undergoing general anaesthetic. Staff asked each patient to confirm when they last ate and drank during the checking process on arrival in theatres. Patients were allowed to drink clear fluids up to two hours before their operation in line with best practice. Patients we spoke with confirmed they had fasted for the appropriate period before surgery in line with pre-operative information given to them by staff.
- Patients told us staff in recovery offered them a drink after their operation. On the wards, we saw patients had water jugs available at their bedsides.
- Staff on the surgical wards monitored patients' fluid balance and recorded observations on fluid balance charts. We reviewed three patients' fluid balance charts on Phoenix Ward and saw staff had completed them fully. However, we reviewed a further five fluid balance charts on McCulloch Ward and found staff had fully completed only one. Local audit results displayed on McCulloch Ward showed staff only completed 60% of fluid balance charts correctly in October 2016. We saw the senior sister took action to address fluid balance charts in the July 2016 ward meeting minutes. However, it appeared staff still did not always complete the charts correctly. The risk of dehydration may have increased if staff did not always monitor fluid balance effectively.

Patient outcomes

- The trust participated in the 2016 National Emergency Laparotomy Audit (NELA). The data in this audit related to patients who had an emergency laparotomy in December 2014 - November 2015. An emergency laparotomy is a surgical operation to urgently find out the cause of severe abdominal pain and in many cases treat it. There are several reasons for an emergency laparotomy, including a bowel obstruction, a bowel perforation (burst bowel) and internal bleeding in the abdominal cavity. Published results showed the trust's case ascertainment of all eligible patients was 94%. This was better than the national target of 80% and better than the national average for other trusts of 70%. The proportion of cases with access to theatres within clinically appropriate time frames was 83%. This was better than the national target of 80% and slightly better than the national average for other trusts of 82%. The crude proportion of highest-risk cases (those with greater than 10% mortality risk) admitted to critical care post-operatively was 93%. This was better than the national target of 80%. It was also better than the national average of 85% for other trusts.
- The trust's risk adjusted 30-day mortality rate (the proportion of patients who died within 30 days of surgery) in the 2016 NELA audit was 14.4%. This was within the expected limits. The trust's data collection for the 2017 audit showed performance in this area at the time of our visit was 8%. This demonstrated a significant improvement in the risk-adjusted 30-day mortality rate. The NELA 2017 audit was not published at the time of our inspection, as the data for this audit related to the period December 2015 – November 2016.
- The 2016 NELA audit showed the proportion of cases with pre-operative documentation of risk of death was 61%. This was worse than the national target of 80%, although only slightly worse than the national average for other trusts of 64%. The proportion of high-risk cases (with predicted mortality of 5% or higher) with consultant surgeon and anaesthetist present in theatre was 53%. This was worse than the national target of 80% and worse than the national average for other

trusts of 74%. However, unpublished data collected by the trust for the 2017 audit showed 100% compliance with the presence of a consultant surgeon in theatres for high-risk cases. Trust data for 2016 also showed 80-90% compliance with the presence of a consultant anaesthetist in theatres. While no national benchmarking data was available at the time of our visit, this demonstrated a significant improvement from the previous year.

- The trust participated in the 2016 RCS falls and fragility fracture audit programme (FFFAP). This national audit measured outcomes for patients who had surgery following hip fracture. The trust's overall performance in this audit put them in the middle 50% of trusts. These meant outcomes for patients who had surgery to repair hip fracture were similar to other trusts nationally.
- The national hip fracture audit 2016 showed the overall length of hospital stay for this group of patients was 17.5 days. This was slightly better than the national average length of stay for other trusts, which was 20.7 days. When compared to other hospitals, Medway Maritime Hospital's result fell into the middle 50%. The hospital's performance in this area remained similar to their 2015 result of 17.3 days average stay. The hospital's perioperative medical assessment rate (the proportion of patients who received specialist orthopaedic or orthogeriatric assessment) was 90.4%. This was better than the national average of 86.2% for the same period and better than the hospital's 2015 result of 83.1%. However, the hospital's 2016 result fell below the national aspirational standard of 100%.
- The national hip fracture audit 2016 showed 71.0% of patients at the hospital had hip fracture surgery on the day of or day after admission. This was worse than the national target of 85%. However, it was only slightly worse than the national average for other hospitals of 72.8% and put the hospital into the middle 50% of hospitals nationally for this indicator. The trust's performance in this area had worsened since the previous year. In 2015, 76.4% of patients had surgery on the day or day after admission. The trust's worsening performance in this area may have been indicative of the flow issues in theatres, which we reported in the responsive section of this report.
- The hospital's risk-adjusted 30-day mortality rate in the 2016 national hip fracture audit was 11%. This meant 11% of patients died within 30 days of surgery. This result was worse than expected, and worse than the average for other hospitals in England of 7.3%. The hospital's 2015 figure was also 11%, and so their performance in this area was unchanged from the previous year.
- Hip fracture in elderly patients is a known risk factor for development of pressure ulcers. The 2016 national hip fracture audit showed 93.9% of patients at the hospital did not develop a pressure ulcer following hip fracture surgery. This result, although only slightly worse than the national average of 94.2%, put the hospital in the worst 25% of hospitals nationally for this indicator. The hospital's performance in this area had worsened since 2015, when 99% of patients did not develop a pressure ulcer.
- In the 2016 Bowel Cancer Audit, the Risk-adjusted 90-day post-operative mortality rate was 5.2%. This was within the expected range. This was slightly better than the trust's 2015 performance in this area, when 6% of patients died within 30 days of bowel cancer surgery.
- The Risk-adjusted 18-month temporary stoma rate for rectal cancer patients who had major resection was 57% in 2016. A stoma is an opening on the surface of the abdomen, which has been surgically created to divert the flow of faeces. A temporary stoma can be used while diseased or damaged bowel recovers before the stoma is reversed. This result meant 57% of patients still had a temporary stoma in place 18 months after their operation to remove rectal cancer. This figure was within the expected range, although worse than the trust's 2015 result of 48%.
- In the 2015 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted, post-operative in-hospital mortality rate of 4.3% for abdominal aortic aneurysms. An abdominal aortic aneurysm is when part of the aorta (a large artery connected to the heart) balloons into the abdomen. This is often fatal if the aneurysm bursts. This meant that 4.3% of patients died in the hospital following surgery. This result was within the expected range.
- The NVR also measured the hospital's performance for carotid endarterectomy surgery. This was surgery to remove a blockage in a carotid artery. The carotid arteries are blood vessels in the neck that carry

oxygen-rich blood to the head, brain and face. The hospital's average time from symptom to surgery was 12 days. This was better than the national standard of 14 days. The hospital's 30-day risk-adjusted mortality and stroke rate (the number of patients who died or had a stroke within 30 days of surgery) was 3.7%. This was better than the expected range.

- The trust participated in the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA). This audit measured outcomes for patients who had surgery to treat cancer of the stomach or oesophagus (the tube that carries food from the throat to the stomach). The age and sex adjusted proportion of patients diagnosed after an emergency admission at the trust was 13.1%. This placed the trust within the middle 50% of all trusts for this measure.
- The trust was part of a strategic clinical network for oesophago-gastric cancer. The proportion of patients with oesophago-gastric cancer treated with the intent to cure (rather than for palliative care) in the strategic clinical network was 40%. This was in line with national results. This measure was reported at strategic clinical network level. Networks can include several cancer units and specialist centres. The result was therefore a marker of effective care at network level, indicating good co-operation between hospitals within the network.
- The trust provided data to national Patient Reportable Outcomes Measures (PROMS). PROMS used patient questionnaires to assess the quality of care and outcome measures following surgery. The trust provided PROMS data from three areas: groin hernia repair, primary knee replacement and varicose vein procedures. The trust used the national EQ-5D and EQ-VAS indexes to assess patients' changes in health.
- PROMS data from April 2015 - March 2016 showed 63.3% of patients at the trust reported an improvement following groin hernia repair. This was better than the overall England figure of 50.8% for the same period according to the EQ-5D index. Under the EQ VAS index, 44% of patients at the trust reported a health improvement. This was better than the England average of 37.4%.
- In April 2015 – March 2016, 93.2% of patients who had primary hip replacement at the trust reported an improvement in their health. This was better than the England average of 89.7% for the same period according to the EQ-5D index. According to EQ VAS, 76.1% of patients at the trust reported an improvement in health. This was better than the England average of 66.4%.
- For varicose vein procedures, the EQ-5D Index showed 60.0% of the trust's patients that reported a health gain from April 2015 to March 2016. This was better than the England average of 50.3% for the same period. However, 40% of patients reported a worsening in their health following varicose vein surgery. This was worse than the England average of 16.5%.
- The average length of stay following different types of surgery was generally in line with, or better than, national averages. The national hip fracture audit 2016 showed patients at the trust stayed in hospital for an average of 17.5 days following hip fracture surgery. This was better than the national average length of stay for other trusts, which was 20.7 days. Data from the national bowel cancer audit showed 62% of patients had a hospital stay of more than five days following bowel cancer surgery in 2016. This was better than the England average of 69% for the same period and slightly better than the trust's 2015 performance of 63%.
- National hospital episode statistics data showed patients at the trust had a worse than expected rate of readmission following elective surgery in March 2015 - February 2016. This meant more patients than expected became ill or developed complications following surgery that required readmission to hospital. We measured the standardised relative risk of readmission to hospital following discharge after surgery. Values below 100 indicated fewer readmissions and a better performance than expected. The overall risk ratio of readmission following elective surgery of 109 was slightly worse than the expected 100.
- The rates of readmission were better than expected for elective ENT surgery, which had a risk ratio of 85.6. The rate was slightly worse than expected for elective colorectal surgery (risk ratio of 102.7). Readmission rates were also worse than expected following elective urology surgery. Elective urology surgery had a risk ratio of 166.7, which was worse than the expected 100.
- The rates of readmission following emergency surgery in March 2015 – February 2016 were slightly worse than expected. The overall emergency surgery risk ratio for

readmissions was 108.6, which was slightly worse than the expected 100. Readmission rates were better than expected following emergency urology surgery (risk ratio of 91.1) and similar to the expected level in trauma and orthopaedics (risk ratio of 101.9). Readmission rates were worse than the expected level for emergency general surgery (risk ratio of 107.1).

Competent staff

- Trust data for April 2015 - March 2016 showed 76.4% of surgical staff had an annual appraisal. This was worse than the trust target of 95%. However, data for April – September 2016 showed 72.4% of staff had already completed their annual appraisal for the year April 2016 – March 2017. This meant the service was on target to meet the required 95% by March 2017. Appraisal data showed 100% of anaesthetists and 100% of pre-assessment nurses had an up-to-date appraisal at the time of our visit.
- We reviewed three staff competency folders on McCulloch Ward. We saw evidence of competency assessment in areas relevant to their roles. This included NEWS charts, aseptic technique, intra-venous (IV) drugs and use of medical devices such as bladder scanners and suction units. All records were up-to-date, with the exception of one nurse's IV competency certificate, which had expired. We highlighted this to a senior sister, who said she would follow this up. We also saw evidence of appropriate competency assessments for staff on Phoenix Ward.
- The trust had improved care for patients with a tracheostomy by increasing the number of nurses trained in this area. A tracheostomy is when a tube is placed into the trachea (windpipe) through an incision in the neck to help the patient breathe. Patients recovered from ENT surgery on McCulloch Ward. A senior sister told us eight out of 10 nurses on the ward had completed tracheostomy care training. Before 2016, only three nurses on the ward were competent in this area. We saw staff training certificates, which provided evidence of competencies in tracheostomy care.
- Nursing staff who applied for a substantive position at the trust had a competency-based assessment. We saw evidence of competency assessment in areas including NEWS, drugs calculation and patient observations in a new member of staff's folder. This meant the trust had assurances of basic nursing competencies when making offers of employment.
- Newly qualified nursing staff completed a preceptorship and recorded evidence in a preceptor booklet. A preceptorship is a structured period of transition for newly qualified nurses when they start employment in the NHS.
- The trust supported staff through revalidation with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We saw evidence of continuing professional development towards NMC revalidation in the staff competency folders we reviewed.
- The service provided agency staff with an induction. Agency staff in theatres and on surgical wards told us they received a trust induction booklet. The nurse in charge went through the booklet with the agency worker and both members of staff signed to confirm the agency nurse received their induction. We saw a copy of the induction booklet. Induction covered a range of areas including hand hygiene, safeguarding, NEWS charts, falls management, incident reporting and sepsis. We also saw a completed induction record for a member of staff on Phoenix Ward. This process ensured agency staff worked to trust policies and procedures.
- We asked a senior sister how she had assurances about the competencies of agency staff. She showed us the electronic rostering system the trust used, which provided details of the competencies of each agency nurse. This meant senior staff had assurances agency staff had the necessary training and skills for their role.
- The trust increased their focus on sepsis education, training, monitoring and reporting in 2016. We saw written information for staff on "recognising patients of concern" and "responding to patients of concern". This included a requirement for a review of all patients with suspected sepsis by the critical care outreach team within 30 minutes. The trust asked all relevant staff to sign to confirm that they understood the policy. Staff were familiar with the national "sepsis six" programme. This involved three treatments and three tests for the diagnosis and management of sepsis.

- An orthopaedic practice development facilitator provided support to permanent and temporary staff on Arethusa and Pembroke Wards.
- The trust measured comparative outcomes by consultant. This meant the trust would be able to identify any deterioration in consultant performance and provide additional training or support.

Multidisciplinary working

- We saw positive examples of multidisciplinary working between clinicians, nursing staff, physiotherapists and occupational therapists on Pembroke and Arethusa Wards. We saw effective multidisciplinary input from the psychiatric teams for patients who needed specialist psychiatric input.
- Entries in the medical records we reviewed also demonstrated a wide range of professional input into patients' care. This included speech and language therapist, pharmacist and acute pain team.
- We observed an occupational therapy assistant discussing discharge plans with a patient's relative on Pembroke Ward. This helped the relative identify how to make the patient's home environment suitable for their needs upon discharge, for example, by rearranging furniture. The discussion allowed occupational therapy staff to arrange appropriate equipment for the patient to take home to maximise their independence while they continued their recovery.
- We observed a discharge on Pembroke Ward. We saw that the patient took a walking frame home them to maximise their independence while they continued their recovery. We saw a nurse counselling the patient on medicines to take home. We also saw the nurse telephone a service providing ongoing occupational and physiotherapy in patients' homes to confirm the patient's discharge from hospital. The service was an initiative provided by the trust in collaboration with the local council and community healthcare trust. The nurse also telephoned the patient's partner to confirm they were at home to receive the patient.

Seven-day services

- All surgical patients had a daily review from a clinician, seven days a week. Consultants mostly led ward rounds, although staff told us registrars often led the weekend ward rounds for general surgical patients with consultant oversight.
- The service had access to an on-call physiotherapy service at weekends. There was also an on call pharmacist available to provide pharmacy support in the evenings and at weekend.
- The hospital's diagnostic imaging department provided a 24-hour, seven-day on-call service. This allowed surgical staff to access to consultant-directed diagnostic services such as x-ray, ultrasound, CT and MRI, seven days a week to support clinical decision-making. This was in line with; NHS services, seven days a week, priority clinical standard five (2016).
- The service had an emergency theatre, which was available seven days a week for urgent operations.

Access to information

- Doctors completed comprehensive discharge summaries for patients, with input from nursing staff around ongoing care. We saw copies of discharge summaries in patient records. These included details of the patient's diagnosis, any infection control risks and the patient's VTE assessment. Staff sent an electronic copy of the discharge summary to the patient's GP to enable continuity of care in their community. Discharge included details of the treating consultant to enable the patient's GP to contact them for advice if they needed to. Staff also gave a copy of the discharge summary to the patient so that they were fully informed of their ongoing care.
- We saw that discharge summaries contained comprehensive plans for ongoing care. This included medication on discharge, wound care, pressure areas, and details of follow-up appointments. Nurses contacted district nursing teams before discharge to arrange ongoing care in the patient's home where appropriate, such as wound care or catheter care.
- We also saw discharge summaries from intensive care unit for patients who received critical care following surgery before 'step down' transfer to a surgical ward. This enabled continuity of care for this group of patients while they continued their recovery.

- Staff told us there was insufficient access to computers on some of the surgical wards. We witnessed an argument between two doctors on Phoenix Ward. The doctors disagreed over which one of them should use the only computer available to them at that time to access the information they needed. Both doctors felt their patients' needs should take priority over the other. Administrative staff told us they were sometimes unable to their jobs because they needed to vacate their computers to allow clinical staff to use them to obtain urgent clinical information. This may have reduced the efficiency of administrative staff time, and prevented staff accessing information in a timely way.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw written consent for surgery in nine sets of surgical patient records we reviewed. We saw that consultants had documented the risks and benefits of surgery, in line with GMC guidance. We saw patients and consultants signed consent forms before the day of surgery. This was in line with guidance from the RCS Good Surgical Practice 2014, which states staff should "Obtain the patient's consent prior to surgery and ensure that the patient has sufficient time and information to make an informed decision". Patients and consultants then provided an additional signature on the day of surgery to confirm their consent to proceed in line with best practice guidance.
- The trust provided staff with Deprivation of Liberty Safeguards (DoLS) training as part of the mandatory adult safeguarding modules. As at 18 October 2016, 80.4% of relevant staff had completed DoLS training as part of safeguarding adults level two. Trust data from 18 November 2016 showed 81.1% of relevant staff had up-to-date Mental Capacity Act (MCA 2005). Staff training rates for DoLS and the MCA (2005) met the trusts target of 80%. This meant relevant staff had training to enable them to assess mental capacity and work within the legal requirements of the Mental Capacity Act (2005).
- Staff knew their roles and responsibilities under DoLS. For example, during a mental capacity assessment, staff on McCulloch Ward told us they recognised a patient was highly agitated and felt it was in the patient's best interests to have one to one support by a dedicated registered nurse day and night. Staff recognised this would constitute a deprivation of liberty under the Mental Capacity Act (MCA 2005) as it would stop the patient leaving the ward. Staff liaised with the trust's safeguarding team, who applied for a standard authorisation for DoLS. This action was proportionate and in line with the requirements of the MCA (2005). We saw dedicated areas on the governance boards in staff rooms to record the details of any patients with a DoLS in place. This ensured all staff were aware of any current DoLS.
- However, on Phoenix Ward, we reviewed the notes of a patient with dementia who lacked capacity. Staff used bed rails, which deprived the patient of their liberty to freely move out of bed. However, there was no evidence of a DoLS application in the patient's notes. This was not in line with the requirements of the MCA (2005). We also saw another patient on Phoenix Ward with a dementia diagnosis who did not have a capacity assessment in their notes. We highlighted this to staff, who immediately arranged an assessment with a specialist dementia and delirium nurse. We saw the dementia and delirium nurse attend the ward and review the patient. On our unannounced visit, we saw that staff had made the appropriate application for DoLS for the patient with bedrails.

Are surgery services caring?

Requires improvement

At our last inspection in 2015, we rated caring as good. However, we have now rated caring as requires improvement following concerns around patient privacy and dignity identified at this inspection.

We rated caring as requires improvement because:

- Bedside handovers on the surgical wards did not always maintain patients' privacy and confidentiality. Staff did not always introduce themselves before the handover or involve the patient in their care.
- We saw a doctor conduct an intimate examination in front of several colleagues. This did not maintain the patient's privacy and dignity. Another patient told us they "felt uncared for by recovery staff", who were "abrupt and unkind".

- NHS friends and family test results were consistently worse than the England average in November 2015 – October 2016.

However:

- We also saw staff treat patients with respect and kindness. Most of the patients we spoke with felt supported and said staff cared about them.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.
- We saw examples of staff demonstrating understanding of patients' needs and respecting their wishes and preferences.

Compassionate care

- We observed nursing handovers on Kingfisher Ward, SAU and Phoenix Ward, which did not always maintain patients' privacy and confidentiality. On Kingfisher Ward/SAU, we saw 10 members of nursing staff crowd into each bay for handovers at the patients' bedsides. The number of staff present meant they could not all fit around the patients' beds and close the curtains. This meant handovers took place in the middle of the bays where other patients could overhear. We saw that staff sometimes discussed personal details during handovers, such as catheter care and enemas. This meant staff did not always maintain patients' privacy, dignity and confidentiality during handovers. We discussed this issue with the deputy director of nursing. She told us the bedside handover should consist of a review of the patient's observations chart and a check that patients had their call bell within reach. Staff should then discuss any personal information at the nursing station before the nursing safety huddle. Therefore, staff did not follow the correct processes for bedside handovers.
- We saw a medical ward round where a consultant performed an intimate medical examination on a patient with several other doctors present. The consultant obtained patient consent and used a chaperone of the same sex as the patient. However, having an excessive number of staff present may have compromised the patient's privacy and dignity.
- We reviewed NHS friends and family test data for November 2015 – October 2016. The percentage of patients who would recommend the service to their family and friends was consistently worse than the England average. Average friends and family recommendation rates for surgical patients at the trust ranged from 74.7% to 89.2% in November 2015 – October 2016. The England average recommendation rate during this period ranged from 94.2% to 95.7%. The friends and family test response rate for surgery at the trust was 25.5% during this period. This was worse than the England average of 30.1%.
- The percentage of patients that would recommend the trust varied between wards and months. Sunderland Ward had the best friends and family recommendation rates, which ranged from 76.7% to 92.1%. The worst recommendation rates came from patients on the SAU (ranging from 61.3% to 77.1%).
- A patient told us they "Felt uncared for by recovery staff". They felt recovery staff were abrupt and unkind. They told us they felt staff rushed them to leave recovery before they felt ready, and they heard staff saying they needed to get patients out of recovery before CQC staff visited. The patient told us this resulted in them having a panic attack. However, the patient told us they were much happier with the care after they transferred to Phoenix Ward, where staff were "Very caring".
- We spoke with patients and relatives on Phoenix, McCulloch and Pembroke Wards. Most of the patients we spoke to felt staff on the wards were caring. Patient comments about ward staff included, "Very caring", "Excellent nursing staff", "Staff very attentive", and "Staff looked after us very well".
- We also saw examples of compassionate care during our visit. This included staff in theatres maintaining patients' dignity. On Phoenix Ward, we saw a matron help cover a patient when their gown slipped as they walked across the ward.

Understanding and involvement of patients and those close to them

- Evidence-based literature identifies the involvement of patients as an advantage of bedside handover. However, we saw staff did not always involve patients during nursing handovers at the patients' bedsides. Staff did not always introduce themselves before the handover or involve the patient in their care. On the SAU, we saw the nursing handover disturbed one patient's sleep. On Kingfisher Ward, we saw a patient

becoming confused by the medical terminology staff used. The patient asked questions, but staff offered very brief answers and did not fully explain. This meant patients were not always fully involved in their care during bedside nursing handovers. However, we also saw an agency nurse greet a patient warmly and involve them in the nursing handover on Kingfisher Ward.

- We saw staff on Pembroke Ward involving patients' relatives in their care. This included keeping them informed about discharge arrangements.
- We saw staff on Phoenix Ward respected a patient's wishes not to be woken up in the night for routine observations. During a handover, a nurse on Phoenix Ward noticed a patient was receiving prescribed enemas in the evening. She recognised this might cause the patient to have disturbed sleep. The nurse then told her colleagues she would ask doctors to re-prescribe the enema so that the patient could sleep well at night. These observations demonstrated staff involved patients as partners in their care and understood their needs.

Emotional support

- Nursing staff provided emotional support to patients and relatives in the first instance. A patient we spoke to on Pembroke Ward told us about a time staff comforted another patient when they were upset and helped them feel better.
- The trust had a chaplaincy service available to provide emotional and spiritual support for patients and their loved ones. Nurses talked about meeting peoples different religious needs. We saw that staff made a referral to the catholic priest for a patient on Phoenix Ward.
- Staff referred patients who had cancer surgery for specialist counselling. The referral form for counselling included an option to refer a patient's relative, carer or friend. This meant patients' loved ones also had access to emotional support.
- The trust provided monthly "carers' coffee breaks" in the hospital canteen. The purpose of the carers' coffee breaks was to provide emotional support to the relatives and carers of patients living with dementia. We saw details of the coffee breaks advertised to carers of patients on Arethusa Ward.
- During nursing handovers, we saw nursing staff showed awareness of patients suffering from anxiety or depression. We saw the service made appropriate referrals for psychiatric support for patients at risk of self-harm.

Are surgery services responsive?

Requires improvement

At our last inspection, we rated responsive as requires improvement. On this inspection, we have maintained a rating of requires improvement, but saw improvements in some areas such as complaints. The trust had cleared its backlog of complaints and complaint response times were starting to meet trust targets. We also saw evidence of learning from complaints, which was lacking on our previous inspection.

We rated responsive as requires improvement because:

- The service did not always use the facilities and premises appropriately due to a lack of available beds. There were inappropriate ward placements, patients staying overnight in the recovery areas in main theatres and mixed-sex accommodation breaches. Patients also had bed moves at inappropriate times, such as during the night.
- Delayed discharges on the surgical wards further affected the availability of surgical beds.
- Problems with access and flow meant operating lists rarely ran on time.
- The proportion of cancelled operations was consistently worse than the England average.
- The trust had not reported referral to treatment (RTT) data since November 2014. The trust returned to reporting around the time of our visit in November 2016. Data showed 18-week RTT times were worse than the England average.

However:

- The service made reasonable adjustments and took action to remove barriers for patients who found it hard to use or access services. This included translation services, services for patients living with dementia and facilities for bariatric patients.

- We saw openness and honesty in complaint responses and evidence of learning from complaints.

Service planning and delivery to meet the needs of local people

- The trust surgical services provided a diverse range of elective and emergency surgery to meet the needs of the local population. Surgical services covered general surgery, anaesthetics, urology, ear, nose and throat (ENT), orthodontics, vascular and orthopaedics.
- We saw evidence of regular engagement with commissioners around the planning and delivery of services. Commissioners set performance targets for improvements in care delivery relevant to surgery around mixed-sex accommodation breaches and waiting times for cancer surgery.
- In the day surgery unit, staff held a weekly meeting to plan theatre capacity and review staffing for the week ahead. Staff told us the service usually cancelled one to two day surgery lists in advance each week. This was usually due to lack of available surgeons or anaesthetic staff.
- Patients planning elective hip replacement had an occupational therapy review before surgery. This allowed staff to arrange appropriate equipment to meet their needs while they recovered in hospital following surgery. This included raised chairs and mobility equipment.
- The service had a dedicated emergency theatre. We saw the team review the emergency list at the start of their shift and move patients to other theatre lists where appropriate. This enabled the service to prioritise urgent surgery for patients with the greatest need.
- Trauma lists had a "golden patient" at the start of each operating list. Staff selected a golden patient to have their operation first on the operating list. This meant staff carried out all the preparation for the patient, for example blood tests and consent, the day before the operation. Advanced preparation of the golden patient helped minimise delays.
- In May - July 2016, theatre utilisation at the trust ranged from 61.7% (in theatre DS02 in July 2016) to 100.2% (in theatre TH03 in June 2016). Theatre TH07 saw the highest variation in theatre utilisation, ranging from 75.2% in July 2016 to 93.5% in May 2016. The service had recently introduced a new dashboard at the time of our visit. The service was beginning to use the dashboard to monitor theatre utilisation more closely in an effort to improve efficiency.
- The Surgical Assessment Unit (SAU) introduced a “hot clinic” in 2016. The clinic ran Monday to Friday, 9am to 5pm. The purpose of the clinic was to reduce waiting times for patients needing ultrasound scans and minor procedures such as abscess drainage. It also helped reduce pressure on SAU beds and the emergency department (ED). For example, the clinic allowed patients who attended ED in the evening to go home overnight if they were well enough and attend a pre-booked scan in the hot clinic the next morning. The clinic also took referrals direct from GPs for patients needing an urgent scan. A surgical registrar led the clinic and also added patients to waiting lists for elective surgery and took consent where this was appropriate following assessment. This also helped reduce pressure on outpatients’ clinics and saved patients from waiting for an outpatient appointment.
- The service had closed the surgical discharge lounge since our previous inspection after we identified a number of concerns relating to inappropriate use of this area. The service had extended McCulloch Ward into this space and increased the number of beds on the ward. Staff told us patients now went home directly from the ward, where they had appropriate access to nursing care before discharge. This was a considerable improvement since our last visit.
- The service had a Pre-Operative Care Unit (POCU). Patients went to POCU before elective surgery for admission checks. Patients changed into their gowns and waited to go to theatres. The facility had 12 small cubicles with comfortable seating for patients and relatives, and four consultation rooms.

Access and flow

- The SAU did not function appropriately as a surgical assessment area. The purpose of the SAU was to reduce unnecessary surgical admissions to the surgical wards by providing quicker access to a review by the surgical team and improve the flow of patients through the surgical pathway. The trust’s SAU operation policy stated the SAU accepted patients with a general surgical or urological condition referred by the surgical registrar

or urology senior house officer on call. However, we saw medical outliers (medical patients on non-medical wards) occupying SAU beds overnight. Staff told us the trust frequently used the SAU as an escalation area for medical outliers due to a trust-wide shortage of beds.

- We saw four medical outliers occupied SAU beds overnight. There were eight SAU beds in total. This meant medical outliers occupied 50% of beds intended for patients needing urgent review by the surgical team. Staff told us the blocking of beds by medical outliers meant patients awaiting surgical review had to wait for extended periods in the SAU waiting room. Patients often found this uncomfortable and staff told us they received regular complaints from patients around extended waits. Staff told us they offered food and drinks to patients in the waiting room if they were not nil by mouth and tried their best to keep them comfortable. On our unannounced inspection, medical outliers occupied seven of the eight SAU beds overnight. An additional medical outlier spent the night in the triage room on SAU. This was not in line with the trust's SAU operational policy, which stated, "The triage room [is] not to be bedded". As a result, staff had closed the SAU and patients needing urgent surgical review stayed in ED to ensure safe care. This situation then affected the flow of patients through ED, potentially causing longer waits for other ED patients.
- The SAU operation policy included escalation to the surgical matron or site team to temporarily reduce demand. The nurse in charge could escalate if SAU exceeded its maximum capacity, defined in the policy as eight patients on trolleys and four patients in the waiting room. SAU staff kept an escalation folder; we saw escalation occurred on a daily basis. This was indicative of the flow problems created by medical outliers inappropriately blocking beds.
- We also saw medical outliers occupying surgical beds on other wards. For example, there were 10 medical outliers on the 30-bed McCulloch Ward. During our unannounced visit, 12 out of the 29 patients on Phoenix Ward were medical outliers.
- Staff used the recovery area in main theatres for overnight stays for patients recovering from surgery when demand for surgical beds exceeded capacity. We identified this as a problem on our last inspection, which had not improved. Trust data showed 91 patients stayed overnight in recovery in August – November 2016. This worst month during this period was October 2016, when there were 37 overnight stays. We saw that staff tried their best to provide appropriate care to these patients. We spoke to two patients who stayed overnight in recovery and both felt satisfied with the level of care staff provided. We saw that overnight patients had access to food and drink and could use the staff toilet facilities. However, this was an inappropriate area to provide inpatient care as it had no facilities for patients to wash. It also resulted in relatives of overnight patients visiting while patients who had immediately left theatre recovered.
- Using recovery as an inpatient area also affected the flow of operating lists. We saw patients recovering in anaesthetic rooms due to the lack of recovery space. This delayed operations for subsequent patients on the list. This was an issue on our last inspection and had not shown signs of improvement.
- Staff told us delays in operating lists caused by the flow issues meant patients further down the operating list often had their operations cancelled. This happened on the day of our visit. The surgeon cancelled the last patient on the list because he felt there was not enough time to complete the operation. We saw the anaesthetist informed the patient within 20 minutes of the decision to cancel. Staff rebooked the patient's operation for the following morning.
- Data showed the proportion of cancelled elective operations was consistently between 1% and 2% between July 2014 and June 2016. The proportion of cancelled operations remained consistently worse than the England average of 1% or below throughout the entire period. However, the most recent available data for April – June 2016 showed the trust's cancellation rate had improved and was closer to the England average for this period.
- The trust cancelled 361 operations at the last minute in July 2015 – June 2016. A last-minute cancellation was a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. Following cancellation, 4% of patients did not have their operation within 28 days during this period. The rate of patients

who did not have surgery within 28 days of a cancellation was consistently better than the England average, which ranged between 4% and 9%, throughout the reporting period.

- Theatre lists often did not start on time. The average surgical start time was after 9am; despite theatre staff being available from 8am.This may have further affected the late running of lists. However, we saw data that showed the average start time of trauma surgery lists had improved since our last visit. The data showed a steady improvement in start times between January 2014 and August 2016. In January 2014, the average start time was 10.25am. This had improved to 9.55am in August 2016. This meant patients' waiting time for their operation to start had improved by an average of 30 minutes. The average time of the first patient into the anaesthetic room and the time the first patient on the list transferred to the theatre suite had improved in line with the improved start times. The average time theatres sent for the first patient had improved from 9.10am in January 2014 to 8.55am in August 2016. The senior leadership team for surgery identified low staffing levels in POCU as a reason for late starts. Insufficient staff in POCU caused delays in patient admission, meaning operating lists did not start on time.
- Sunderland Ward was a day case ward intended for patients recovering from day surgery. We saw the trust's admission criteria for the Sunderland Day Case Centre. This document set out clear guidance around patient acceptance criteria. The ward did not accept 16 categories of patient, which included major surgical cases, medical patients, direct admissions from ED and patients needing major nursing or medical input. Although the ward was not intended for overnight stays, the admission criteria stated the ward would accept up to 14 patients staying more than 23 hours.
- During our announced and unannounced visits, we saw breaches of this policy and inappropriate placement of patients on Sunderland Ward. This included 26 patients staying overnight during our announced visit. This included seven medical outliers and a patient transferred from ED. On our unannounced visit, there were two medical outliers on Sunderland Ward. Staff told us 26 patients had again stayed on the ward the night before our unannounced visit. However, staffing rotas demonstrated staffing levels were safe for the increased number of patients on Sunderland Ward. Patients also had beds rather than trolleys to ensure they were comfortable. The team on Sunderland Ward worked incredibly hard to provide the best care they could, despite the challenges they faced. One member of staff told us, "It's like this every day. We never know how we are going to manage, but we do".
- We observed a telephone call from the bed management team while we were on Sunderland Ward. The ward had 26 patients at that time and the bed management team asked staff to take another patient who was in recovery following surgery. Staff told the bed management team they had no capacity on the ward and were awaiting beds to admit nine patients for the day surgery list. However, the bed management team did not listen. They told ward staff to "take the patient's name and just tell theatres you cannot take them when they call". This would further affect the flow of patients by blocking recovery beds, as well as delaying the day surgery list by delaying admissions.
- Surgical bed occupancy rates ranged from 82.5% to 100% in September 2015 – August 2016. Bed occupancy rates reached 100% in three months during this period. This meant all surgical beds were occupied during these months, with no spare capacity for additional patients. This was similar to the bed occupancy rate of 99.1% at our last inspection in 2015.
- Some patients had bed moves and discharges at inappropriate hours. During our visit, staff moved a patient from the high dependency unit to Kingfisher Ward at 2am. We reviewed the admissions and discharge book on Phoenix Ward. In the week between our announced and unannounced visits, we saw evidence of three night-time bed moves. One of these was at 10.30pm, one at 2am and one at 3.30am. We also saw that Phoenix Ward discharged six patients the day before our unannounced visit. The earliest discharge took place at 4.20pm and the latest one at 8.20pm. The late timing of discharges reduced the availability of beds on the ward and contributed to night-time bed moves. It also may have caused some patients to arrive home from hospital late in the evening. This could cause difficulties for vulnerable patients, such as those with

additional social care needs or elderly patients. A member of staff on McCulloch Ward told us they recently submitted an incident report after two vulnerable patients living with dementia had overnight bed moves.

- In April 2015 - March 2016, the average length of stay for elective surgical patients was 2.1 days. This was better than the England average of 3.3 days. For non-elective surgical patients, the average length of stay was 4.8 days during the same period. This was better than the England average of 5.1 days.
- The trust had not reported referral to treatment (RTT) data since November 2014. The hospital started to prepare data for a return to reporting in November 2016. Trust data for October 2016 showed 55.2% of surgical inpatients had their operation within 18 weeks of referral. This was worse than the England average of 71.4% for the same month.
- For eight out of nine surgical specialties, RTT times were worse than the England average. Urology was the only surgical specialty with RTT times better than the national average. In October 2016, 93.7% of urology patients had their operation within 18 weeks of referral. This was better than the England average of 80.2%.
- The trust's performance around cancer waits was improving. Performance in this area met the agreed trajectories with local commissioners for incomplete and 52 week performance. Trust data from January - November 2016 showed 95.5% of patients with colorectal cancer had surgery within two weeks of referral. This was a significant improvement on the trust's 2015 performance in this area when only 5% of patients had treatment for colorectal cancer within two weeks of referral.
- The trust introduced a new emergency surgery pathway for patients with fractured neck of femur (NoF) (hip fracture) in 2016. The pathway involved collaborative working with the hospital's emergency department (ED) to ensure patients had their surgery more quickly and within the 48-hour national target. An ED consultant was starting to audit the pathway, although no data was available at the time of our visit. Although the pathway was new at the time of our visit, clinical leads in surgery said they were already seeing improvements in mortality rates.

Meeting people's individual needs

- During our announced visit, we saw mixed sex breaches in the SAU and Sunderland Ward. A mixed sex breach is when male and female patients share the same bay. In the SAU, we saw two male and two female patients who had stayed overnight in B Bay. We discussed this with the senior sister, who confirmed there were occasional mixed-sex breaches in the SAU. This was because of a lack of available beds. Trust data showed there were 38 mixed-sex breaches in the SAU over a four-week period in July and August 2016. The reasons for breaches were a lack of available surgical beds.
- On Sunderland Ward, we saw a mixed sex breach in Bay One, where two female and three male patients shared the bay. We spoke to the senior sister, who told us the ward often had mixed sex breaches with day cases. Staff reported breaches on the trust's incident reporting system and escalated to senior management. However, mixed sex breaches were a common occurrence due to bed shortages. We saw a further mixed sex breach on Sunderland Ward during our unannounced visit. On this occasion, two female and three male patients shared Bay One.
- We saw some inappropriate ward placements of patients with mental health conditions and learning disabilities. We saw a patient with learning disabilities and a history of a mental health conditions had been on Sunderland Ward for seven nights. During our unannounced visit, there was another patient on Sunderland Ward recovering from self-harm who had transferred from the intensive care unit. These patients' additional needs meant an extended stay on a day case unit intended for low acuity patients was an inappropriate environment for them. However, we saw evidence of specialist psychiatric input on the wards for patients with mental health conditions.
- We saw patients using interpreters, such as a Portuguese patient in theatres and a Polish patient on McCulloch Ward. The trust had access to interpreters of many different languages, who provided both face-to-face and telephone interpreting services. Staff could book interpreters via the trust intranet or by telephone. Staff we spoke to knew how to arrange interpreters for patients who needed them
- However, during a ward round on the SAU, we saw nursing staff saying they would contact a patient's daughter to ask if she would translate for the patient. It

is not considered best practice to use family members for translation. Interpreters should be impartial and have appropriate training so staff have assurances they communicate important medical information correctly and do not try to influence the patient's decisions. We spoke to the senior sister, who told us staff always offered an interpreter but that some patients declined. However, we checked the patient's notes and saw no evidence staff had offered the patient an interpreter.

- The trust had a dedicated dementia and delirium team consisting of one clinical nurse specialist and one clinical support worker (CSW). We saw the clinical nurse specialist for dementia and delirium reviewing patients of Phoenix Ward and providing specialist input. The service used the "blue butterfly scheme". Staff placed a blue butterfly magnet above the bed of patients living with dementia. This provided a discrete way to help staff easily identify patients living with dementia and better meet their needs. The trust also had "dementia buddies". These were trained volunteers available to spend one to one time with patients living with dementia.
- Patients living with dementia and their carers completed a "this is me" passport. The passports provided person-centred information about the patient. This enabled staff to recognise and respond to the patient's individual needs. Patients with learning disabilities also had individual care passports. However, staff told us patients and carers sometimes completed the passports once the patient was on a ward recovering from surgery. For patients having elective surgery, staff should ideally complete these before admission. This would allow staff to begin meeting the patient's individual needs as soon as they arrive in hospital for their operation.
- However, staff on the surgical wards did not always follow individual care plans for patients living with dementia. We reviewed the notes for a patient living with dementia on Phoenix Ward. The patient had one to one care from a CSW as part of their care plan. The care plan stated the patient often became agitated at night, therefore it was important to keep the patient awake and stimulated during the day. This included taking the patient for a walk away from the ward if it was safe to do so. We saw the patient was asleep during our daytime visit. We spoke to the CSW providing one to one support, who said they were unaware of the care plan. This meant the service did not meet the patient's individual needs.
- The trust had resources available for patients living with dementia who were recovering from surgery. This included "twiddle muffs". Twiddle muffs are knitted bands with attachments to provide comfort and stimulation to patients living with dementia. Patients on Arethusa Ward also had access to a digital activity reminiscence system (DART). DART was a very large touch-screen tablet. Staff could programme a patient's favourite vintage TV programmes, sports matches and music linked to their "this is me" passport.
- At the time of our visit, Arethusa Ward was trialling "John's Campaign". This was a national initiative to allow open visiting for carers of patients living with dementia. This enabled carers to provide stimulation and help with the patient's recovery. Carers had a carer's passport, which enabled them to visit patients living with dementia at any time they wanted.
- In the Day Surgery Unit, we saw a list of the maximum weights for equipment such as operating tables and trolleys. We also saw a list of bariatric equipment in main theatres. This allowed staff to safely treat bariatric patients. Staff told us they could request additional bariatric equipment, such as wheelchairs, from the hospital's equipment library. Staff gave us examples of times they had done this.

Learning from complaints and concerns

- In August 2015 - July 2016, there were 113 formal complaints about surgery at the trust. The trust took an average of 105 days to investigate and close complaints. This was not in line with the trust's complaints policy, which states the complaints response time should be within 30 days, unless the complainant agreed to a longer period. However, surgical services brought in additional staff and cleared its backlog of complaints. At the time of our visit, the service had started to respond to complaints within the 30-day target.
- As well as responding to complaints more quickly, surgical services had made other improvements to complaints processes in 2016. This included matrons contacting complainants over the telephone within 48 hours and inviting them to come into the hospital to

discuss their concerns. This helped prevent complaints from escalating. A matron gave us an example of how improved communication with a patient's family had helped resolve their concerns informally without the need for escalation to a formal complaint.

- Since our last inspection, surgical services carried out broader analysis of complaint trends and themes and fed this information back to different areas of the service. Between August 2015 and July 2016, the most frequently complained about specialty was general surgery with 47 complaints. The most frequently complained about ward during the same period was Phoenix Ward with 13 complaints. The most common themes for complaints were lack of care/attention and treatment (36 complaints), and waiting times for procedures (24 complaints).
- Staff we spoke to at all levels told us they received learning following complaints. We saw copies of ENT specialty and ward meetings, which showed staff received learning information from complaints. We also saw complaint feedback displayed on the governance boards on the surgical wards. Nursing staff were able to tell us about changes to practice following lessons learnt from complaints.
- We reviewed five formal complaints relating to surgical services in 2016 and the trust's responses. In all five cases, we saw evidence of investigation, explanation and apology. We saw the trust was honest in its responses, for example, if staff had made mistakes or should have done things differently. This was in line with the regulatory Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. From complaint responses, we also saw the trust implemented changes to practice following complaint learning. An example of this was the introduction of "intentional rounding" on the wards every two hours to ensure patients were comfortable and had sufficient fluids available. During our visit, we saw daily care round charts on Pembroke Ward, which showed staff completed two-hourly rounds.

Are surgery services well-led?

Requires improvement

At our last inspection in 2015, we rated well-led as inadequate. However, following significant improvements in key areas including staff engagement, culture and senior leadership, we now rate well-led as requires improvement. Improvements in staff morale and culture were particularly visible on the surgical wards.

We rated well-led as requires improvement because:

- Staff satisfaction was mixed in some areas, such as main theatres
- Staff sometimes experienced pressure from management. Examples included pressure to take additional patients on the wards, and pressure on theatre staff to continue working beyond their expected finish time.
- Not all leaders had the necessary experience, knowledge, capacity or capability to lead effectively. However, the trust recognised this and introduced training to support and develop leaders, such as matron development days.

However:

- Quality received sufficient coverage in board meetings, and in other relevant meetings below board level.
- Staff in all areas knew and understood the vision and values.

Vision and strategy for this service

- We saw that surgical services had made significant improvements in a number of areas since our last inspection in 2015. This included recognition and escalation of deteriorating patients, learning from incidents, improved complaints processes, staff recruitment and referral to treatment times for colorectal cancer.
- However, the service recognised they still had more work to do. The strategy for surgical services was to reduce weekend mortality, improve theatre productivity, and recruit and retain more nursing staff. The trust had partnerships with local universities, which helped

recruitment of newly qualified nurses. The trust also held nursing open days every other month to help attract registered nurses considering coming to work for the trust.

- The strategy included plans to improve patient access and flow, which we also identified as areas for improvement during our visit. This included plans to use Sunderland Ward for day case patients only. The strategy also included plans to expand the Surgical Assessment Unit (SAU) to include four additional beds. We saw a surgical flow proposal describing these plans. Matrons and senior sisters we spoke to were aware of the strategy for surgical services.
- The trust's values were bold, every person counts, sharing and open; and together (BEST). We saw the trust values displayed throughout the hospital. Staff we spoke to knew the values and could describe how they worked to them. For example, staff told us being bold was not being afraid to raise concerns and report incidents. This showed the values were embedded within the service.

Governance, risk management and quality measurement

- Each branch of surgery (orthopaedics, vascular, urology, orthodontics, ear, nose and throat (ENT), general surgery and anaesthetics) had a clinical lead. The clinical lead for each surgical specialty reported to the clinical director for surgery. Each surgical specialty held monthly meetings, which included consultant, matron and management representation.
- Surgical specialty meetings fed into perioperative programme board minutes. The service discussed governance and quality issues at monthly perioperative programme board meetings and emergency surgical services programme board meetings. We saw copies of the minutes, which showed evidence of coverage around key areas. These included safety alerts, updates to NICE guidelines, incidents, performance dashboard, risk register and clinical audit.
- The lead for perioperative governance also held weekly incident review meetings. At these meetings, staff discussed incidents related to surgery from the previous week. The perioperative governance lead took forward any incidents categorised as moderate harm or above for discussion at the weekly trust wide harm free meeting. This enabled further investigation and sharing of learning across other areas of the trust.
- We reviewed the surgical directorate risk register. We saw that items on the register matched the things senior staff told us were on their "Worry list". This included patient flow and the lack of nursing vacancies. This also fitted with areas we identified for improvement during our inspection. We saw evidence of mitigation of risks, for example, appropriate induction processes for agency staff filling vacant shifts.
- We saw the surgical dashboard, which monitored monthly performance in a number of areas. These included mortality, complaints response times, discharge times, waiting times for surgery and mixed-sex accommodation breeches. We saw that the service compared performance to the previous month to identify trends. This meant managers were able to identify emerging concerns, and obtain assurances they were performing well or improving. Any corrective actions had a named lead and a timescale to ensure accountability.
- We also saw the theatre dashboard, which monitored theatre activity. The theatre dashboard included trends in operation start times, use of the emergency theatre, consent and WHO surgical safety checklist compliance.

Leadership of service

- The service had identified shortfalls in leadership in some areas. Staff in some areas told us they escalated issues to matrons, such as the behaviour of some agency staff in theatres, but felt leaders did not take action. This led to some staff feeling a lack of faith in their managers to empower change. The service subsequently introduced matron development days to help educate and develop matron leadership. The first matron development day took place on the day of our unannounced visit. Therefore, it was too early to measure the impact of this training.
- The service also held regular band 6 development days to help band 6 nurses learn the skills they needed to develop into future managers. At the time of our visit, 30

staff had attended the band 6 development days. Another aim of the band 6 development days was to help retain staff by giving them the skills to progress their career within the trust.

- We saw that senior leaders were visible and approachable. Staff were able to identify the chief executive and deputy director of nursing. Staff told us the deputy director nursing was approachable. For example, staff said the deputy director of nursing was approachable when they needed to escalate concerns around patient access and flow in the SAU. A consultant anaesthetist felt the senior management team were more visible in trying to address the access and flow issues in theatres. The executive stability and support helped staff feel valued. This was a significant improvement from our 2015 inspection, when staff could not name any members of the executive team and did not know who the director of nursing was.
- Most staff we spoke with felt well supported by their line managers. We also saw that the matrons were visible on the wards and supported staff with patient during busy times. Matrons filled clinical shifts in theatres when necessary, for example, due to staff sickness. However, not all staff felt the matrons supported them. For example, staff in the pre-operative care unit POCU told us about a time they asked a matron to help by giving an enema. The matron responded, "What do you want me to do about it?" Staff working (POCU) told us they sometimes felt isolated. They told us the executive team never told them they were doing a good job. This negatively affected staff morale.

Culture within the service

- Overall, staff morale had improved since our last inspection although it was still low in some areas. In main theatres, nurses and operating department practitioners (ODPs) told us they felt "Exhausted" due to the lack of permanent staff. Staff in main theatres also told us they felt pressured to continue working past their allocated finish time when operating lists overran. Staff said managers and consultants sometimes told them, "You can tell the patient they cannot have their operation because you want to finish on time".
- Before our inspection, we received information about bullying on a surgical ward. However, managers told us the trust carried out a full investigation into these allegations. The investigation found the allegations were unsubstantiated. We spoke with six members of staff on the ward, and all told us the ward was a positive environment to work in with no bullying or harassment. All staff we spoke to on the ward reported positive, supportive working relationships with managers and colleagues.
- We saw pressure from the bed management team towards staff on Sunderland Ward. The bed management team wanted them to accept an additional patient, even though they were full and had three patients awaiting admission for day surgery. Staff told us sometimes the matrons over-rode them when they told the bed management team they could not accept additional patients because they were full to capacity.
- However, staff we spoke to on the surgical wards felt the culture had significantly improved since our last inspection. Staff we spoke to on Kingfisher Ward/SAU, Phoenix Ward and McCulloch Ward felt morale was much better because of improved nurse staffing levels. Staff on the wards talked of positive working relationships with their colleagues and managers. On Sunderland Ward, we saw staff supporting each other and working as a team during very busy periods. Staff on POCU also spoke of positive team working with colleagues.
- The trust awarded "wow awards" to staff nominated by patients for providing a great patient experience. Staff on McCulloch Ward also told us they could nominate colleagues for the "team member of the month" award. Each month, a member of staff received a box of chocolates and a certificate. This helped staff feel valued by patients and colleagues.
- The service encouraged openness and honesty. The trust provided training to staff around Duty of Candour (DoC) as part of the "lessons of the week". We saw information and guidance on DoC available to staff on the surgical wards. All staff we spoke to knew what DoC was and could describe their responsibilities relating to it.

Public engagement

- At our last inspection, we found little evidence of public engagement. Since then, we saw the trust had

introduced regular listening events for patients, their relatives and carers. Additionally the trust provided a newspaper every other month updating the public on developments at the hospital.

Staff engagement

- There was a consultation between the executive team and theatre staff around theatre working patterns. The trust proposed a new contract, with the mixing of main theatres, day surgery and obstetrics and increased weekend working. Some theatre staff told us they felt the new contract would not be workable for them. Theatre staff subsequently raised a grievance against the trust through their union. However, the executive team actively consulted with staff to discuss their views and attempt to find an agreeable solution. At the time of our visit, the trust was in the process of setting up a clinical working group to help resolve the contract issues.
- Staff told us the chief executive ran weekly staff forums to engage with staff. Staff who had attended a session said they found it useful. However, many staff working in the surgical directorate said they did not have time in their working day to attend a session because they were so busy.
- The surgical directorate workforce task group identified that the morale of band 5 nurses was particularly low. In response to this, the governance lead held meetings with groups of band 5 nurses to discuss their views and target areas for education and support.
- Approximately four months before our visit, the service introduced surgical work streams to help drive improvements. There were three groups, pre-operative, perioperative and post-operative, with representation from staff at all levels. At the time of our visit, it was too early to measure the impact of these groups.
- The trust's 2016 staff survey response rate was 49.5% for acute (including surgical directorate) staff. This was better than the average response rate of 39.9% for other NHS trusts that used the same survey. The results showed improvements in several areas from the previous year, which reflected the changes in culture. For example, 69% of staff said their immediate manager valued their work. This was better than the trust's 2015 performance in this area of 64%. In the 2016 survey, 76% of staff said they could identify senior managers. This was better than the 2015 result of 69%.

Innovation, improvement and sustainability

- The new pathway for patients with fractured neck of femur meant patients had their surgery more quickly following admission. Clinical leads in surgery said they were already seeing improvements in mortality rates because of the pathway, although no data was available at the time of our visit.
- The trust was one of 13 pilot sites in the national Royal College of Surgeons Cholecystectomy Quality Improvement Collaborative (Chole-QuIC). The aim of Chole-QuIC was to reduce time from admission to emergency cholecystectomy (removal of gall bladder). The project used quality improvement methodology to empower consultants to drive change within the trust. The anticipated completion date of this project was January 2018.
- The hospital introduced a trust-wide deteriorating patient programme in 2016. We saw evidence of improved staff education and training in key areas including national early warning scores (NEWS).
- The service introduced twice-daily "safety huddles" for nursing staff on the surgical wards. We saw that staff highlighted patients at increased risk for extra monitoring to help improve patient safety.
- At the time of our visit, the service had recently introduced a "transforming care" group to improve the quality of nursing care. The group had different work streams where a surgical matron each led one area of care to improve. Areas included food and drink, communication and continence. While this was a relatively new initiative, improvements were starting in some areas. For example, improved mouth care and the introduction of a mouth care nurse to support nursing staff on the wards. Since our last visit, surgical services had worked hard to reduce patient waiting times for surgery. For example, compliance with the two-week target for colorectal cancer surgery improved from 5% in 2015 to 95.5% in 2016.

Surgery

- There were improved staff recruitment processes, including nursing open days, to attract more staff to the trust.

Critical care

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

Information about the service

Critical care services at Medway NHS Foundation Trust consist of a nine-bedded intensive care unit (ICU), a six-bedded medical high dependency unit (MHDU), a ten-bedded surgical high dependency unit (SHDU) and a four-bedded coronary care unit (CCU). The ICU typically provides level three care and the HDUs and CCU typically provide level two care. The level of care refers to the acuity of the patient, the number of organs that need mechanical support and whether the patient is being ventilated.

The ICU has seven beds in a spacious open area, two individual side rooms and two beds in an annex with direct access to the main unit. Patients in the SHDU and MHDU are cared for in a mixture of bed-bays and private rooms.

The CCU provides a separate area within the hospital for the care and monitoring of acutely ill cardiac patients who can be admitted from the emergency department, acute medical unit, cardiology and respiratory department, rapid access chest pain clinic, cardiac catheter suite as well as other wards. It has four beds in a single area equipped for level two patients. A separate room for pacing and procedures is available for emergencies. Although the CCU is reported in this part of the report in this hospital coronary care is managed and delivered in the acute and continuing care (medical) directorate.

Between November 2015 and October 2016, the ICU had 531 admissions, the MHDU had 536 admissions and the SHDU had 991 admissions.

We last inspected critical care in September 2015 and rated the service overall as requires improvement. This reflected insufficient medical staffing and cramped conditions on the MHDU, delayed flow of patients through critical care due to insufficient ward capacity and no strategy to direct improvements in the service.

To come to our judgement we spoke with 46 members of staff, including 14 doctors and 19 nurses and a range of allied health professionals, managers and other clinical and non-clinical staff. We also spoke with five patients and nine relatives. We inspected each area in which critical care services are provided, observed care being given and attended ward rounds and multidisciplinary meetings. We looked at the minutes of meetings, improvement planning, audits as well as 35 other items of evidence.

As well as out announced inspection, we returned to the hospital on 17 December 2016 for an unannounced inspection and visited the ICU, MHDU and CCU.

Critical care

Summary of findings

At our previous inspection in 2015 we rated the critical care service overall as requires improvement. This reflected insufficient medical staffing and cramped conditions on the MHDU, delayed flow of patients through critical care due to insufficient ward capacity and no strategy to direct improvements in the service. At this inspection we also rated the service as requires improvement. However, we found improvements had been made in a number of areas. This included improvements in leadership and governance structures, safety equipment and processes and a significant improvement in patient mortality.

At this inspection overall we rated critical care services as requires improvement because:

- Nurse staffing cover did not always meet the minimum requirements of the Intensive Care Society (ICS) core standards for intensive care medicine. This included the ratio of nurses to patients and the availability of a supernumerary nurse in charge.
- The cardiac care unit (CCU) did not have consistent presence from the medical team and at times nurses struggled to cope with the acuity of patients combined with their lack of resources. An informal agreement existed that enabled them to ask doctors in the adjacent intensive care unit for help and although an operational policy was in place for the CCU, we did not see this used or have a positive impact on how the unit operated.
- There were gaps in fire safety and evacuation planning, including a lack of control and oversight of fire risks in the environment and a significant proportion of staff without up to date fire safety training.
- Due to short staffing in the allied health professionals (AHP) team, patients in the intensive care unit (ICU) did not receive the minimum amount of physiotherapy per day as recommended by the ICS and there were often delays in initial assessments such as swallowing and choking risk. This also meant there was not routine AHP presence at ward rounds, handovers or in multidisciplinary meetings.
- Between November 2015 and October 2016, bed occupancy was higher than the national average in every month and at 100% of capacity in four months.
- Between September 2015 and August 2016, 31% of patients experienced a discharge delay of over 24 hours. In the same period, 17% of discharges took place out of hours between 10pm and 6.59am.

However, we also found:

- There was evidence of tangible and sustained improvement in leadership and governance. For example, a new critical care programme had established a clinical director post and a more multidisciplinary triumvirate model of leadership to link clinical and non-clinical staff.
- A range of improvements had been made to quality, safety and training. This included training in sepsis and shock for foundation-level doctors and the delivery of a regional intensive care course.
- Patient mortality rates had significantly improved in the medical high dependency unit following improved consultant availability and discharge planning.
- Consultant intensivist cover met the requirements of the Intensive Care Society core standards for intensive care medicine in the time to initial review, ratio of consultants to patients and the accreditation of consultants with the Faculty of Intensive Care Medicine.
- Practice development nurses and senior staff supported clinicians to undertake professional and academic development in line with their specialist interests. This included degree programmes in the CCU and post-registration qualifications in the ICU.
- Clinical staff benchmarked care and treatment against national guidance and used local audits to identify areas for improvement. For example, improved interprofessional understanding between dieticians, speech and language therapists and the catering contractor led to improved nutrition for patients.
- Staff provided consistently compassionate and kind care, treatment and involved patients and relatives in

Critical care

care planning where possible. This included in discussions around decision-making in line with National Institute of Health and Care Excellence (NICE) guidance.

- Overall numbers of complaints were very low; with only two formal complaints receive between all critical care services between August 2015 and July 2016.
- Feedback from staff about the culture of the service was variable but most of the individuals we spoke with agreed bullying and harassment had decreased and was no longer tolerated.

Are critical care services safe?

Requires improvement

At our last inspection we rated safe as requires improvement in critical care. We have maintained this rating. However, the senior team had implemented a number of improvements following our last inspection and there was a clear trajectory of on-going progress. This included a formalised mortality review process that meant consultants led monthly reviews of mortality and morbidity, the learning from which was shared with the critical care programme board. In addition, an audit of the environment had begun to benchmark facilities against Department of Health standards. The trust had increased the amount of emergency equipment in clinical areas, including resuscitation trollies, difficult airway trollies and tracheostomy grab boxes. In addition, a deteriorating patient programme board had convened and an acute response team implemented to improve the response to deteriorating patients.

At this inspection we rated critical care services as requires improvement for safe because:

- The vacancy rate and turnover rate of nurses was significantly higher than trust's target and overall 82% of the required number of nurses were in post. Nurse staffing levels did not always meet the requirements of the Intensive Care Society (ICS) core standards for intensive care that meant nurse to patient ratios were not consistently maintained and there was not always a supernumerary nurse in charge.
- The vacancy rate for doctors was 24%, which was significantly higher than the trust target of 8% and the turnover rate was 20%, which was higher than the trust target of 8%. The cardiac care unit (CCU) did not have consistent access to a medical team. Although a consultant led a daily ward round, this was often interrupted and there were no other doctors immediately accessible to staff. This meant CCU used an informal agreement with doctors in the adjacent ICU to provide urgent medical care. The trust had a policy for medical and nursing staff in this unit, which included

ensuring there were enough staff available at one time. However, we did not see evidence staff followed this policy and in our conversations with staff we found the unit was frequently under staffed.

- In the 2016 staff survey, which included a range of clinical and non-clinical staff, 76% of respondents said there were not enough staff to do the job properly.
- Less than half of those who responded to the 2016 staff survey said they felt those who reported errors were treated fairly or received feedback on reports. When we spoke with staff, there were broad variations between those who said they received feedback from incidents and those who said they did not. We saw several methods of communication were in place and could not identify reasons why some staff were unaware of learning.
- To address our previous concerns around the identification and treatment of deteriorating patients, a deteriorating patient programme board had been established and the critical care outreach team transitioned into an acute response team (ART). However, this had been implemented without testing and resulted in significantly increased numbers of referrals from the wards for deteriorating patients. Combined with a failure to recruit to this team and lower triggers for the escalation of unwell patients, we saw this could result in delays of over 12 hours in reviewing patients.
- Standards of hand hygiene and infection control were generally good, including compliance with trust policies and hand washing practice during our observations. However, audits highlighted a need for improvement in some areas for consistent screening of patients for some infections and it was not always evident disinfection practices were thorough.
- Environmental hazards and risks were not always well managed. This included the storage of used sharps and medicine lines, fire exits and evacuation routes and storage of chemicals.
- The number of staff with up to date mandatory training in basic life support and fire safety did not meet trust minimum requirements and overall training rates for ICU doctors was 16% lower than the trust minimum target at 64% compared with the target of 80%.
- Although the senior team tracked and monitored incidents, there was limited evidence this had an impact on reducing incidents relating to a lack of bed capacity and delays in treatment.

However, we also found:

- Consultant cover met the minimum requirements of the ICS core standards, including time to assessment after admission and the ratio of consultants to patients. Consultant cover in the medical high dependency unit had been increased and had contributed to a reduced mortality rate.
- This change provided additional training, a higher level of expertise and a recruitment programme for advanced nurse practitioners.
- The majority of reported incidents resulted in no or low harm, which meant staff reported them as a strategy to improve routine practices. Contractors had access to the electronic reporting system and allied health professionals told us multidisciplinary learning from incident reports had improved referrals between teams.
- Medicines management procedures were in line with national guidance, including the secure storage and documentation of controlled drugs. Local teams took action when medicines errors occurred to reduce the risk it could happen again.
- Consultant cover in the medical high dependency unit had been improved to include on-call provision 24-hours, seven days a week.
- Overall mandatory training rates exceeded the trust's minimum target of 80%.
- Standards of care records met national clinical guidance including in the standard of risk assessments and the information documented that helped to protect patients from avoidable harm.

Incidents

- Between October 2015 and September 2016 critical care services reported no Never Events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Critical care

- In accordance with the Serious Incident Framework 2015, critical care services reported one serious incident (SI) that met the reporting criteria set by NHS England between October 2015 and September 2016. This related to an unplanned readmission of a patient who tested positive for MRSA after readmission.
- Between January 2016 and November 2016, the intensive care unit (ICU), medical high dependency unit (MHDU) and surgical high dependency unit (SHDU) reported 707 incidents. Of this, 42% related to MHDU, 31% related to SHDU and 26% related to ICU. Overall 72% of incidents resulted in no injury or harm, 26% resulted in low harm and 2% resulted in long term harm, an injury that lasted over seven days or death. The service tracked incidents to identify themes and trends. For example, 35% of incident reports related to the unsafe or inappropriate transfer of a patient and 16% related to a pressure sore noticed by staff on admission.
- In the 2016 staff survey, 89% of respondents said they felt the trust encouraged the reporting of errors, 48% said they felt the trust treated those involved in errors fairly and 45% said they received feedback about errors.
- We looked at the investigations and outcomes of the incidents that resulted in harm or death. One incident of harm that required intervention occurred because of a lack of ICU beds. Although staff provided treatment in the emergency department and theatre recovery before making a transfer, the delay meant the patient did not receive optimal treatment. Where an incident occurred as a result of actions from another hospital, staff liaised with them to investigate the circumstances, including in an instance of a missed diagnosis.
- An incident that involved the death of a patient occurred after they had been admitted inappropriately to the CCU for 48 hours because of a lack of beds in the ICU. Risks associated with this were mitigated by care provided by respiratory nurses and an ICU doctor in training. Another death occurred when a patient waited three days for an MHDU bed and was transferred three times during this time. We looked at the root cause analysis of both of these incidents. Learning had been identified with an action plan in both cases, including improved training for nurses in the MHDU on managing intravenous lines and for doctors on managing deteriorating patients. A lack of consultant intensivist oversight for transfers and inadequate monitoring of the patient were highlighted by the root cause analysis of the CCU patient. In addition, the investigation highlighted that senior clinical staff did not have authority to authorise bed moves when they considered it to be essential for patient safety. Instead this process was managed by the site team. This investigation outcome resulted in more comprehensive guidelines for transferring patients and senior critical care nurse presence at daily bed meetings.
- Staff described varying experiences of the incident reporting process. Three consultants said they received no feedback or learning outcomes from incident investigations and said they did not feel sharing of serious incidents was consistent. We looked at four root cause analyses of incidents and found they were thorough and involved the appropriate people although they did not include a dissemination list or plan. Nurses in SHDU had formed a secure digital communication group using software that meant they could access information at any time and used this to find out about the outcomes of incidents.
- A morbidity and mortality (M&M) meeting for each unit took place every two months. We looked at the minutes for six M&M meetings representing all four critical care areas. A cardiologist, the matron, senior sisters, doctors in training, catheter laboratory technicians and cardiology staff attended cardiac care unit (CCU) meetings and contributed to mortality investigations. Learning outcomes were established following meetings, including better training for staff in the accident and emergency department to manage deteriorating patients and improved care coordination with community nursing teams to manage long-term conditions such as asthma.
- Allied health professionals (AHPs) did not routinely attend M&Ms due to a lack of staff, which meant multidisciplinary input was inconsistent.
- Clinical contractors had access to the electronic incident reporting system. For example, some AHPs were contracted in from another organisation and were able to submit incident reports at this hospital. We spoke with three AHPs who told us feedback from incident reports was provided in a timely manner and they felt senior staff in the trust supported them with this. For

example, therapists submitted an incident report whenever a referral to them had been delayed and told us this had resulted in more efficient referrals from critical care staff.

- Senior nurses used a communication book in each staff room as well as e-mails, handovers and team meetings to communicate the outcomes of incidents to their team. The staff room in MHDU included details of a previous incident in which a patient was found to have an infection on transfer to a ward and it was found staff on MHDU had not completed infection control assessments or swabs with the patient on admission. The information for staff included the cause of the clinical incident and learning from the incident that included new procedures to ensure all patients had appropriate risk assessments on admission.

Safety thermometer

- The NHS Safety Thermometer is used to record patient harm in clinical areas that can be used to monitor safety performance. Between September 2015 and September 2016, critical care services reported no hospital-acquired pressure ulcers, no falls with harm and no hospital-acquired urinary tract infections.
- Staff in the MHDU used a colour-coded safety cross system to indicate instances of falls, missing patient wristbands, Clostridium difficile (C.Diff) and methicillin-resistant staphylococcus aureus (MRSA). Other units also displayed monthly safety data and used the national NHS Saving Lives criteria to highlight periods of harm-free care.

Cleanliness, infection control and hygiene

- Staff demonstrated good hand hygiene and infection control practices throughout our inspection. For example, clinical staff washed their hands and used antibacterial gel appropriately and adhered to the 'bare below the elbows' policy. We observed staff challenge visitors to the unit who did not adhere to infection control principles.
- The trust had a hand hygiene policy that included monthly auditing in each clinical area. The trust's target required staff to meet policy standards 100% of the time. Between April 2016 and November 2016, the CCU achieved an average of 99% compliance. This included seven months in which staff achieved 100% and one month in which they achieved 95%. In the same period the ICU, MDHU and SHDU achieved an average compliance of 99%.
- A dedicated housekeeper was based in the ICU and CCU and demonstrated an in-depth knowledge of maintaining a clean and hygienic environment. Housekeepers visited MHDU and SHDU daily and maintained cleaning checklists, which we saw reflected in the standards of local cleanliness.
- The National Specifications of Cleanliness in the NHS (NSC) defines the standard of cleaning and frequency of cleaning audits required in hospital wards and departments depending on their level of patient risk. The ICU and SHDU were considered very high-risk areas by the NSC and as such underwent a monthly cleaning audit. Between April 2016 and November 2016, the ICU passed 38% of cleaning audits and the SHDU passed 25% of cleaning audits. The trust operational cleaning plan stated that any areas failing to meet the minimum target of a cleaning audit should be re-audited within 48 hours. During the reporting period above, no re-audits took place. We asked staff in critical care about this. One senior nurse said they did not receive feedback after infection control audits, which meant it was difficult to understand where they needed to improve.
- Environment and cleanliness audits did not always result in effective monitoring of standards or improvements. For example, a damaged wall in the equipment storage area in ICU had been stuffed with towels, which were visibly dirty. In addition, a dirty pillow had been discarded on the floor underneath the damaged section of wall. As this presented an infection control risk, we asked a member of staff about it on our inspection who said they would report it and get it fixed. However, we saw the damaged wall and dirty items were still in place on our unannounced inspection. In addition, boxes were stored on the floor in some areas. This presented a further infection control risk because cleaners could not access all areas.
- Between April 2016 and August 2016, there were no reported cases of MRSA, methicillin sensitive staphylococcus aureus (MSSA) or C.Diff. in critical care services. In this period, the CCU and MHDU screened 100% of new admissions for MRSA and the ICU and SHDU screened an average of 98% of new admissions.

Six cases of Escherichia coli (E.Coli) were reported in ICU, MHDU or SHDU, three of which were detected after the patients had been on the respective unit for over 72 hours.

- Critical care services audited high impact interventions as part of the NHS Saving Lives programme. This included checking best practice in the use of urinary catheter care, peripheral lines and central lines. Between April 2016 and August 2016, the CCU reported 100% compliance with the central line care bundle and 97% compliance with the urinary catheter care and peripheral line care bundles. Between April 2016 and September 2016, ICU, MHDU and SHDU reported an average of 97% compliance with the urinary catheter care and peripheral line care bundles and 99% compliance with the central line care bundle.
- Staff in each critical care unit audited the cleanliness and decontamination of commodes on a monthly basis. Between April 2016 and November 2016, the CCU, MHDU and SHDU recorded 100% compliance with commode cleaning standards. In the same period, ICU reported an average of 94% compliance, which included seven months of 100% compliance and one month of 50% compliance. During our inspection we found two commodes in the clean sluice were labelled as clean and ready for use but were visibly soiled in places.
- Clinical support workers in SHDU signed daily cleaning logs to record which items of equipment were decontaminated and safe for use.
- Reusable personal protective aprons were stored on the unit and a cleaning record system was in place to track which aprons were ready for use. Single-use infection control consumables were stored for outbreaks of seasonal flu, pandemic flu and Middle East respiratory syndrome. Urgent care pathways were in place and staff had undergone training on managing significant infection control events.

Environment and equipment

- At our previous inspection we found there was insufficient emergency equipment in some areas. The trust had responded to this and all clinical areas had emergency equipment including resuscitation trollies, difficult airway trollies and tracheostomy grab boxes. In each case staff documented daily safety and stock checks, which were up to date although there were four gaps in recording in the three months prior to our inspection.
- There was a general lack of storage space in ICU and MHDU that meant access to some equipment or areas was sometimes restricted. For example, a bin and oxygen cylinders partially blocked access to the hand washing sink in the clean utility room on ICU, which meant staff may not be able to use the sink properly.
- During our weekend unannounced inspection we found an open sharps container on the floor of a sluice room with an open door. The sharps box contained used IV containers, some of which still had drawn-up liquid medication in them. This presented an immediate safety risk and we spoke with a member of staff, who said they would secure it.
- A fire safety risk assessment had taken place in October 2016. The fire safety adviser documented the need to maintain a clear escape route from ICU into the theatre area. During our inspection, we did not find staff always adhered to this recommendation. For example on three days of our inspection, including our unannounced inspection, we found one of the emergency exits from the ICU annex was partially blocked by equipment. This meant an evacuation could be impeded because staff would have to spend time moving equipment. On one day of our inspection a bariatric patient was cared for in the annex and it was not clear that this patient could be safely evacuated through the emergency exit due to the restricted manoeuvring space on the other side of the door. We asked a doctor about this. They told us they had received evacuation training but they did not know whose responsibility it was to keep fire exits free from equipment or if it was possible to evacuate patients in bariatric beds through the emergency exit.
- Fire safety and evacuation procedures were standardised in the hospital. Although the ICU had an existing evacuation plan, the trust had identified this did not include the CCU, which geographically formed part of the same area. To address this, the trust planned a desktop evacuation planning exercise with all staff with fire and safety responsibility in the whole area, which included ICU, CCU and theatre recovery. This was a requirement, along with better staff training in fire safety, of a fire safety adviser in October 2016.

- MHDU was connected to Bronte ward and shared a fire safety plan and both units had a named fire warden, although there was no deputy if this person was not on shift. However, there was no specific evacuation plan in place and the MHDU was very cluttered during our inspection, with equipment stored immediately adjacent to a fire exit. A fire safety adviser in November 2016 highlighted this as a requirement, along with better staff fire training. We asked the trust about this after our inspection and found the fire safety requirements were due to be implemented in February 2017 but there were no specific plans as of mid-January 2017.
- An interim fire safety adviser had worked with local fire and rescue services to improve fire safety in the hospital, including the implementation of new risk assessments and a fire safety resource portal for staff on the intranet. However, it was not evident from our discussions with staff that this had improved their knowledge or understanding.
- Staff in the CCU did not have an immediate way of calling for help in the event of an emergency unless they were next to a telephone. For example, one nurse was sometimes left alone while the second nurse had a break. The nurse station did not have a panic alarm and if the nurse had an emergency in a bed bay, they relied on reaching a bedside call bell to attract attention or shouting to be heard outside of the unit. One nurse said they had been left alone with four patients whilst their colleague took a break during a night shift. During this time a delirious patient had attacked them and they had to try and protect the patient from harm whilst avoiding being injured. This involved distracting the patient and manoeuvring them towards the side room, where the member of staff was having a break, in order to get help. This was not a safe strategy but staff told us they were not given individual panic alarms or other means of communication.
- Electronics and medical engineering staff managed a planned preventative maintenance programme for all medical equipment. This system was used to ensure equipment was calibrated and maintained in accordance with manufacturers' guidelines. At the time of our inspection all critical care equipment, with the exception of two pacemakers in CCU, had undergone up to date maintenance.
- The trust had begun to audit compliance with the Department of Health, Health Building Note (HBN) 04-02, which provides guidance on the layout and planning of critical care facilities. As this was a new audit, there were no data available. However, on a previous inspection we identified the MHDU as an area of risk because the bed spaces did not meet the minimum safe requirements of HBN 04-02. The trust recognised this and had prepared an architectural plan in August 2016 as part of a planning strategy to relocate the unit elsewhere in the hospital.
- Staff documented daily temperature checks of the fridges in the ICU kitchen, which meant food and drinks were stored consistently at safe temperatures.
- Hazardous chemicals subject to the control of substance hazardous to health regulations were not always stored safely. For example, on SHDU we found chlorine tablets were stored in an unlocked cupboard and liquid chlorine had been made up in an unmarked container with no hazard warning symbols or notices attached.
- There was not an effective system in place for the reporting of faults with non-medical equipment or for obtaining repairs. For example, staff had attached handwritten notes regarding faults to an ice machine in the ICU kitchen. The first note was dated September 2016, two months prior to our inspection; indicated staff had reported an equipment fault. Two further contacts between ICU staff and the estates department were documented, but the equipment was still not in use. There were no reference numbers recorded and three members of staff we spoke with said they did not know what the procedure was for tracking repair requests.
- An estates reporting log book was kept in ICU but there was no record of a resolution date or signature from the estates team in any of the most recent 25 reported faults we looked at. In addition, the system did not enable staff to obtain timely equipment repairs. For example, a faulty macerator had been reported in March 2016 and reported a further three times in the proceeding four weeks before a comment from ICU staff six weeks later noted the situation had been escalated to an estates supervisor. There was no documented record the faulty equipment had been repaired and no noted communication from the estates team.

- Seven doctors told us new medical equipment often arrived and was put into place without full training being given, which they said was a safety risk. For example, new central venous catheter equipment had been delivered two months before our inspection but because doctors had not been trained in its use, an incident had occurred through incorrect use of it.

Medicines

- An electronic prescribing system was in place and a dedicated pharmacist attended the ward round on each unit daily. An antimicrobial pharmacist was due to start in January 2017 and would provide dedicated support to critical care.
- We looked at the temperature recording logs for medicine refrigerators in all critical care areas. In each case, the records were up to date with no gaps in the previous three months.
- A pharmacy area was located inside the ICU that included Controlled Drugs (CDs). These were stored in locked cupboards that required keypad access. Staff accurately and consistently completed CD record books in line with trust and national policy. Intravenous medicines and antibiotics were stored securely and in line with the medicines policy and all of the 22 items we checked were within their expiry date.
- New ICU shift summary documentation had been introduced that did not include space for staff to document the temperature of fridges used to store medicines. Although the medicines fridges displayed the temperature electronically, the change in documentation meant staff did not maintain a continuous record that medicines were stored safely within manufacturers' minimum and maximum temperature range. We spoke with the matron about this who said she would update the new shift documentation. A laminated card on the outside of the fridge provided instructions for staff if they noticed the temperature exceeded the safe maximum.
- There was no doctor based in the CCU other than for daily ward rounds. This meant nurses had to call the cardiology ward or on-call medical team to approve prescriptions. Nurses told us this could often result in a delay and so they approached ICU doctors to authorise the prescription. During our unannounced inspection, we saw this in practice when a CCU nurse had to ask the duty ICU doctor to approve a prescription because the nurse could not reach a doctor in the main cardiology ward. Although this meant the patient received prompt pain medicine, the authorising doctor had no access to the patient notes or their current condition. It also meant the responsible cardiologist was unaware a doctor from a different department had approved medicine for one of the patients in their care. We spoke with a nurse about a previous medicine administration error in which a patient had received an incorrect dose of a prescribed medicine. An investigation had taken place and learning had been shared but the member of staff told us the incident was indicative of the workload in the unit and they felt neither the prescribing doctor nor the administering nurse had identified the mistake because they were so busy.
- Nurses in the CCU said they often experienced delays in arranging 'to take away' medicines for patients awaiting discharge because of a lack of medical cover. Staff told us it was common to bleep the on-call physician repeatedly without a response. In such circumstance, they would ask a doctor in ICU to help. This was based on a historic relationship between the units and did not form part of a formal agreement. This team also said they were concerned about the ability to get medicines when a doctor was not present. For example, they asked doctors to leave a supply of 'as needed' (PRN) medicines at the morning ward round in case they were needed during the rest of the day when no doctors were present. A nurse then had to call a doctor for permission to administer the medicine if the patient needed it. This system did not enable patients to receive the timely administration of medicine.
- The acute response team (ART) had adopted patient group directions to enable nurses to administer medicines in line with national legislation without the need to wait for a doctor.

Records

- Critical care units used a mixture of electronic and paper records. Risk assessments were completed on the electronic system and included venous thromboembolism, the malnutrition universal scoring tool, pressure ulcers, fluid monitoring and pain. We looked at a sample of risk assessments for 31 patients in all of the areas we visited, including five records during our unannounced inspection. In each case, staff had

completed risk assessments fully and within 24 hours of admission. A clinical member of staff updated each risk assessment at appropriate intervals, including during hourly observations for patients with a high level of acuity.

- In all 31 records we looked at, staff documented the time of the decision to admit the patient in line with National Institute for Health and Care Excellence clinical guidance 50, in relation to acutely ill patients. In addition, each record entry had a legible signature, name and bleep number for the clinician writing the entry. This meant staff could trace the member of staff in the event of a query.
- The trust did not always proactively update risk assessments documentations or processes to avoid risks to patients. For example, an incident had been reported by staff in the SHDU after a patient experienced a fall whilst unsupervised. Although the patient had been assessed as having mental capacity, staff had used an out of date falls risk assessment that meant a falls care plan was not completed. A more appropriate risk assessment tool was implemented as part of learning from the incident. Staff submitted another incident report following the incorrect documentation of a patient's allergy and ensured doctors discussed this in more depth with each patient before recording it.

Safeguarding

- The trust had a minimum target of 80% for up to date safeguarding training amongst all staff grades. In October 2016, 93% of critical care staff were up to date with safeguarding training to the level required by their role and responsibilities. This was an average figure and represented 100% of staff with up to date child safeguarding level one training, 93% of staff with up to date adult safeguarding level one training and 85% of staff with up to date adult safeguarding level two training.
- All of the staff we spoke with demonstrated an in-depth knowledge of local safeguarding policies, how to contact the hospital safeguarding lead and how to access national guidance.
- Safeguarding training included identifying and acting on abuse and neglect and Department of Health national professional guidance in female genital mutilation.

Mandatory training

- The trust had a minimum target of 80% for up to date mandatory training amongst all staff grades. Overall, staff in critical care had 87% compliance with mandatory training. This was an average figure and staff did not meet the minimum target in adult life support (79%) or fire training (72%). In addition, doctors in the ICU had a training compliance rate of 64%.
- Staff were given protected time for mandatory training but short staffing on a day-to-day basis meant this was not always completed within planned deadlines.
- An up to date sepsis management policy was in place and we saw examples of completed sepsis screening and action tools in line with the UK Sepsis Trust Sepsis Six Pathway.

Assessing and responding to patient risk

- On our previous inspection, we found the trust was not always able to identify and respond to deteriorating patients in a timely or safe manner. In response, a deteriorating patient programme board (DPPB) was convened and introduced a restructure of the critical care outreach team (CCOT) into an acute response team (ART) to provide 24-hours, seven days a week support to staff on wards who identified deteriorating patients. The transition included the creation of six additional advanced nurse practitioner (ANP) posts and scope for all members of the team to deliver care in line with the national profile for ANPs. At the time of our inspection the CCOT transition had been completed, the ART model of working had been implemented and recruitment was underway. This included the introduction of a new escalation pathway alongside a hospital-wide education programme of the safe use of the national early warning scores (NEWS) system. Some of the nurses we spoke with in this team felt negatively about the changes because they said it resulted in frequent inappropriate referrals from wards, including patients on end of life care pathways. Ward staff were not trained in the use of the situation, background, assessment, recommendation (SBAR) tool, which meant the ART nurse had to conduct additional assessments when they arrived to see a patient.
- The ART model aimed to review patients within established referral times depending on their condition. For example, patients with a NEWS score over seven or

who were septic, were to be seen immediately. Patients with an acute kidney injury were to be reviewed within four hours and patients who had been discharged from ICU were to be reviewed three times within 36 hours after discharge. Any patient with a NEWS of five or higher was to be referred to the ART. We looked at the NEWS calculations for ten patients and found them to be accurate and correct.

- Some staff raised concerns that the new referral thresholds and medical model approach to responding to deteriorating patients meant some patients waited longer to be reviewed by the ART. A nurse gave an example of one patient who was highlighted as a clinical concern and needed a review but because their NEWS score was low, it took the team 48 hours to see them as a result of the increased workload in relation to the new model of care. Another nurse cited a shift in which an ART nurse handed over 19 patients to the next shift, six of whom had not been assessed in the previous 12 hours due to workload. The avoidable harm group met weekly and had initiated a rolling audit programme to monitor the number of patients seen by the ART, the timeliness of their response and the appropriateness of the referrals. The group planned to use the information the audit would gather to improve practices for staff.
- When patients deteriorated on the CCU, staff initially requested assistance from the medical team in the adjacent ICU. If the doctor in ICU was not immediately available, staff could bleep the on-call middle career doctor or the ART.
- Speech and language therapists, dieticians and physiotherapists reviewed relevant risk assessments, including for falls and choking, in the ICU. All patients admitted to the MHDU had a specialist diabetes foot check within 24 hours of admission.
- Out of hours, nurses working in the MHDU had a fast bleep to on-call middle career doctors in the medical wards and the emergency department if a patient deteriorated in addition to the ART and on-call consultant.
- Doctors in training used a 'green book' that contained algorithms for the management of acute clinical emergencies to support them when on call. The book included emergency treatment pathways for acute situations in 10 specialties, including respiratory, gastroenterology, oncology and haematology.

Nursing staffing

- In August 2016, overall nurse staffing levels in critical care were 82% of the established number required to operate all areas safely. This was an average figure and reflected 78% of planned nurses in post in ICU and 96% in CCU. This meant the ICU was short of 12 full time nurses. The SHDU was short of five full time nurses and the MHDU was short of three full time nurses. The trust's target nurse vacancy rate was 8% and in July 2016 critical care services overall had a vacancy rate of 19%. Between January 2016 and November 2016, 12% of incidents submitted for the ICU, SHDU and MHDU related to staffing levels or issues.
- The trust had a nurse turnover target of 8%. Between October 2015 and September 2016, critical care services reported a turnover of 12%. In the same period, the nursing team had slightly lower levels of sickness than the trust target of 4%. Between April 2015 and March 2016, the trust reported a nursing bank and agency usage rate of 4.9% for Critical Care.
- The Intensive Care Society (ICS) core standards for intensive care establish safe staffing levels as a ratio of one nurse to one patient for level three care and a ratio of one nurse to two patients for level two care. In both cases, a supernumerary nurse in charge should always be in place. The ICU did not always meet the ICS guidelines due to short staffing. On one day of our inspection, the nurse in charge had to take a patient and was therefore no longer supernumerary. On another day the supernumerary nurse in charge had to take a patient with high acuity who was admitted during the shift because of staff shortage.
- Agency nurses were used to maintain safe staffing levels and only worked following an induction and a check of their clinical competencies. This meant units could book the same agency staff, who had the necessary skills and experience to provide continuity of care.
- In ICU we observed nurses did not always constantly observe ventilated and haemofiltered patients. For

example, we saw a nurse left their patient to assist with a new admission because there were not enough supernumerary staff to initially support the new patient and their nurse.

- A team of ten registered nurses led care on the CCU and there were always two nurses on duty in this unit. This met the requirements of the ICS that a nurse to patio ration of 1:2 for level two patients be maintained. However, this requirement was not met on occasions when a fifth bed, situated in a side room, was used or when a nurse left the unit, such as for a break. We spoke with four nurses about this who told us they did not get cover for breaks, when patient acuity was higher than expected or when patients were deteriorating. This significantly increased the workload of the nurse left on the unit, which was self-contained, without immediate means of calling for assistance. In the event of an emergency, nurses relied on help from the adjacent ICU.
- We asked the trust about nurse lone-working in the CCU. We were told that nurses ensured the doors separating CCU and ICU were kept open when one nurse left the unit and that emergency call bells in the CCU also sounded in ICU. Nurses we spoke with were unaware of this and we saw several occasions of one nursing leaving the CCU without ensuring the automatic doors were kept open. All of the staff we spoke with in CCU and ICU told us the arrangements of support between then were informal and depended on the staff on duty in ICU as to whether they were honoured.
- We looked at the occupancy level of the CCU and actual staffing level in detail for the period between 1 January 2017 and 17 January 2017. Occupancy was at 100% on all but two days and there were three days when the minimum requirement of two registered nurses was not met.
- The standard planned staffing for MHDU was four registered nurses (RNs) and one care support worker (CSW) during the day and three RNs and one CSW during the night. We looked at nurse staffing rotas for the HDU from October 2016 to January 2017. On three occasions there was no CSW was available for a 24 period and in the same period, 20 shifts that were requested to be covered by agency staff went unfilled. On these occasions, the unit operated with one less RN than needed.
- A team of 12 senior nurses led the ART, formerly the critical care outreach team. This team was in a process of restructure and recruitment including the promotion of staff to more senior roles. This team responded to referrals from staff on wards for deteriorating patients according to the risk escalation tool and needed 2.5 nurses per shift to operate to full capacity. Due to sickness and staff shortages this team sometimes operated with only one nurse on shift. During our unannounced inspection we looked at the workload of the ART staff on shift. As one nurse had spent several hours supporting colleagues in the emergency department and another had spent the same time responding to new referrals from ward staff, none of the planned patients given during their morning handover had been seen eight hours after the start of the shift. This was a cause of significant stress for nurses in this team and it was clear a new escalation policy meant referrals from ward staff had increased without the provision of extra resources for the team.
- In addition to twice daily handovers, the matron led a daily board round, which took place with staff nurses, the acute response team and doctors to review each patient and to plan discharges.

Medical staffing

- A team of nine consultant intensivists led care on the ICU and SHDU and eight chest consultants led care on the MHDU. Consultant intensivists were accredited by the Faculty of Intensive Care Medicine.
- In July 2016, critical care services had a vacancy rate of 24% for doctors, which was significantly worse than the trust target of 8%. In addition, medical teams had a turnover rate of 20%, which was worse than the trust target of 8%. Sickness rates in the medical teams were slightly worse than the trust target of 4%, at 6%.
- A consultant-led ward round took place twice daily in ICU. We attended a ward round and found it included doctors in training, the senior nurse and nurses responsible for individual patient care. The consultant used this as a teaching experience for the junior medical team and nurses were involved in each review. In addition, each patient had a review by a consultant

intensivist within 12 hours of admission and the ratio of consultants to patients was never more than 1:18. This met the ICS core standards requirements for intensive care units.

- A doctor in training was available in both the ICU and SHDU 24-hours, seven days a week. A doctor in training covered the MHDU seven days a week between 8am and 6pm but there was no dedicated out of hours cover in this area. The trust told us the on-call specialist registrar covered the MHDU if needed, with support from staff in ICU, SHDU and anaesthetics. The doctors in training in ICU and SHDU were expected to support the site medical team and ward teams out of hours in the management and care of deteriorating patients. This meant they could be called away from critical care for significant lengths of time to help with patients elsewhere in the hospital. This meant there were periods when nurses did not have immediate access to doctors, which could impact patient care and safety. For example, one incident occurred whereby a patient was discharged from the MHDU to a ward without a discharge summary because there was no doctor available.
- Locum doctors filled shifts that could not be staffed by permanent doctors in the trust. The rate of locum doctor use varied between units and dates. Between August 2015 and August 2016, the highest rate of locum staff seen was in the SHDU in August 2015 at 46%.
- Weekend medical cover for the ICU and SHDU included one consultant intensivist from 6pm on Friday to 8am on Monday. One middle career doctor (previously called a senior house officer) was available on both the ICU and SHDU. The consultant also covered the SHDU and the doctor was responsible for critical care patients who were cared for on wards due to a lack of capacity. For example, during our unannounced inspection we found the doctor spent some time away from the ICU to support ward staff with the care of a high dependency patient. We spoke with the consultant and doctor about this. Both individuals said they were happy with this level of medical cover and said it met patient needs.
- There were no medical staff based on the CCU. Instead, six consultant cardiologists with a special interest in cardiac care shared cover, including a CCU clinical lead. This arrangement was established by the unit's operational policy. This was extended to 24-hours, seven day a week cover by a cardiologist of the week. Although a consultant led a daily ward round, other doctors did not routinely visit the unit unless needed urgently by nurses. Cardiology doctors were based on Nelson ward, which was geographically separate from the CCU. This meant if a patient needed a medical assessment or prescription, staff had to call the ward duty team, which they told us could result in a lengthy delay. During our unannounced inspection, we saw a nurse from CCU left the unit to ask a doctor on the adjacent ICU to sign off a prescription for analgesia. This meant one nurse was left alone with four patients in the CCU and a doctor without direct knowledge of the patient prescribed analgesia. We spoke with the doctor about this who told us it was a common occurrence and was part of a historic agreement between staff in both units, as they understood nurses in the CCU did not have fast access to their own doctors. Out of hours cover was not always readily available to nurses. In the week prior to our inspection, staff in the CCU had submitted an incident report after they found it difficult to reach an out of hours doctor when they needed urgent support.
- A doctor in training and a consultant led a daily morning ward round in the CCU. After this, the doctor in training checked in with staff at 5pm daily either by phone or with a ward visit. After this time nurses relied on the medical registrar on duty as part of the on-call site team for medical support. The ward round was often interrupted as only one hour was allocated for this and the consultant was required to return to the cardiology ward at 9.15am to lead a ward round there. This meant they sometimes left the CCU and then returned later in the morning to finish the ward round. In addition, ward rounds were not multidisciplinary and allied health professionals did not routinely attend. Medical staffing cover in the CCU had affected patient safety. For example, one incident occurred whereby an urgent referral from a cardiologist was not followed up because of a lack of continuity and processes for communication between doctors. This resulted in delayed treatment. Although the incident had been investigated, it was not evident that the processes in place were sufficient to prevent the same incident happening again.
- Shortfalls in medical cover in all critical care areas by doctors in training was highlighted on the service risk register as a risk to patient safety. Between August 2016 and October 2016, nine shifts had been uncovered by

doctors in training because of a lack of substantive staff and no available locum doctors. The service was actively recruiting to increase the number of doctors available to implement cover in the MHDU on a 24-hour, seven days basis.

- An on-call MHDU consultant rota had been established and had resulted in the lowest level of mortality in the unit in the previous nine years.

Major incident awareness and training

- Thirteen critical care staff had completed emergency preparedness resilience and response training and MHDU staff had recently undertaken fire and evacuation training.
- Staff in the CCU had evacuation training specific to their environment but individuals we spoke with expressed concern about how they could move four bedbound patients in an emergency with typically only two members of staff present and only one exit. Staff said a light switch had previously caught fire in the unit and an agency nurse had extinguished this themselves without calling the central emergency number or the fire service. During fire and evacuation training, a nurse said they had been asked to draw up their own evacuation plan by the fire safety officer but did not feel appropriately qualified to do so. They told us this task had been passed to the matron but they did not know if it had been put in place.

Are critical care services effective?

Good

At our last inspection we rated effective as good for critical care. We have maintained this rating and found a number of areas of improvement. For example, a new medical model of care had been introduced that significantly improved mortality rates in the medical MHDU. The hospital had provided clinical staff with more in-depth training on managing sepsis and shock and overall clinical competencies were being increased through the introduction of a critical care practitioner role.

At this inspection we rated critical care services as good for effective because:

- Care and treatment was provided according to national best practice guidance, including from the National Institute of Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the South East Coast Critical Care Network. Consultants and doctors in training led a local audit programme to benchmark care against this guidance. Sixteen other local and national audits were in place for 2016/17. The range of audits included to assess patient outcomes after discharge as well as to explore the quality of care provided.
- Rehabilitation was provided in line with NICE clinical guidance 83, including in discharge planning and specialist support provided to patients on inpatient medical wards.
- In the ICU, 69% of nurses held a post-registration qualification in intensive care nursing. This was better than the minimum standard recommended by the ICS and Royal College of Nursing. Staff had access to specialist training, professional and academic development and practice development nurses were in post to support this.
- A new medical model of care had been introduced that meant each patient had a named responsible consultant, more frequent consultant review and more effective monitoring of patients who were deteriorating.
- Improvements had been made in clinical training and skills competencies. This included sepsis and shock training for foundation-level doctors and the delivery of a regional basic assessment and support in intensive care course.
- A training programme had commenced to establish advanced critical care practitioners on a 24-hour, seven days a week basis in the acute response team.
- Patient outcomes in the medical high dependency had significantly improved in the previous year in relation to reduced mortality following improved consultant cover and more robust discharge reviews.
- An improved and proactive working relationship between dieticians, speech and language therapists (SaLTs) and the catering contractor meant patients had access to a menu that offered a wider range of appropriate and diverse meals.

Critical care

- A nutrition steering group monitored standards of nutrition and hydration assessment tools and ensured clinical staff received timely support, including from nutrition link nurses and a gastroenterology and nutrition matron.
- Unplanned readmissions to each unit was less than 1% of patients between September 2015 and August 2016 and in the same period 4% of patients experienced a delayed admission of four hours or more to the intensive care unit (ICU) or medical high dependency unit (MHDU).
- All staff had undertaken Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) training and all patients underwent a mental capacity and cognitive assessment on admission.
- However, we also found areas for improvement:
- There was significant short staffing amongst multidisciplinary teams including pharmacy, physiotherapy, speech and language therapy and occupational therapy. This meant patients sometimes experienced delays in initial assessment and patients in ICU did not receive the minimum amount of physiotherapy required in the ICS Core Standards for Intensive Care.
- Also due to short staffing, there was limited scope for allied health professionals to attend ward rounds, handovers and multidisciplinary meetings unless this was specifically requested for a patient.
- Between September 2015 and August 2016, 17% of patients experienced a delayed admission of four hours or more to the surgical high dependency unit (SHDU).
- Admissions to the cardiac care unit were not always assessed by an appropriate consultant and there was evidence patients were sometimes cared for in the unit that staff could not provide full care for.
- Although most staff spoke positively about their appraisal experience, in the 2016 staff survey 25% of staff said their appraisal helped them to improve their job and 32% said they felt valued as a result of their appraisal.

Evidence-based care and treatment

- Individual wards and units conducted audits of the use of the National Early Warning Scores as part of the deteriorating patient programme. There had not been a formal audit of care against National Institute for Health and Care Excellence (NICE) clinical guidance 50 in relation to acutely ill patients but the internal audit followed similar principles.
- All staff who were responsive for providing or monitoring intravenous (IV) fluid therapy had undergone appropriate competency training and assessments in line with NICE quality standard 66 in relation to prescribing and administering IV fluids.
- Staff conducted a risk assessment for each patient on admission for venous thromboembolism (VTE) in accordance with NICE quality statement three on VTE prophylaxis.
- Critical care consultants led a programme of 17 local audits as part of a quality improvement programme. This included scope for doctors in training to support the consultant for each audit to develop their skills and auditing competencies. Local audits included a review of patient deaths after they had been discharged from the intensive care unit (ICU), medicines errors and rehabilitation.
- Patients received rehabilitation in line with NICE clinical guidance 83 in relation to integrated rehabilitation pathways. This meant they received rehabilitative care on an inpatient ward and a rehabilitation plan on discharge. However, due to short staffing in the allied health professional (AHP) team, patients did not always receive 45 minutes of physiotherapy per day as recommended by the Intensive Care Society Core Standards for Intensive Care Medicine.
- Critical care units were part of the South East Coast Critical Care Network (SECCCN), which established minimum standards of care and treatment in the region. The SECCCN published a gap analysis in January 2016 that benchmarked 18 critical care units against each other. Overall, critical care at Medway Hospital demonstrated 81% of the standards required were met, 13% of the standards were partially met and 6% of the standards were not met. Areas of non-compliance included staffing in the ICU and the number of out of hours discharges.

Critical care

- ICU and surgical high dependency unit (SHDU) consultants had introduced the international modified frailty score to ensure care and treatment planning for patients with a high mortality risk were appropriately risk assessed.
- Physiotherapists had conducted an exercise to benchmark their work against national figures and found they cared for the highest number of patients with the lowest number of staff.
- Best practice guidance from the Difficult Airway Society was available on each difficult airway trolley and appropriate staff had been trained in the use of this equipment.
- All staff had electronic access to NICE guidelines and local policies on the intranet, which they could access from all clinical areas.

Pain relief

- Staff completed pain scores and risk assessments on admission for each patient and these were updated regularly.
- The directorate had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). For example, each patient had an individualised analgesic plan and staff responsible for pain management had appropriate training and proven clinical competencies.
- An acute pain service was available and staff worked with nurse specialists in this team to assess and monitor patients with complex pain needs.

Nutrition and hydration

- Dieticians and speech and language therapists (SaLT) had developed starter- feeding regimes for patients with nasogastric feeding and parenteral feeding needs. This meant clinicians could start feeding plans before the specialist team reviewed them.
- Nurses in the ICU undertook nutrition and hydration training as part of their foundation course in intensive care medicine.
- A new catering manager was in post and the AHP team told us their relationship with the department had improved as a result. This improved relationship also resulted from an audit that showed ward staff and catering staff did not understand how to prepare specific types of food, such as soft or pureed food and that as a result patients were given repetitive and unsuitable meals. In response, the AHP team worked with the catering team in a scoping exercise to identify new products that could be bought in or prepared on site to meet a wider range of patient needs. In addition, dieticians were planning to introduce extra training for catering hostesses to help them provide a more individualised service to patients.
- Dieticians and SaLTs represented critical care patients on a nutrition steering group, which was overseen by a gastroenterology and nutrition matron. The matron provided support to dieticians and SaLTs if a patient's condition deteriorated or there was a problem with their care.
- A specialist nutrition nurse had been recruited by the trust and was leading training for staff in multidisciplinary approaches to nutrition and the care of patients with neutropenic sepsis.
- Each critical care area had a nutrition link nurse who attended additional training and meetings with the nutrition steering group to help support colleagues.
- Enteral feeds and oral nutritional supplements were stored on each unit with a stock rotation system in place to ensure consistent stock levels.
- There was a lack of staff trained in vascular access in the hospital, which meant nutrition plans could be delayed when patients needed feeding through parenteral means.

Patient outcomes

- The ICU, medical high dependency unit (MHDU) and SHDU contributed to the Intensive Care National Audit Research Centre (ICNARC). This meant the outcomes of care delivered as well as mortality could be benchmarked against other units nationally.
- Mortality rates in the three units that contributed to INCARC were in line with national averages. This included an 89% overall survival rate between April 2015 and March 2016. This was an average rate and reflected a 66% survival rate in ICU, a 75% survival rate in MHDU and a 92% survival rate in SHDU. The mortality rate in MHDU had significantly improved in the previous 24 months, during which it had become in line with the

national expected average for the size of the unit. This resulted from increased consultant input, including a consultant-led discharge review for each patient and 24-hour seven day a week consultant on-call cover.

- As part of the clinical improvement programme, clinical leads had updated care pathways to be delivered using a medical model that meant each patient had a designated consultant and received more frequent consultant review.
- Between September 2015 and August 2016, there were three unplanned readmissions to ICU within 48 hours of discharge, or 0.5% of the patients treated. In the same period, eight patients (0.8% of those treated) were readmitted to the SHDU within 48 hours and five patients (0.9% of those treated) were readmitted to the MHDU within 48 hours.
- Between September 2015 and August 2016, an average of 4% of patients experienced a delayed admission of four hours or more to ICU or MHDU and 17% of patients experienced a similar delay in admission to the SHDU. Between November 2015 and November 2016, 42 patients were ventilated outside of ICU due to a lack of available beds. In each case a critical care outreach nurse, a critical care nurse or anaesthetist remained with the patient.
- The acute response team (ART) led multidisciplinary rehabilitation clinics for patients who had been discharged from ICU. This team also visited all patients on the wards after they were discharged from ICU and would visit patients discharged from one of the HDUs if ward staff requested it.
- A critical care consultant, nurse consultant and lead physiotherapist delivered a training and awareness session to GPs in the region. This was to help GPs understand the complex needs of patients after intensive care treatment so they could provide more targeted support to their patients. ICU staff also intended this work to result in improved opportunities for patient rehabilitation through their GP practice.
- ICU, MHDU and SHDU staff assessed patients' expected rehabilitation needs within 24 hours of admission. Between September 2015 and August 2016, 100% of patients in SHDU and MHDU had their rehabilitation needs assessed and all but one patient, or 99.8% of the total admissions, in ICU had their rehabilitation needs assessed.
- The site team and acute physicians made the decision to admit patients to the CCU but this did not always include input from consultant cardiologists. Four members of staff we spoke with said this sometimes resulted in inappropriate admissions and as a result, the matron and consultants were preparing a new admissions procedure. The risks associated with in appropriate admission was an item on the unit's risk register. In addition, CCU staff had worked more closely with their colleagues in accident and emergency to improve communication for admissions and ensure patients could be cared for appropriately.

Competent staff

- In the ICU, 69% of nurses had a post-registration qualification in intensive care medicine. This was better than the ICS and Royal College of Nursing core standards that a minimum of 50% of nurses should have this qualification.
- Staff in each unit had access to a range of training days in addition to mandatory training and could apply for these based on their professional development plan and clinical interests. For example, recent study days included psychological care, peripherally inserted central catheter lines, sepsis and echocardiograms. In MHDU, a member of staff presented a monthly education topic to the rest of the team during a teaching session. Although nurses could apply for training, staff shortages had impacted this. For example, staff in the MHDU were prevented from applying for training in August 2016 due to a lack of staff available for shifts.
- In addition to the trust induction, staff who joined the ICU team undertook a foundation course in the unit that included practical training with medical equipment they were expected to use. Nurses peer assessed each other in their use of medical equipment at least three times per year as part of their clinical equipment competency checks. Two practice development nurses (PDNs) provided one-to-one support and additional teaching

sessions where peer reviews or staff themselves indicated they needed more support. The PDN used team days to deliver targeted training sessions, such as a recent physiology day.

- A senior sister in the CCU was responsible for nurse training and ensured the team remained up to date with mandatory and role-specific training. This team had two days of protected training time per year.
- Cardiac specialist nurses, including an arrhythmia nurse and a coronary heart disease nurse, supported the CCU and provided specialist training for the team. The CCU matron supported nurses to pursue academic development. All nurses in this unit either had or were working towards a cardiology degree and a senior nurse had begun Masters-level study.
- In September 2016, 81% of critical care staff had an up to date appraisal. This was below the trust target of 95%. However, this was an average figure and included the ICU medical team, of which 100% had an up to date appraisal. We asked seven nurses about their experience with appraisals. In each case, they told us it had been a positive process that helped them to identify training needs and what they wanted to achieve in the next year. Staff told us they were aware the trust planned to introduce a new appraisal system and hoped it would offer a more structured approach to establishing their needs. In the 2016 staff survey, 25% of staff said their appraisal helped them to improve their job and 32% said they felt valued as a result of their appraisal.
- Staff we spoke with in CCU described varying experiences with training opportunities. One nurse said they found it took a lot of effort to book training because scheduled days were often cancelled at short notice, including a recent tissue viability course. Three consultants told us they had not been able to take any study leave for a year and had no continuing professional development support. Nurses in the SHDU said they were happy with clinical competency training opportunities and said they were offered regular educational days and support from senior nurses. New nurses in the SHDU undertook a six month preceptorship to help them build their skills and abilities.
- Doctors in training were offered training in completing mortality reviews by consultant mentors as a result of learning from morbidity and mortality reviews. In addition, consultants offered doctors in training mentoring in local audits.
- Consultant intensivists delivered the basic assessment and support in intensive care (BASIC) course for all ICU trainees in the region on an annual basis.
- ART staff were trained in responding to deteriorating and acutely unwell patients. This included the acute life-threatening events, recognition and treatment (ALERT) course and bedside emergency assessment training. Staff in the acute response team felt opportunities for education and research had diminished with the transition of the team from a critical care outreach model.
- AHPs provided critical care nurses and doctors with specialist competency training, including the management of tracheostomies and the care of patients with a swollen tracheostomy.
- New ICU nurses spent a morning with the physiotherapy team and in a reciprocal agreement, new physiotherapists spent time in the ICU. This arrangement helped both teams to understand their respective roles and identify areas for more efficient working together.
- ICU nurses were encouraged to take bank shifts in the CCU to maintain their coronary skills.
- A new training and development programme had been established, to create advanced critical care practitioners with a plan for a new team to prove cover 24-hours, seven days a week. At the time of our inspection, the first trainee had successfully completed their first year of study and training.
- Senior band seven nurses were given protected time each month for management days and where the matron was unavailable they presented their unit's situation report at the bed meeting. This operational structure enabled the band seven nurse team to develop their leadership skills and was in addition to a new targeted rota system that aimed to increase the range of skill mix per shift.
- In the 2016 staff survey, 78% of staff said they had training, learning or development in the previous year.

For the same period, 86% of staff said their training had resulted in a better patient experience and 86% said it helped them to stay up to date with professional requirements.

- A competency protocol and framework had been established for the ART team and a training plan was due to commence in February 2017. This would include a four-day programme to ensure the team met NICE guidelines.
- In May 2015 critical care service began to make use of the hospital simulation department to offer simulation training to nurses. A simulation technician and operating department technicians led sessions based on previous adverse events to help nurses establish their response competencies to unexpected events and deteriorating patients. The senior team had received positive feedback about this approach to training and planned to include simulation training for doctors in training.

Multidisciplinary working

- A dedicated pharmacist was available in critical care services but the level of cover did not meet the minimum requirements of the ICS core standards for intensive care. Based on the number of beds in critical care, the hospital needed 2.5 whole time equivalent (WTE) pharmacists to meet the requirements of the ICS standards. The clinical lead for critical care had recognised this as a risk on the service risk register and acknowledged a meeting with the chief pharmacist but as of August 2016 there was no planned resolution. We spoke with a pharmacist about this who said despite the short staffing, morning handovers always had pharmacy presence and two pharmacists from elsewhere in the hospital undertook rotations in critical care to ensure there were no gaps in service.
- The senior nurse in SHDU held the senior sister bleep for the hospital for one day at weekends and for two late shifts per month. This meant they supported ward staff with access and flow and infection control and helped services work together to reduce admission delays.
- There were significant gaps in staffing provision in allied health professional (AHP) teams. To meet with ICS guidance in regards to rehabilitation for critical care patients, a team of 10 physiotherapists was required. However, only six physiotherapists were in post, which meant patients in ICU received two to three rehabilitation sessions per week. This fell short of the 45 minutes of daily rehabilitation required in the core standards. Physiotherapists offered group gym rehabilitation for up to eight HDU patients to try and mitigate the risks associated with low levels of rehabilitation activity. The sessions were offered to HDU and ward patients, which therapists told us facilitated supportive new relationships between patients. An occupational therapist was available for patients in ICU but worked across the hospital, which meant it was not possible for them to be dedicated to any one area on a full time basis. The therapist reviewed every new critical care admission and provided support to the nursing team. Patients admitted to ICU should have received a SaLT assessment within 24 hours of admission but low staffing levels in this team meant this was not always achieved. A chest physiotherapist was available on-call for the CCU and provided assessments before patients were discharged to a ward, where rehabilitation could be continued.
- There was varying levels of multidisciplinary AHP input on ward rounds due to low staffing levels. Physiotherapists and SaLT's could join ward rounds on request but could not do so routinely. A dietician joined an ICU ward round three times per week. We spoke with three AHPs about this who told us they had consistent, frequent communication with clinical staff in each unit and so this did not represent a risk to patients.
- Dietician cover was available for ICU, CCU and MHDU and two surgical gastroenterology dieticians worked in the SHDU.
- Clinical nurse specialists in various disciplines were available for patient reviews, care planning and risk assessments.
- Weekly multidisciplinary team meetings took place to review patients with complex needs but not all specialties were represented. For example, SaLT's and dieticians were not routinely invited to the meetings although could attend on an ad-hoc basis.
- The AHP team had presented their work to the SECCCN and engaged with them to ensure their work with patients met ICS standards.
- We observed an admissions handover between the ICU team and an emergency department transfer team. The

handover was well coordinated and led by one person from the emergency team who identified themselves immediately. Staff from both teams demonstrated a structured approach to working together that enabled the ICU staff to take over care and treatment safely.

- Clinical staff spoke positively about the support provided from the hospital's security team. A nurse told us they called security after a delirious patient became violent and they wanted to try and calm them down without using restraint. The nurse said, "The security officer arrived really quickly and I was very pleased about how he dealt with the patient. He was gentle, obviously very well trained and just sat on the patient's bed next to them and talked to them. It worked really well and he stayed for as long as he was needed." This approach avoided the needed for chemical restraint and meant both the patient and staff were kept safe from harm.
- Two consultant microbiologists were available but staff said because of the relatively low numbers of staff it was difficult to get input or reviews after 5pm although an urgent on-call service was available.

Seven-day services

- Consultant cover was available 24-hours, seven days a week through an on-call system. This included a consultant available overnight who could attend the hospital within 30 minutes of being called in line with ICS guidance.
- Pharmacy cover was available Monday to Friday from 8.45am to 5pm, Saturdays from 9am to 3pm and Sundays from 10am to 2pm.
- Physiotherapy cover was available Mondays to Fridays from 8.30am to 6pm, with an on-call physiotherapist, including cardiac physiotherapist, available out of hours.

Access to information

- Doctors used an online referral system for SaLT and dietician support that meant these teams had access to patient records and care plans prior to their first assessment.
- Staff used a formal handover document to discharge patients from critical care to an inpatient ward. In all of the records we looked at, this information met the requirements of NICE clinical guidance 50 and NICE quality statement 15 that relates to clear and accurate information.
- Staff in the CCU said discharge letters were often delayed because there was insufficient medical cover to sign them off, which we saw reflected in the incident log.
- Staff used both paper and electronic records between units and there was a system in place to ensure information was coordinated and avoided unnecessary duplication.

Consent and Mental Capacity Act

- All staff were required to complete Deprivation of Liberty Safeguards (DoLS) training as part of their mandatory safeguarding training. As at October 2016, 100% of staff had completed adult safeguarding level one training and 92% of staff had completed adult safeguarding level two training. This was better than the trust target of 80%.
- As at November 2016, 81% of staff had completed Mental Capacity Act training, which was better than the trust target of 80%.
- Nurses at band six and above were trained to complete DoLS applications with input from a consultant. Staff nurses were given the opportunity to observe DoLS assessments to build their skills and knowledge with a safeguarding lead.
- The medical team assessed mental capacity using the Confusion Assessment Method (CAM) in ICU and the Richmond Agitation-Sedation Scale (RASS). Staff completed a RASS and CAM score for each patient on admission. This formed part of a broader assessment of mental capacity that enabled staff to establish if patients had cognitive impairment or delirium. We looked at eight completed CAM and RASS assessments and found them to be fully completed by an appropriate clinician.

Critical care

Are critical care services caring?

Good

At our last inspection we rated caring as good in critical care. We have maintained this rating, which reflects the consistently kind and compassionate approach of staff.

At this inspection we rated critical care services as good for caring because:

- We observed consistently compassionate and kind care from staff in all areas we visited regardless of their role or level of responsibility. We also observed staff involving patients and their relatives in discussions about their care, including in decision-making. Staff used the outcomes of such discussions to provide individualised care.
- Staff took note of patients' wishes or preferences in regards to whom they shared information with in their family. This helped to ensure people were treated with dignity and staff respected their privacy in line with quality standards set by the National Institute of Care and Health Excellence.
- Staff in the intensive care unit (ICU) had designed and implemented a new patient and relative's survey to identify areas of the service patients were happy with and where improvements could be made.
- A surgical high dependency unit nurse met with each patient with a planned admission prior to their surgery to discuss their fears and anxieties and to help them understand what to expect.
- Counselling and psychology services were available and staff had developed emotional support resources including friendship bracelets and memory boxes.

Compassionate care

- Staff in the ICU had implemented a local patient and relative survey to collect more detailed feedback. This had been launched shortly before our inspection and therefore no analysis was available. However, staff in ICU had displayed initial comments from the survey in the unit. Positive comments included, "Very warm and caring [staff]" and, "Thank you for all you have done."

  Negative comments were made, regarding a patient who did not feel included in the ward round and another patient who noted they could not communicate with staff because they were not given anything to write on.
- On ICU, we saw a physiotherapist leave a patient's bedside to ask their relative to come from the waiting room and see their progress in sitting up. This was a simple act of compassion that had a demonstrably positive affect on both the patient and their relative.
- Staff in all areas and at all levels of clinical and non-clinical responsibility demonstrated they had the skills, knowledge and ability to treat people with kindness and compassion and that they knew how to maintain dignity and privacy. This included in routine considerations such as closing curtains around patients' beds when conducting an examination or offering relatives the time to be alone with their family member.

Understanding and involvement of patients and those close to them

- A nurse in the surgical high dependency unit (SHDU) met with each patient with a planned admission in the pre-operative stage of their procedure. This helped the patient to understand what would happen after their surgery and helped them to feel more relaxed by recognising a familiar face afterwards.
- We spoke with two patients and their relatives in the SHDU who had previously experienced cancelled elective admissions due to emergencies. In both cases patients told us staff had kept them informed, apologised for the situation and explained what would happen next.
- In ICU we observed a nurse explaining to a patient what their tubes were for asking for consent to change one of them. The nurse explained why they needed to change the tube and talked to them about their family throughout the procedure, reassuring the patient that a relative was due to visit shortly.
- Nurses in the CCU used body models to help explain treatment to patients, such as where the problems were in the body they were receiving treatment for.
- Clinicians noted conversations with patients and relatives in care records, including the outcomes of

discussions about decision-making. This contributed to the provision of individualised care in line with National Institute of Health and Care Excellence quality statement 15 with regards to individualised care.

- Staff had the knowledge and tools to provide additional support to patients and their families when needed, including making sure they had time to time to talk and ask questions and arranging for other services such as interpreters and clinical nurse specialists to visit them.

Emotional support

- An occupational therapist reviewed the needs of every new critical care admission and provided targeted stress and anxiety management for patients during their recovery.
- An ICU housekeeper had worked in the unit for 13 years and had developed an emotional support role for patients, staff and relatives. We saw this member of staff proactively approached those in distress or who were anxious and provided them with the chance to talk or to have some company at a time they could feel isolated.
- Staff in ICU had made friendship bracelets for the relatives, including children, of patients to help them feel connected. In addition the team had developed memory boxes for bereaved children that could include a handprint and lock of hair of their family member. This was used as an emotional support resource along with clinical counselling and psychology support services.

Are critical care services responsive?

Requires improvement

At our last inspection we rated responsive as requires improvement in critical care. We have maintained this rating. However, we also found areas of improvement. For example, care pathways had been improved for patients after they were discharged to a ward and the introduction of an acute response team meant more patients would receive a follow-up. In addition, the critical care team had establish better relationships with the site management and emergency department teams to improve access and flow.

At this inspection we rated responsive as requires improvement because:

- Between November 2015 and October 2016, bed occupancy was higher than the national average in every month and at 100% of capacity in four months.
- Discharge delays were commonplace and between September 2015 and August 2016 31% of patients experience a delay of over 24 hours. In the same period, 17% of discharges took place out of hours between 10pm and 6.59am.
- Patients did not always have access to appropriate multidisciplinary care after they were discharged to a ward. This was because a lack of staff were trained in vascular access and so patients' nutrition plans could be delayed if they needed to be fed through a tube.
- A shortage of staff and lack of training in the allied health professionals team meant multidisciplinary weaning plans could be delayed.
- Discharge processes from the cardiac care unit were inconsistent and had resulted in a delay to a patient accessing community care and another patient in receiving their prescribed medicine.
- Admissions decisions to the cardiac care unit were inconsistent and often resulted in patients being admitted who would not normally be under the care of cardiac staff.

However we also found:

- In response to our previous findings, critical care had engaged with the trust site management team to facilitate more coordinated flow with accident and emergency and inpatient wards.
- Facilities for relatives included bedrooms, kitchens and food and drink was available 24-hours.
- The acute response team offered a follow-up clinic that gave patients the opportunity to discuss their experience and recovery for emotional support and to speak with staff who had cared for them.
- Staff worked to develop care pathways that would provide innovate rehabilitation to patients, such as the use of pet therapy.
- All nurses were able to establish link roles that involved undertaking specialist training and responsibilities in areas of professional interest to them and of need to patients.

- There had been no non-clinical transfers out of the high dependency units and non-clinical transfers out of the ICU were rare.

Service planning and delivery to meet the needs of local people

- Patients who were discharged from the intensive care unit (ICU) or one of the high dependency units (HDUs) to a ward did not always have access to appropriate multidisciplinary care. For example, a lack of staff trained in vascular access meant patients who needed to be fed through a line were sometimes given only fluids without nutrition for up to seven days. We spoke with a dietician who said a business plan to introduce vascular access training to more nurses had been stopped and there sometimes shifts with no staff available to insert a line.
- Planning processes were in place to ensure patients only underwent planned surgery if an critical care bed was available for their immediate needs after the procedure. This included cardiac procedures but due to an overall lack of flow through the hospital, patients were sometimes cared for in theatre recovery or were cared for in areas that could not fully meet their needs. Between January 2016 and November 2016, 48% of reported incidents related to issues with access, admission, transfer or lack of resources to provide care.
- Staff in the medical HDU (MHDU) had developed a philosophy of care that outlined a holistic approach to care delivery to meet patient need, including their physical, social, spiritual and psychological needs and the needs of their relatives.
- Organ donation was a specific function within the co-ordinated surgical directorate and critical care services had a tissue donation link nurse in post, based in the MHDU. The tissue donation link nurse met with colleagues in ICU on a six monthly basis and reviewed referrals for tissue donation. The hospital performed consistently well in organ donation and between 2011 and 2016 was the highest performing district general hospital in south east England. To acknowledge and celebrate this achievement, the trust had commissioned commemorative artwork in a large atrium area that patients, visitors and staff could access.
- The allied health professional team worked with consultants to develop weaning rehabilitation plans for patients but the speech and language therapy (SaLT) team had only three members of staff to cover the hospital and not all therapists in the team had the clinical skills to establish tracheostomy weaning.
- Two bedrooms were available for relatives of patients in the ICU. These were adjacent to the unit and also had shower and toilet facilities. Relatives of patients in the CCU could also use the facilities and senior staff prioritised bedroom space based on the level of acuity of the patient and the distance their family had to travel.
- The critical care consultant nurse offered a follow-up clinic for patients discharged from ICU that included the opportunity to speak with the team that had cared for them as well as to visit the unit. They also ensured patients had access to appropriate psychological support through the follow-up clinic.

Meeting people's individual needs

- The allied health professionals (AHP) team had established a relationship with an organisation that brought therapy animals into the hospital. This meant patients on a rehabilitation pathway in the gym could interact with pet therapy dogs and cats, which improved their recovery as well as their emotional wellbeing. The team had risk assessed taking a pet therapy dog into ICU as a restorative strategy for patients with low mood.
- The ICU and surgical HDU (SHDU) had quiet areas for relatives with kitchens and drink-making facilities and staff provided colouring books for children.
- Nurses were encouraged to specialise in individual areas of interest, undertake additional training in the area and ensure their units remained up to date with the latest changes to practice and national guidance. Link nurses were available in Parkinson's disease, dementia, education, tracheostomy care and nutrition, end of life care, moving and handling and diabetes. The nurses acted as a link with clinical nurse specialists to ensure patients received timely and appropriate referrals.
- A range of additional services were available to help support patients' care, treatment and rehabilitation. This included a learning disability nurse who was available on demand and supported staff to

communicate with patients using non-verbal techniques. A drug and alcohol liaison nurse was available and could also refer patients into community recovery providers on discharge for help with reducing alcohol and substance use.

- Staff used the butterfly scheme to help care for patients with dementia. This meant a discreet butterfly sign was displayed near their bedside to indicate their condition to staff. Printed information on the scheme was provided for relatives and visitors.
- Discharge procedures in the cardiac care unit (CCU) were inconsistent. For example, one patient had called the unit directly when the community mental health support they had expected had not been provided. A CCU nurse liaised with the patient, their GP and a community mental health nurse to arrange this. On another occasion, a patient had not been able to wait after a delay in finding a doctor to prescribe to take away medicine. Instead, a CCU nurse delivered the essential medicine to them after they finished their shift.
- Staff in the ICU and CCU had sourced beds and chairs to accommodate bariatric patients, who could be cared for more safely with this equipment.
- Staff in each critical care unit had access to interpreting services, which they prioritised for clinical discussions with patients.

Access and flow

- Between November 2015 and October 2016, bed occupancy fluctuated between 89% and 100%. Occupancy was at 100% for four of the 12 months reported and was higher than the England average for the whole period.
- Between September 2015 and August 2016, 29% of patients in the ICU experienced a delayed discharge of between four hours and 24 hours and 26% experienced a discharge delay of more than 24 hours. During the same period in the MHDU, 34% of patients experienced a discharge delay of between four hours and 24 hours and 41% experienced a discharge delay of over 24 hours. In the SHDU, 45% of patients experienced a discharge delay of between four hours and 24 hours and 30% experienced a discharge delay of over 24 hours.
- A 'non-clinical transfer out' is a transfer out of a unit that occurs for non-medical reasons, such as operational or logistical reasons. Between September 2015 and August 2016, there were no non-clinical transfers out of the MHDU or SHDU. In the ICU, three patients were transferred out for non-clinical reasons, which was 0.5% of all patients seen.
- Out of hours discharges are those that occur between 10pm and 6.59am and should normally be avoided because of the discomfort and additional risk to recovering patients. Between September 2015 and August 2016, 20% of discharges from the ICU, 17% of discharges from the MDHU and 13% of discharges from the SHDU took place out of hours.
- Access and flow was part of the critical care programme to improve several areas of care and patient experience, including reducing delayed discharges. However, doctors told us it was a regular occurrence that patients waited so long in ICU for a hospital bed that they were discharged directly home because they had recovered sufficiently. There was a wider impact of this, including the need to use beds in theatre recovery for new ICU patients. Patients were sometimes ventilated in recovery but staff told us additional critical care nurses were always provided in such circumstances and an anaesthetist monitored the patient. However, where this happened, nurses were moved from ICU to recovery and the senior team in ICU tried to make up the shortfall with agency nurses.
- Access and flow in the CCU was not always consistently managed. There was an admissions criteria and operational policy but staff told us these were often overridden to admit inappropriate patients to avoid problems elsewhere in the hospital. For example, one patient was admitted to the CCU from accident and emergency to avoid a breach in that department. The patient did not need cardiac care and when another patient arrived at the hospital who did need this specialist treatment, they had to be admitted to another ward because CCU was full. In addition, staff said it was not clear to other departments in the hospital that the fifth CCU bed was no longer in regular use and was to be used for emergencies only. Staff told us they sometimes submitted an incident report regarding this but did not feel it made a difference and so were less inclined to do so every time. One incident report had been submitted that related to insufficient clinical management of access and flow between the ICU, CCU and emergency

department(ED). This related to the failure to transfer one patient from the CCU who was ready for discharge to make space for an emergency patient. Instead the transfer was made from the ED to the last ICU bed to avoid a 12-hour breach in the ED. This indicated an inappropriate admission and a delayed discharge.

- SaLT's and dieticians had a target to see patients within two days of initial referral. The team tracked patients who were not seen in this timeframe because of low levels of staffing. In the week prior to our inspection, there were 200 breaches of the two day referral target.

Learning from complaints and concerns

- Between August 2015 and July 2016, critical care services not including the CCU received two formal complaints. In both cases, the trust investigated and closed the complaints within the 30 day target in the complaints management policy. The CCU received no formal complaints between May 2016 and December 2016.
- In the 2016 staff survey the trust asked staff to rate their experience of how patient complaints were dealt with and 70% of staff said they felt the trust acted on complaints.
- The critical care matron led complaint investigations relating to the ICU, MHDU and SHDU. The cardiology matron performed this role for the CCU. Learning was disseminated to staff through team meetings, the daily communication record and by e-mail.

Are critical care services well-led?

Requires improvement

At our last inspection we rated well led as requires improvement in critical care. We have maintained this rating. However, we found a number of strategies for improvement were in place, with some evidence of progress. This included a reduction in reported bullying and harassment through better engagement from the senior team. The improvement strategy had resulted in a more coherent and effective clinical governance structure and a staff engagement programme to address the poor levels of communication we previously found.

At this inspection we rated critical care services as requires improvement for well led because:

- Staff demonstrated widely varying understanding of and engagement with the trust's vision and values. This was despite 600 members of staff being involved in their development.
- A significant number of staff did not feel that changes to clinical care or operating procedures had been implemented safely or with consultation. This included the implementation of a medical model that some nurses said meant they worked continually without a break and they were not able to review every patient referred to them. In addition, therapists were allocated to attend patient review meetings but did not have the capacity or resources to do so consistently.
- Although the trust had implemented a number of staff engagement strategies, we received variable feedback from staff we spoke with about these. In addition, the 2016 staff survey indicated only 28% said senior managers involved them in important decisions.

However we also found:

- An improvement strategy was in place for critical care services that included engagement with the trust's internal professional standards, implementation of a new leadership structure and commitment to a research and development portfolio.
- A critical care programme board had been established to ensure services engaged with the trust's governance structure.
- Senior leadership and clinical teams had improved how they engaged with staff, including through more regular meetings and a wider range of communication strategies. Doctors in training spoke positively about the supervision and training opportunities available to them.
- Staff proactively contacted patients and relatives after they were discharged to discuss their experience and use this feedback for service development.
- Clinical governance systems, meeting structures and directorate risk registers formed part of the quality assurance and risk management system. There was evidence senior staff used the systems effectively to identify and mitigate risk.

- Services had successfully recruited to research studies that aimed to improve outcomes for critical care patients, including to studies of psychological impact of intensive care.
- Feedback from staff about the culture of the service was variable but most of the individuals we spoke with agreed bullying and harassment had decreased and was no longer tolerated.
- Results from the 2016 staff survey indicated the trust engaged positively with patients and relatives, which we saw evidence of in each unit through the information provided and staff interactions.
- Cardiac care unit staff had been recognised with a national award for staff service and care.

Leadership of service

- The cardiac care unit (CCU) was part of acute specialist medicine program in the acute and continuing care directorate. The intensive care unit (ICU), medical high dependency unit (MHDU), surgical high dependency unit (SHDU), acute response team (ART), resuscitation team and organ donation team formed the critical care program in the coordinated surgical directorate. A director of clinical operations, supported by a deputy medical director and deputy director of nursing, led services in each directorate. Both the acute specialist medicine program and the critical care program had a tripartite leadership structure in place, formed of a clinical director, general manager and at least one matron. Both programs also had a service manager and the acute specialist medicine program had specialty leads.
- Staff we spoke with described different experiences of the visibility of senior staff. In most cases staff told us they had a positive working relationship with their matron but they did not often see their deputy director of nursing or anyone more senior.
- Each band seven team leader nurse in the ICU led three meetings per year with their team. This enabled team leaders to support staff to maintain their training levels and stay up to date with practice in the unit.
- Doctors in training gave positive feedback about their relationship with the clinical leads and clinical director. They said in all cases senior clinicians were approachable and felt they were effective teachers.

Vision and strategy for this service

- As part of the trust's recovery plan, 600 members of staff had engaged with a consultation to contribute to the vision and values they wanted to work within. This included being inspiring, ambitious and bold in taking on new opportunities. Staff we spoke with demonstrated varying knowledge of the trust's developmental objectives, including 20 individuals who said they did not know what they were. Staff who demonstrated engagement with the recovery plan said they felt the support from the executive team was forthcoming and said the senior team had an 'open door' policy, which was useful for discussing ideas.
- A critical care programme strategy had been established for 2016/17 for the ICU, MHDU and SHDU. The strategy outlined 15 short, medium and long-term aims including the establishment of an advanced critical care practitioner team, the development of a research programme and the facilitation of improved patient outcomes after they were discharged from critical care. The directorate team acknowledged potential challenges to achieving the strategy; including staff recruitment and increasing demands on the service incorporated these into the plan.
- Critical care staff were working towards four key quality improvements in the immediate future to continue to work towards the improvement strategy. This included establishing 24-hour, seven day a week cover from doctors in training, develop pharmacy reviews of medicines errors and continue to deliver staff support and training and improve rehabilitation after step-down to a ward or discharge. In addition, a capital project plan was in progress that aimed to develop an integrated critical care unit. This would result in the relocation of the MHDU and ICU to be adjacent to the SHDU to make better use of shared resources and staffing and reduce the need for transfers for patients.
- The senior team planned to continue the success of improved working relationships between critical care and accident and emergency by developing a nurse rotation programme.

Governance, risk management and quality measurement

- Senior divisional teams used a monthly performance review meeting as part of the clinical governance and

quality assurance system that monitored performance using a 49-point scorecard. Staff used this system to maintain an overview of quality measures such as incidents, complaints, patient feedback, pressure ulcers and staff sickness. Where targets were not met, a senior member of staff in the unit or area investigated this and implemented an action plan for improvement, such as where there was an increase in delayed discharges or transfers.

- Staff in each unit held team meetings and operational meetings every two months. We looked at a sample of seven meeting minutes, which demonstrated senior clinical and leadership staff attended operational meetings and appropriate nursing staff attended team meetings. Actions and learning were documented in each case and there was continuous tracking of the requirements identified at previous meetings. Minutes showed us the outcomes of incidents and complaints were shared with staff and they were given the opportunity to discuss new policies and procedures.
- The senior directorate team monitored significant risks to the service through the use of a risk register. A risk register is a risk management system that establishes the likely impact of a risk by assessing the likelihood and consequence of it occurring. In October 2016 there were four risks identified for ICU, MHDU and SHDU. The most serious risk was delayed admissions to critical care due to a lack of step-down beds in hospital wards. This meant patients spent longer in critical care than necessary and the health of those waiting to be admitted was put at risk as a result. To reduce the frequency at which this happened, the clinical lead for intensive care medicine was working with the site management team to ensure patients leaving critical care were prioritised for ward beds over elective admissions, who were at significantly lower risk than those leaving ICU or one of the HDUs. Other risks related to a lack of dedicated pharmacy cover, a lack of doctors in training and the environment in the MHDU. There was evidence the director of clinical services reviewed the risks regularly and progress was documented towards minimising risk. This included new recruitment campaigns for a critical care pharmacist and doctors in training and a plan to relocate the MHDU.
- The risk register for the CCU included the admission of inappropriate patients and the location of cardiology services over three separate locations in the hospital. Senior members of the team were re-writing the admission criteria to try and achieve more appropriate future placement. Staff in the unit highlighted the separate locations of cardiology services as a significant risk because it meant they did not have rapid access to cardiologists or the catheterisation laboratory.
- A deteriorating patient group monitored how patients were reviewed and cared for around the hospital and reported to the deteriorating patient board, with input from senior nurses in the acute response team (ART).
- Although the new medical model approach to care and treatment had contributed to improved patient outcomes in the MHDU, there was a lack of evidence an appropriate governance structure was in place to ensure staff had the capacity and resources to safely manage the changed approach. For example, one nurse said their team regularly worked for 12 hours without a break and then had to work late as a result of the implementation of the new model with no additional nursing staff.
- The trust had a confidential reporting and escalation system in place that meant staff could report any concerns about clinical practice without fear of reproach. In the 2016 staff survey, 96% of staff indicated they knew about this policy but only 70% said they would feel secure using it and only 52% said they felt confident the trust would address concerns raised.

Culture within the service

- Three consultants told us they felt there was an element of favouritism and victimisation in the leadership team as some staff were permitted up to three weeks off work consecutively whereas others were not permitted more than six consecutive days off work. One consultant said their annual leave had been cancelled with just six weeks' notice, which they said was indicative of a culture of inconsistent treatment of the consultant team. Doctors in training did not always feel they were treated equally by other staff. For example, some doctors in training said they felt there was a lack of opportunity for clinical teaching unless they were based in the ICU and said there was little career or development advice available. Three doctors said they felt they had to work hard to secure their study leave, which should have been provided readily by the trust.

- Nurses gave varying feedback about the working culture of the hospital. One individual said morale in their team was low because of sickness, continuous levels of low staffing and a lack of input from the senior team. Staff in the ART team felt low staffing levels meant they could not achieve professional clinical standards in their new model of working but they had not been able to discuss this with appropriate senior staff. Another member of staff said they felt morale was "exceptionally low", which they attributed to higher levels of stress in the team. This issue had been acknowledged in a team meeting and the minutes indicated new bi-weekly meetings between nurses and manages had been implemented to improve communication. Nurses in other areas felt more positively and said they felt there had been a change of leadership in their areas of work that meant it was a much more positive environment to work in.
- We asked staff who worked across different units in the hospital about the working culture. One individual said, "I've noticed a change in how managers deal with bullying and harassment. It seems they don't tolerate this anymore and take action when it is reported." Another member of staff said, "I feel that matrons are now much more visible and senior staff are listening to us; they seem excited about the transforming care programme." Staff described variable experiences with local clinical leadership. Most members of staff we spoke with described ongoing positive change and a noticeable decrease in bullying and harassment. Staff nurses in particular cited an improvement in relationships with matrons and their encouragement to develop. However, one individual said, "No matter how bad it gets or how busy we are, some senior staff will not roll their sleeves up and get involved, even when we desperately need help." Another person said, "I have had to beg senior staff to help when I was really struggling." Staff in some areas told us the hierarchy was used only when it was needed, which meant they felt more able to approach each other and the senior team with concerns or problems. Five doctors said they felt "very supported" by the consultant team but worried that the new matron was under excessive pressure.
- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients or other relevant persons of 'certain notifiable incidents' and provide reasonable support to that person. Senior nursing and medical staff on each unit were trained in the principles of the duty of candour. This meant when something went wrong staff discussed this openly and honestly with the patients and/or relatives involved. All of the staff we spoke with were aware of this policy and could describe how they made sure their communication met its requirements.

Public engagement

- Each unit provided relatives and visitors with information on common types of treatment and what to expect when visiting the unit. This included the importance of hand hygiene and how to use hand washing and disinfection stations as well as how to contact key unit staff. Each unit also had a staff photograph board and a poster to help people identify staff by the colour of their uniform. Staff in the SHDU had produced an information board titled 'What we do' that include photos of equipment such as arterial lines and tracheostomies and an explanation of what they did.
- In the 2016 staff survey, 92% of staff said they felt their department asked patients and relatives for their feedback, 57% said they received updates on changes made as a result and 57% said public feedback was used to make improvements.

Staff engagement

- The senior leadership team had implemented a number of new processes for staff engagement. This included a monthly critical care programme board, nurse team meetings at least three times each year, monthly matron meetings and more accessible communication by e-mail and informal discussions.
- In the 2016 staff survey, 28% of staff said senior managers involved them in important decisions and 27% of staff said they felt senior managers acted on their feedback.
- Staff in the ICU identified 11 key areas of focus as part of the quality improvement project. A consultant and nurse took responsibility for each area, including improved venous thromboembolism risk assessment compliance, pain management, reducing medicines errors and managing diabetes.
- Work-based 'listeners' were in post in each directorate to provide staff with a confidential means of talking if

they had concerns or worries. Not all of the staff we spoke were aware of this but those individuals who did have knowledge of this were positive about it. One nurse said, "There is a new focus on listening to how we all feel and the change in attitudes from [the senior team] has been phenomenal."

- Staff we spoke with described varying experiences of involvement with and consultation from the trust. Some staff in the ART felt there was room for improvement in how the trust engaged with staff during restructuring and change. For example, a nurse told us the consultation was almost finalised and the key plan in version 20 before any staff were asked for their input. They also felt a lack of openness and honesty in the recruitment process made them feel disconnected to the process and uncertain about the future of the team. As part of the transition of the critical care outreach team into an ART model, the team were relocated to another part of the hospital, which they said they were not consulted on. We asked the trust to provide more information on this. We saw an assistant director of nursing had set up a weekly drop-in session for nurses to discuss their ideas, feedback or concerns about the transition to the ART model of working. The assistant director of nursing had also delayed the launch of the ART by one week to accommodate more communication time with staff. Although this was evidence of communication with staff, no formal consultation of the changes took place.
- Similarly, some therapists said they had not been consulted on the introduction of a medical model of care that required them to attend board rounds. They said this had been imposed on them without discussion and they were expected to increase their level of cover with no additional resources.
- In the 2016 staff survey, 73% of staff said they felt able to make suggestions to improve their team or department and 48% said they were involved in decisions to make changes in their work.

Innovation, improvement and sustainability

- Staff in critical care units were research active and engaged in local, national and international research to contribute to studies that would improve care and outcomes for patients as well as drive innovative practice. Critical care services were the highest single recruiter to research in Kent and as of January 2017 had recruited 112 patients into five studies taking place between March 2016 and April 2017. At the time of our inspection, the team had achieved the recruitment of 500 patients into research projects in 2015/16 and had successfully participated in the national provision of psychological support to people in intensive care (POPPI) study. The POPPI study aimed to improve patient wellbeing after intensive care treatment by improving teaching for nurses on managing psychological distress and facilitating a therapeutic environment. Critical care had been acknowledged as the best of the 24 hospitals taking part, for patient recruitment. Other research studies included end of life care, outcomes for patients over the age of 80, respiratory care and abdominal sepsis care.
- Staff nurses were able to undertake shifts as the nurse in charge as part of a leadership development programme. An experienced senior nurse mentored those taking part to ensure they were given the opportunity to develop their skills whilst maintaining patient safety. In addition, band six nurses were encouraged to take a line management course and band seven nurses were supported to deputise for matrons, including at site meetings.
- Nurses in the HDUs were able to apply for a three-month rotation into ICU once they had at least one year's experience. Staff who had completed a rotation spoke positively about the experience and said it had helped them to develop their intensive care skills.
- AHPs who worked in critical care services said they were supported to develop with the completion of Masters and PhD programmes but there were no other incentives or different opportunities to encourage them to stay. One member of staff said, "There is no next step, no consultant therapist posts to move into, it's very frustrating." Another member of staff said, "We run around the hospital trying to find nurses who have enough training to help us with things like inserting a vascular line but there are so few of them this is often delayed and we waste time trying to find staff." One member of staff said, "We can't see all of the patients referred to us because there just aren't enough of us. We don't have time to take part in any projects or research and so people leave to work somewhere they can do this."

Critical care

- The trust participated in the national 'WOW!' staff recognition scheme, which awarded staff in a number of nomination categories based on nominations from colleagues and patients for high standards of care. The CCU nursing team had achieved the 'best team' award just before our inspection following a nomination from the relative of a previous patient. Two members of the nursing team had presented the unit's work at an awards ceremony to receive their recognition, which they attended with the dedicated housekeeper as representative of the non-clinical team. Some members of the team said the award was motivational and others said they were disappointed the senior team had not acknowledged their achievement. In the 2016 staff survey, 48% of staff said they felt recognised for their work.
- In the 2016 staff survey, 85% of staff said the trust acted fairly in relation to career progression.
- A critical care consultant, nurse practitioner, GP lay member and physiotherapist led an innovative programme to improve patient rehabilitation during their ICU admission and after discharge. This included a training and awareness session for all area GPs and a business case to recruit a dedicated rehabilitation coordinator. In addition, a critical care consultant had developed app software to be used on digital tablets to help communication and rehabilitation led by nurses. The consultant was due to present this at a critical care nurses rehabilitation group to gather feedback and plan a national launch.

Maternity and gynaecology

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

Information about the service

Medway Maritime Hospital (MMH), maternity and gynaecology services are managed by the women and children's division. From April 2015 to March 2016 4,920 women delivered their babies at the trust.

The antenatal and fetal medicine unit (FMAU) is led by sub-specialist consultants; and is the only centre in Kent; it has a high volume of work. The antenatal service supports high-risk pathways and public health initiatives, for example, the FMAU provides ambulatory and emergency access in a multidisciplinary setting with consultants from various specialities.

The Delivery Suite consists of 10 delivery rooms, with four beds allocated for women requiring an induction of labour. The delivery suite also provides two obstetric theatres.

The Birth Place is the trust's midwifery-led unit. It offers more choice for women about where they give birth. In the unit there are: five birthing rooms, four postnatal beds, two birthing pools, a low risk triage (assessment) and an education room to help prepare women and their partners for life as parents. The Birth Place can care for ten women at any one time.

The maternity enhanced care unit (MCU) provides an intermediate level of care for women or those in the postnatal period requiring a higher level of care above that readily available on the antenatal or postnatal ward.

Kent Ward is a 24 bed postnatal ward. The ward provides care for women who have uncomplicated deliveries, either vaginally or by elective or emergency caesarean section. A range of staff including: midwives, nurses and maternity care workers, care for women.

Pearl Ward is a 23-bed ward that provided care for women who require antenatal, postnatal, and transitional care. The ward provides care for women who are considered at risk following birth and are expected to stay for over 24 hours. Pearl ward also provides a six-bed transitional care unit for babies who require close observation but not intensive medical input.

Ocelot Ward is a dedicated women's health ward. The ward caters for both gynaecology and general women's health.

To help us understand and judge the quality of care in maternity and gynaecology services at Medway Maritime Hospital we used a variety of methods to gather evidence. We spoke with over 30 staff including: consultants, doctors, midwives, nurses ward managers, supervising midwives, and maternity and health care assistants. We interviewed the divisional management team. We also spoke with 15 women and visiting relatives. We observed care and looked at women's care records. We also looked at a wide range of documents, including audit results, action plans, policies, governance reports and meeting minutes.

Maternity and gynaecology

Summary of findings

At our previous inspection in 2015 we rated the service as good. On this inspection we maintained a rating of good as the overall quality of care for patients had been maintained. However, the addition of Abigail's Place improved the care and support provided to families of stillborn children.

At this inspection, overall we rated maternity and gynaecology services as good. This was because:

• People were being protected from avoidable harm and abuse.

• Openness and transparency about safety was encouraged. Staff understood their responsibilities in relation to incident reporting. Incidents were investigated appropriately by staff with the necessary clinical knowledge and who had received training in leading such investigations. We were given examples of where changes to practice had been made following incidents.

• Overall, medicines practice met practice guidelines. However, we found two areas were medicines were not stored appropriately.

• The services, wards and departments were clean and, overall, staff adhered to infection control policies and protocols. However, we found some areas that had not been cleaned appropriately following spillages, and areas which were not cleaned to required standards. We also found that staff were not always washing their hands in line with trust policy

• Performance demonstrated a consistent track record and steady improvements in safety. Record keeping was comprehensive and audited on a regular basis.

• Decision making about the care and treatment of patients was clearly documented. The service used systems of observation to drive improvement in the timely identification of patients at risk of unexpected deterioration. It had allowed for oversight of patients with elevated risk and concerns were escalated for review by the medical teams.

• Treatment and care was generally provided in accordance with the National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) evidence-based national guidelines. Maternity and gynaecology had an MDT approach in the care of women and babies.

• There was a range of national and local audits with action plans. In response to audit results action plans were reviewed and monitored providing evidence of good outcomes for children and young people.

• Leadership was good and staff told us about being supported and enjoyed being part of a team. There was evidence of multi-disciplinary working with staff working together to problem solve and develop child-centred evidence based services which improved outcomes for children and young people.

• Development opportunities and clinical training was accessible and there was evidence of staff being supported and developed in order to improve services provided to children and young people.

• Feedback from women and their families was continually positive about the way staff treated people. We saw staff treated children and young people with dignity, respect and kindness during all interactions. Women and families told us they felt safe, supported and cared for by staff. A caring culture was embedded in staff values, which was reflected by the fact that women were active partners in care and staff empowered them to make decisions regarding their own care.

However:

• The maternity service was not meeting it ratio of staff to patients every month.

• There were no guidelines in place in regards to babies' identification.

• The maternity unit had closed on seven occasions between April 2015 and July 2016 due to the neonatal unit (NNU) being closed. However, the service had followed trust procedures in regards to unit closures.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

At our last inspection we rated the service as good. On this inspection we have maintained a rating of good.

We rated maternity and gynaecology services as good for safe. This was because:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. We were given examples where learning had taken place and had changed practice. All incidents were analysed and reported to the monthly governance meetings for further discussion and action. The culture of reporting and the feedback received had been maintained since our last inspection.
- There were systems, processes and standard operating procedures for example in infection control that were reliable and kept patients safe. Overall, we saw adherence to the trust infection prevention and control polices when compared to our inspection in August 2015. However, we found some areas that had not been cleaned appropriately following spillages, and areas which were not cleaned to required standards. We also found that staff were not always washing their hands in line with trust policy.
- The service had effective systems to assess and respond to risks to patients. We observed staff recognised and responded appropriately to any deterioration in the condition of patients. The early warning observation systems were being used to monitor patients and there was consistent identification, escalation and oversight when a patients' condition deteriorated.
- Handovers and safety briefings were effective and ensured staff managed risks to people who used the service. Information was shared and staff felt able to challenge and voice concerns.
- Appropriate safeguarding arrangements were in place to identify and protect children and young people from the risk of abuse.The trust worked within multi-agency policies and had strong relationships with other agencies. Policies and procedures were known and understood by staff.
- Patients care records were mostly written and managed in a way that kept them safe. The service monitored and recorded 'harm free' care.
- There were staffing levels met planned levels most of the time for medical, midwifery and nursing staff to ensure staffing levels were safe. Agency and locum staff were used to address any shortfalls in staffing
- Overall, systems for the safe handling of administration of drugs were in place and effective. However, we found on Pearl Ward ampoules of two drugs commonly used for stomach problems, stored in a box together and IV fluids that were not securely stored.

However, we also found:

- The maternity service had not regularly met its ratio target of staff to patients every month, as recommended by Birthrate Plus.
- The service did not have a policy or guidelines in place in regards to babies' identification bracelets.

Incidents

- The maternity and gynaecology service used an incident reporting system widely used in the NHS. We found incidents were consistently reported across teams; and staff used the reporting system appropriately. There was a comprehensive process of review and monitoring of incidents.
- We viewed the incidents reported on the trust's electronic incident reporting system. There were 903 incidents reported between September 2015 and August 2016.
- The majority of incidents resulted in no harm (701, 77.6%). The numbers of incidents reported increased from January 2016 onwards with an average of 26 incidents reported per month between September 2015 and December 2015, compared to an average of 100 per month from January 2016 to August 2016. As the majority of these were no harm, this demonstrated an improvement in the reporting culture of the department.

Maternity and gynaecology

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From September 2015 to August 2016 the trust reported no incidents which were classified as never events for maternity and gynaecology.
- The trust had reported five serious incidents (SI) on the NHS strategic executive information system (StEIS), from November 2015 to October 2015. StEIS is the national framework for monitoring serious incidents in the NHS. Three serious incidents (SI) involved a maternal death. We reviewed the incidents and found the trust had investigated and identified learning from the investigations. For example, a SI investigation in March 2016 found that staff had used an out of date version of the trust' venous thromboembolism (VTE) tool. As a result the services clinical skills facilitator rolled out further training on the new tool staff should have being using, the incident was also discussed with staff at safety huddles and the trust sent a 'Friday News' alert to alert staff to stop using and dispose of any old VTE tools.
- There were two other SI's that were under investigation, one in September 2016 was being externally reviewed by another hospital; the secondone in November 2016, staff were waiting for the coroner's report. Both incidents had immediate learning identified and disseminated to staff at safety huddles.
- The most frequently reported incident type was treatment, procedure (289, 32%). Thirteen of these incidents resulted in moderate harm. Five of the moderate harm incidents were in gynaecology and eight were in obstetrics. All five of the gynaecology incidents related to injury following surgery. The second most frequently reported incident type was 'transfer/delay/failure/inappropriate' with 96 incidents (10.6%). In a review of a selection of these incidents the majority of these incidents were related to the delivery suite not being able to take the patient. There were two incidents identified as pressure ulcers. Both of these incidents were grade one pressure ulcers and the trust had classed them both as resulting in no harm.
- All incidents were posted by email and text to the director of operations, head of midwifery and the trust's risk lead. Incidents were reviewed at weekly incident reporting meetings.
- There was a SI flowchart to provide staff with guidance on the trust intranet; we also saw copies of the flowcharts displayed in staff rooms and offices across maternity and gynaecology services.
- Staff understood their responsibilities to report incidents using the trust's electronic reporting system and knew how to raise concerns. Staff spoke positively about learning from incidents and confirmed they received feedback from incidents that took place in other areas of the service as well as their own via the trust's newsletters, head of midwifery briefings, and safety huddles and team meetings.
- Management reviewed serious incidents at monthly governance meetings and presented findings to next of kin at a closure panel. We reviewed a sample of investigation reports submitted by the service. Staff completed root cause analysis (RCA) as part of the investigation of incidents. RCA's identified learning from incidents. Management shared lessons learned from incidents across teams. Management developed action plans because of RCA findings. The director of operations, head of midwifery and the risk lead monitored action plans and next steps until the serious incident investigation closed.
- The trust's adverse incident policy carried guidance and templates for staff on incident reports, recording and reporting; as well as patient safety case reviews (PSCR), these were reviews of incidents where patient safety may have been compromised. PSCR's were led by governance leads and reported at monthly governance meetings. PSCR's were action plan driven, this meant required improvements had plans in place and were monitored to completion.
- The service was meeting the requirements of the Royal College of Obstetricians and Gynaecologists (RCOG) 'Improving Patient Safety' document via the gynaecology and labour ward governance meetings. Every PSCR and serious incident for moderate/severe

harm, or lower levels of harm if there were concerns about care or service delivery, were discussed within the multidisciplinary team at governance meetings and an action plan was generated if required.

- We saw that all maternal mortalities were investigated as serious incidents; the findings were discussed at governance meetings and were shared with staff at departmental audit meetings.
- The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The trust had a Duty of Candour form in place. This provided staff with guidance on the actions that should be taken, in regards to the Duty of Candour, in the event of harm or a near miss involving a patient.

Safety thermometer

- The maternity safety thermometer is a national tool that has been designed to measure commonly occurring harms within maternity care. It integrates measurement for improvement into daily routines and supports improvement in patient care. The maternity safety thermometer collects data on the following harms: maternal infection, perineal trauma, post-partum haemorrhage, term babies Apgar score scores (a simple assessment of how a baby is doing at birth, which helps determine whether the baby requires additional medical assistance), term baby treatment, mother and baby separation and women's perception of safety. Up to date safety thermometer results were displayed on noticeboards in the Delivery Suite, as well as Pearl and Ocelot wards.
- A maternity dashboard was in use that gave information about various measures of safety as well as outcomes and responsiveness of the service. This was up to date. Senior staff we spoke with used some of this information to monitor and improve safety. For example, the dashboard indicated that Ocelot, Pearl and Kent Wards were achieving 100% harm free care, which was better than the trust target of 95%. However, in maternity outpatients and the community, there was no specific, adapted maternity safety thermometer in use.

Cleanliness, infection control and hygiene

- The service performed "better than" other trusts in the CQC maternity survey 2015 for the question "Thinking about your stay in hospital, how clean was the hospital room or ward you were in," scoring 8.9 out of 10.
- There were no MRSA or clostridium difficile (C-diff) cases reported in the maternity services in the year to November 2016.
- Waste disposal was managed appropriately with different types of waste and laundry separated. Boxes for the disposal of needles were assembled and dated.
- We checked the resuscitaire on the Delivery Suite and found a large amount of dust on the bottom tray of the equipment, even though the equipment had been signed off as clean. We drew this to the cleaning staffs' attention and they told us they were unaware that this area of the resuscitaire required cleaning. The cleaning of the resuscitaire was the nursing staffs' responsibility. Therefore some areas of the department were not cleaned in accordance with NICE (CG139) 'Healthcare-associated infections: prevention and control in primary and community care' guidelines. We also found dried in blood in a variety of places on the Delivery Suite. For example, there was dried blood on the sharps bin in the sluice; there was dried blood in a shower and toilet; and dried blood on a washing bowl and 'wet floor' sign. There was also a sharps box on the floor in the dirty utility room, as well as blood splashes on some clean containers. This created an infection risk to women, babies and staff on the Delivery Suite.
- Staff at the maternity care unit (MCU) told us there was no sluice facility on the MCU. This meant staff could not clean equipment on the MCU and had to use facilities on a different ward. Therefore, staff moved dirty equipment around the maternity department, increasing the risk of cross infection. Managers told us a sluice facility was under review and the service were looking at ways to provide a sluice on the MCU.
- Hand hygiene was audited on a monthly basis across maternity and gynaecology services. Between April 2016 and December 2016 we found 100% compliance with hand hygiene across maternity and gynaecology services, with the exception of the Delivery Suite which achieved 100% compliance with the exception of August 2016 when the compliance rate was 88%.

- Overall, we found staff compliance with hand hygiene policies and procedures was good. However, we monitored visitors hand hygiene on the Delivery Suite during the two days we visited the maternity service. During this period, we saw 11 visitors and staff not washing their hands or using hand-sanitising gels. Staff told us they usually challenged visitors about hand hygiene; however, we did not observe staff challenging visitors during our visit. This created a risk that germs from outside and inside the ward could be spread to other areas.

Environment and equipment

- Overall, all equipment including resuscitation equipment was checked on a daily basis and a report was given to senior staff by 9am. However, there were a few exceptions. There was a suction catheter exposed on a resuscitaire on the Delivery Suite, this could have led to the equipment being damaged or contaminated. We also saw a maternal suction catheter that was open with no date recorded of when it was connected.
- Staff had access to satisfactory amounts of equipment including fetal blood analysers and fetal heart rate monitors.
- Eclampsia kits were available to staff this meant that if a woman suffered convulsions, staff could provide care and treatment in a timely way.
- Laboratory facilities were available for blood and blood products. A cardiotocograph (CTG) monitor was available in all delivery suites and additional monitors were available on the ward. Satisfactory numbers of neonatal resuscitaires were available; these had been checked on a daily basis to ensure they were functioning correctly and were fully equipped.
- Pearl Ward staff told us they had good access to equipment and repairs were timely. We found resuscitation trollies on Pearl Ward were checked on a daily basis and the checks were up to date.

Medicines

- Intravenous (IV) sodium chloride fluids were stored in a draw on a corridor on Pearl Ward. We were able to open the draw, remove and replace the fluids. This was not secure as it did not ensure that IV fluids could not be tampered with. We also found IV saline fluids unsecured in trolleys on the Delivery Suite.
- We found ampoules of metoclopramide and ranitidine, drugs commonly used for stomach problems, stored in the same metoclopramide box together. These should have been stored in separate boxes. The metoclopramide box did not indicate that there was an ampoule of ranitidine also being stored in the box. This created a risk that patients may have been given the incorrect medicine.
- The maternity and gynaecology service did not have a ward based pharmacist. However, in a presentation by senior divisional managers we were told this was recognised as an area for improvement. However, Ocelot Ward had a ward-based pharmacist. This gave staff easy access to pharmacy advice and support.
- Medicines records demonstrated medicines were being stored at the required temperatures. All the drug store cupboards were locked and controlled medicines were stored in separate locked cupboards. Where medicines required refrigeration, fridge temperatures were checked daily. There was segregated storage of drugs for epidurals.
- To take out (TTO) packs, which are medicines patients take home with them on discharge, were available to women to facilitate a timely discharge.
- Drugs were stored according to temperature limits set by the manufacturers. Staff checked ambient temperatures regularly in the treatment rooms. This was recorded on paper based notes.
- Any allergies were recorded on women's treatment charts. This meant staff would be aware to provide women with care and treatment that would not cause adverse allergic reactions.
- We viewed the women and children's divisional governance meeting key issues report dated 6 September 2016 and saw that new patient group directions (PGD) pathways were discussed; these permit the supply of PGD medicines to groups of patients without a prescription. The meeting also reviewed and confirmed that all junior doctors had been informed how to access pharmacy drugs out of hours (OOH).
- There were trust wide medications audits. However, we viewed the September 2016 audit summary report. This recorded that across maternity and gynaecology services medications audits were overdue. For example,

the Birth Place controlled drugs audit was due in May 2016 and the NHS Protect audit was due in April 2015. This means that the department could not assure itself that all medicines were accounted for and in date.

- The service had conducted an n line with the 'Start smart, then focus' government initiative, November 2011 and the antimicrobial stewardship policy issued to all clinicians in August 2015, a rolling audit program had been established to assess antimicrobial prescribing on all adult wards across the trust. The re-audit focused on the obstetrics and gynaecology wards namely Kent, Ocelot and Pearl. The audit identified improvements were required in antibiotic prescribing on Kent Ward; as well as ensuring teaching regarding antimicrobial stewardship in induction and departmental/trust teaching was robust.

Records

- Overall, staff wrote and managed patient care records in a way that kept patients safe. Maternity patients were issued with patient held maternity records at their booking appointment. If a patient attended a clinic in the hospital, a hospital record was used to record the details of the visit. Any tests results, such as blood tests or scans, were filed in the hospital record.
- Hand held records were transferred with the patient across the service. Staff recorded information contained on the hand held notes on the trust's electronic records system.
- Hospital records were stored safely in locked cabinets in a locked room and for clinics in a locked trolley. The trust had conducted a trust wide records audit in August 2016. The audit included: Kent, Pearl, and Ocelot Wards. Overall compliance across the trust was not identified, but areas of non-compliance across the trust were identified and an action plan was in place to address deficiencies in record keeping. For example, a key areas of concern was adherence to the trust's standard case-note structure, with compliance falling from 46% to 41%. The service had identified the problem to the booklets and documents used in an admission episode with no clear guidance of where they should be filed. Staff were provided with guidance on the admission documentation case note structure.
- The trust also completed monthly 'vital signs' records audits. We viewed the results for maternity and gynaecology from January 2016 to October 2016 and found they regularly achieved 100% compliance.
- Kent, Pearl and Ocelot Wards had been part of an adult services records audit in August 2016. The audit identified areas for improvement and adult services were arranging a re-audit of these areas.
- Newborn babies were issued with personal child health records, known as 'red books'. Women we spoke with on the postnatal ward confirmed they had received a red book and had received advice from staff on their use. Community midwives issued red books to parents who had home deliveries.
- We observed maternity staff completing and updating records across the service. We viewed four women's paper based records on the delivery suite. The hand held notes contained information for women on the purpose and use of the notes. Staff also informed women that other records were kept electronically on the trust's system.
- Leaflets explaining patients' rights to access their medical records were available on the wards we visited. For example, we saw copies of the trust's leaflet 'Protecting Personal Information, a Guide for Patients' were readily available. The trust's website provided information on patient's rights under the Freedom of Information Act 2000.

Safeguarding

- Staff we spoke with demonstrated understanding of the types of abuse people may experience. This included an understanding of women who may have been at risk of domestic violence and also those who had disclosed a history of substance (drug and/or alcohol) misuse.
- The trust's safeguarding children's policy was compliant with the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines 3.8 the abuse of vulnerable children.
- The trust's child abduction policy provided clear guidance for staff to protect babies from being abducted from the hospital's wards. Staff were aware of the policy and how to access it.

- Staff were able to describe the antenatal and postnatal mental health referral process, which was consistent with the trust's perinatal mental health guidelines.
- The maternity service had a safeguarding lead midwife, who provided advice and training to staff on safeguarding matters.
- Staff told us if there were safeguarding concerns about a birth they would liaise
- closely with local authority social workers. Staff completed safeguarding care management plans when they identified safeguarding concerns. Staff were able to show us the contact details for the local authority safeguarding team.
- We saw information on how to report safeguarding concerns and concerns about domestic abuse was available on all women's wards. For example, the Delivery Suite had a patient information board that contained a poster 'adult abuse' with contact details for reporting safeguarding concerns to the local authority safeguarding team. Ocelot Ward had discreet credit card sized information cards women and visitors could take.
- Midwives and nurses we spoke with were aware of the trust's safeguarding guidance and multi-agency procedures. Staff told us this was readily accessible on the trust's intranet. Staff demonstrated how they could access safeguarding information on the intranet.
- We viewed the maternity services staff training spread sheet for level 3 safeguarding training. We saw most staff had received level 3 safeguarding training. Most staff had updated their training in 2014.It is a requirement of the intercollegiate document, 'Safeguarding Children and Young People, Roles and Competencies for Health Care Staff', March 2014, that over a three-year period, professionals should receive refresher training equivalent to a minimum of six hours; for those at level 3 this equates to a minimum of two hours per annum.
- Entrances to all the ward areas we visited were secure with entry via key fob for staff or by an intercom to the ward reception for visitors. The ward entrances were also signposted to remind people not to allow entry to anyone they didn't know when they were entering the wards.
- The service had produced local guidance on female genital mutilation (FGM) and there was a trust wide policy on FGM available to staff on the trust's intranet.

Mandatory training

- Mandatory training included: information governance, health and safety, manual handling; health and safety; equality and diversity; and conflict resolution, amongst others.
- The trust provided us with information that maternity and gynaecology staff had met the trust's 80% compliance rate on mandatory information governance training in November 2016. The trust had a red, amber, green (RAG) rating for mandatory training.
- We viewed information the trust had provided on mandatory training dated November 2016. This showed that across maternity and gynaecology services most medical, midwifery, and nursing staff had completed the required mandatory training updates. However, there were exceptions where some staff groups had not achieved the trust's 80% mandatory training target. For example, 58% of gynaecological medical staff had up to date adult life support training; 72% of gynaecological medical staff had up to date infection control level 2 training; 65% of gynaecological medical staff had up to date newborn life support training; 50% of maternity staff in the obstetric theatre had up to date adult life support training; 41% of maternity staff in the obstetric theatre had up to date paediatric life support training; and 72% of staff in the obstetric theatre had up to date safeguarding adults level 1 training.
- Staff told us they completed all their mandatory training in an allocated week every year. Staff told us they were facilitated to complete their training in a timely way, by staff covering each others training times.

Assessing and responding to patient risk

- Women were risk assessed at every antenatal appointment and a plan of care was documented in their hand held records.
- Staff offered advice to women during the antenatal period, including fetal anomaly screening, this screens expectant women for a number of fetal anomalies including Down's syndrome; external cephalic version

(ECV), this is a procedure to turn a baby in a breech position to a head down position; and smoking cessation. Staff offered women a fetal scan at 36 weeks. The trust also had an 'obesity in pregnancy' guideline.

- Risk assessments were carried out for patients and risk management plans were developed in line with national guidance. Community staff were responsible for carrying out full assessments of women at their initial booking visit. These assessments included social and medical assessment and referral, as well as assessment of maternal mental health. Other assessments included smoking, drug use, family history and previous pregnancies.
- Risk assessments were used to help patients choose their preferred place of delivery, recommend further investigations and inform a plan of care. This included whether a patient should have midwife or consultant led care or be referred to other professionals within the multidisciplinary team. There were clear pathways in place based on National Institute for Health and Care Excellence (NICE) national guidelines.
- The service used a maternity early warning tool, the modified maternity early warning system (MMEOWS) to enable staff in recognising acute illness or whether a baby was deteriorating and aid staff to escalate appropriately. The MMEOWS policy was up to date. We looked at six MMEOWS charts and found that they had been completed in accordance with the trust's policy.
- Ocelot, Kent, and Pearl Wards and the Delivery Suite used a national early warning screening (NEWS) tool to enable them to recognise whether a woman was deteriorating. These were audited on a monthly basis. The wards regularly achieved 100% compliance with the national standard in using NEWS.
- Risk assessments for venous thromboembolism (VTE) were completed in accordance with NICE recommendations on VTE risk assessments, 2010.
- High risk obstetric patients on Pearl Ward had their details circulated by the ward clerk who send out a list to all the professionals involved in the woman's procedure. High risk women were also discussed at the labour ward handover.
- The service held monthly stillbirth review meetings. We viewed minutes from the August 2016 meeting and saw that the group discussed previous training sessions provided for doctors and registrars on post-mortem consenting in November 2016.
- Most staff working on maternity wards had undertaken paediatric immediate life support courses (PILS) and newborn life support courses, the trust target was 80% or above and these had been annually updated. This allowed staff to provide care to seriously ill babies. The neonatal intensive care unit was also available to provide care to babies.
- Most staff across maternity and gynaecology had completed adult life support training; this meant staff could respond immediately to an adult that suffered a cardiac arrest or other immediate risk to life.
- In four paper based notes we viewed, staff had completed postnatal VTE assessments, which were up to date, risks had been identified and birth summaries were completed.

Midwifery staffing

- The service used varying grades of nursing and midwifery staff to meet women's needs. Women received one to one care by a qualified midwife when in established labour. Women we spoke with told us there were enough staff to meet their needs.
- 97% of women received 1:1 care in the Delivery Suite from November 2015 to October 2016, the trust's target was 100%.
- A midwife was allocated to support women during elective caesarean section. There were operating lists, and elective caesarean section surgery took place three days a week. Midwives, surgical nurses and maternity support workers supported women on the postnatal ward.
- Staff displayed the staffing establishment and acuity figures on safer staffing boards in all the wards we visited. The service used the Birthrate Plus e-rostering tool to ensure there were sufficient staff to meet the demands of the service.
- Information provided by the trust dated October 2016 stated that the establishment staffing figures for the Delivery Suite, Kent Ward, Pearl Ward and the Birth

Place whole time equivalent (WTE) established staff figure was 94.8. The actual number of WTE staff was 90.3. The WTE in the Antenatal Department establishment figure was 15.4; the actual number of staff was 13.8. The WTE staff establishment on Ocelot Ward was 12.3, the actual number was 11.6.

- Overall, staffing across maternity and gynaecology services reflected the number of staff rostered. However, the established figure for Pearl Ward was three midwives, one band 3 health care assistant and a band 2 health care assistant. Staff on the ward told us they frequently did not have a band 3 nurse during the day and this could place pressure on staff, although it did not have any adverse impact on patient care.
- The trust vacancy rate target was 8%. As at July 2016 the trust reported a vacancy rate of 6.3% for nursing and midwifery staff in maternity and gynaecology. This was worse than the trust target of 8%. However, staff informed us that recruitment was in place to fill vacant roles and there had not been a negative impact on patients care.
- Where there were shortfalls in staff due to sickness or annual leave, staff across the ward areas were flexible and covered shifts. Agency staff were used when this was not possible. Between April 2015 and March 2016, the trust reported a nursing band and agency usage of 8.7% for maternity and gynaecology.
- Procedures were in place to request agency staff. Staff told us that if agency staff were required they would request midwives and nurses who were familiar to the service. Staff told us agency staff were covering an average of two to three shifts per week.
- The staff turnover rate between October 2015 and September 2016 was 5.6% for nursing and midwifery staff, this was better than the trust target of 8%.
- The nursing and midwifery staff sickness rate between October 2015 and September 2016 was 4.2%, this was worse than the trust target of 4%.
- The service used the maternity dashboard to monitor staffing ratios. The trust had a WTE staffing ratio target of one midwife to every 29 women. Birthrate Plus recommendations in 2014 were that the trust works towards a one in 27 ratio. Between September 2015 and August 2016 the trust had a funded midwife to birth ratio of 1:29. However, on a monthly basis between January and August 2016 the actual midwife to birth ratio was 1:32 for four months; 1:33 for three months; and 1:34 in one month. The actual midwife to birth ratio was not available for the period between September and December 2015. This meant the service had not regularly met its target of 1:29 every month and had not achieved the ratio of 1:27 recommended by Birthrate Plus. The head of midwifery told us high rates of maternity leave had an impact on staffing ratios. The trust were using qualified agency midwives to cover maternity leave. Staff on the Delivery Suite also told us that five new band 5 nurses had been recruited and were undergoing their pre-employment checks.
- Staff on the high dependency unit (HDU) told us there was no additional staff establishment for the maternity enhanced care unit (MCU), the MCU offered women an enhanced level of care and staffing, and this could sometimes detract from the availability of midwives for women in labour on the MCU.
- Management assessed acuity (the number of staff actually on shift) in maternity services every four hours in order that staff could be flexed across services dependent upon demand on particular wards.
- Labour Ward meeting minutes showed management reviewed actual staffing numbers and staffing issues were identified and discussed.
- We attended a handover on Pearl Ward which was attended by both midwifery and medical staff. Staff discussed patients individually to identify any risks, such as domestic abuse or sepsis and ensure staff were aware of the risks.
- Staff on Pearl Ward told us there was a high use of bank staff on the ward, but the use of agency staff was occasional. This meant temporary staff were familiar with services procedures.

Medical staffing

- In June 2016, the proportion of consultant staff reported to be working at the trust was lower than the England average (28% of medical staff compared to an England average of 40%). The proportion of junior (foundation year 1-2) staff reported to be working at the trust was higher than the England average (10% compared to an England average of 7%).

Maternity and gynaecology

- The maternity dashboard provided a threshold for the consultant presence on the Labour Ward. The trust's maternity dashboard had a target of 91 hours whole time equivalent (WTE) between January 2015 and October 2015. The trust had consistently met this target.
- In September 2015 and October 2015, the trust had 98 hours of consultant cover per week on the Labour Ward. Between November 2015 and August 2016 consultant cover on the labour ward was 91 hours per week. The service told us the 98 hour consultant cover in 2015 had a negative impact on day time work, resulting in significant loss of elective activities with no improvement in safety indicators. It also had a negative impact on consultant workforce retention. The number of hours for the labour ward consultant cover was discussed with RCOG. The service were advised that the hours for dedicated consultant cover needed to be tailored to the individual unit's needs. This was agreed by the Trust Board. The service conducted a comparison of safety incidents for both the 98 and 91 hour rotas; this showed a 50% reduction in the number of reported incidents during the 91 hour rota. The service said the 91 hours rota had demonstrated it was in keeping with the RCOG workforce document 'Providing Quality Care for Women: Obstetrics and Gynaecology Workforce 2016.'
- There was on-site consultant cover in Pearl and Ocelot wards from 8:00am to 9.00pm seven days a week. Consultant cover between 9.00pm and 8.00am was provided by an on-call consultant.
- The trust target for vacancy rates was 8%. As at July 2016 the trust reported a vacancy rate of 6% for medical staff in maternity and gynaecology, this was better than the trust target.
- The trust target for turnover rates was 8%. Between October 2015 and September 2016, the trust reported a turnover rate of 2.2% for medical staff in maternity and gynaecology. This was better than the trust target.
- The trust target for sickness rates was 4%. Between October 2015 and September 2016 the trust reported a sickness rate of 0.4% for medical staff in maternity and gynaecology. This was better than the trust target.
- The trust provided bank and locum staff usage by specialty. Obstetrics and gynaecology had the highest bank and locum usage, with the highest usage seen in July 2015 with a usage rate of 5.4%.
- Junior doctors told us it could be difficult for them to get timely support out of hours (OOH)as the registrar on-call was often busy. The junior doctors thought this was adequately managed, as the registrar would contact them when they were free.

Major incident awareness and training

- The trust had a 'maternity and gynaecology patient management business continuity plan', which had been updated on 21 November 2016. Staff were aware of the plan and knew how to access it.
- Staff on the Delivery Suite showed us the staffing plan for Christmas and the New Year, this included a 50% reduction in the number of staff allocated to take annual leave during the holiday period to ensure adequate staffing numbers were available.
- Some staff were required to complete Emergency Preparedness Resilience and Response (EPPR) training. As at 21 November 2016, 60 staff had completed this training, however the trust did not provided figures for how many staff required this training.

Are maternity and gynaecology services effective?

Good

At our last inspection we rated the service as good. On this inspection we have maintained a rating of good as the overall effectiveness of services had been maintained.

We rated maternity and gynaecology services as good for effective because:

- Staff were able to demonstrate how they could access policies on the trust's shared drive. The trust's policies routinely made reference to the source guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) and the National Institute for Health and Care Excellence (NICE).

- Pain relief was available across maternity and gynaecology services. Entonox and pethidine pain relief was routinely available on the Delivery Suite.
- Staff had access to support and training to ensure their competence. Staff received regular supervision and appraisals. There were training calendars for both midwifery and medical staff. Staff were supported with their professional registration revalidation.
- There were daily multidisciplinary (MDT) safety huddles. Maternity and gynaecology had an MDT approach in the care of women and babies.
- The Delivery Suite, Birth Place, Kent Ward, Pearl Ward, and Ocelot Ward operated a 24-hour service, seven days of the week. The pharmacy department offered seven days a week support.
- There was a range of national and local audits with action plans. In response to audit results action plans were reviewed and monitored.
- Women's consent was sought prior to care and treatment. Staff were aware of their responsibilities in regards to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

However, we also found:

- The service did not have a policy or guidelines in place in regards to babies' identification bracelets.
- The service was not meeting NICE targets for initiation of breast-feeding.

Evidence-based care and treatment

- The trust's policies routinely referred to the source guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) and the National Institute for Health and Care Excellence (NICE). Policies clearly referenced the guidance the policy was based upon. For example, we reviewed 10 sets of guidelines, including hypertension in pregnancy maternity enhanced care unit (MCU) guidelines; breech delivery and the antenatal care for low risk women guideline.
- The service had introduced a new intrapartum monitoring policy in November 2015, in accordance with NICE guidelines, the requirement for systematic monitoring of cardiotocographs (CTG). All policies and guidelines we reviewed were in date and had a date for review. However, the trust did not have a baby identification guideline, even though there were guidelines for adults. Even though identification labels were in use and staff told us there had not been any incidents in regards to baby identification, this meant the service did not have a robust system in place in regards to baby identification and there was a risk that babies identities could be mixed up
- The service had an annual audit plan in place. The plan included both national and local audits. For example, a rolling longitudinal audit for intrapartum monitoring had resulted in the new intrapartum monitoring policy and a report that evidenced standards of compliance with the trust's policy had improved over time as a result.
- The maternity dashboard indicated that the number of women who successfully opted for a vaginal birth following caesarean section (VBAC) ranged from between 83% in November 2015 to 46.7% in October 2016. The service had achieved their VBAC thresholds , which were set at 75%, on two occasions between January 2016 and October 2016; these were 90T in January 2016 and 83% in April 2016..
- The Labour Ward forum minutes dated 26 September 2016 reviewed the new world health organisation (WHO) checklists for different kinds of procedures the service had introduced. We also viewed WHO checklists when we visited the surgery and found these to be compliant with WHO procedures.

Pain relief

- Entonox pain relief (gas and air) was routinely available in the Delivery Suite and in the Birth Place. If a woman's pain exceeded this, staff offered paracetamol, then Pethidine, a pain killer for women in established labour. If their pain was not controlled then women may be offered an epidural.
- The service had an anaesthetic registrar who covered the labour ward daily and provided an epidural service. Staff provided epidurals within 30 minutes of a patient's request, which met The Association of Anaesthetics of Great Britain and Ireland Obstetric Anaesthetic Guidance. Staff offered remifentanil PCA when a woman

had a contraindication, (a procedure that should not be used as it may be harmful to the woman), to an epidural, when a midwife who would not leave the room would care for the woman.

- Staff asked patients if they required pain relief during regular comfort rounds.

Nutrition and hydration

- The trust had achieved UNICEF 'Baby Friendly' accreditation in breast feeding standards level one, this is an initiative to promote and support breast-feeding. The head of midwifery told us the service was working towards level two accreditation.
- There was a lead midwife for breast-feeding that women and staff could liaise with for advice and guidance on breast-feeding.
- The maternity dashboard indicated that the maternity service was not meeting quality statement 5 of the NICE quality standard 37 for postnatal care. The standard relates to ensuring that women receive breastfeeding support through an evaluated and structured programme. The data indicated that the service was failing to ensure that at least 85% of women were supported when beginning breastfeeding. The maternity dashboard indicated that between January 2016 and October 2016 the service had consistently failed to meet the key performance indicator (KPI) of 85%. The service had not met the target for initiation of breast feeding for every month in the period.
- Women we spoke with across maternity and gynaecology wards provided mixed reviews on the overall quality of food provided by the hospital. Some women reported the food as good, a few women said the quality of food was poor and there was a lack of choice.

Patient outcomes

- The trust did not have any CQC outliers and results were in the expected range for: maternity readmissions; emergency caesarean sections; elective caesarean sections; neonatal readmissions; and puerperal sepsis and other puerperal infections.
- The trust's policy on 'clinical risk assessment (antenatal)' was consistent with NICE quality standard 22 for antenatal care. This meant women who used the service could be sure that the trust was providing care in accordance with national guidelines.
- Staff provided care that was in line with the NICE quality standard 32 for caesarean sections. However, the maternity dashboard indicated that the service had exceeded their 15% threshold for emergency caesarean sections between January 2016 and October 2016, with the exception of May 2016, when the figure was 14.96%.
- The maternity dashboard indicated that for elective (planned) caesarean sections the service had performed better than the trust target of 10% in four months between January 2016 and October 2016, in these months figures ranged from 8% in June 2016 to 9.57% in October 2016.
- The risk register recorded a potential risk of poor clinical management and outcomes for women and their babies. For example, staff did not complete a proportion of glucose tolerance tests (GTTs) within the recommended period as indicated by NICE guidelines. However, the register recorded actions the service had taken to mitigate the risk, including the pathology department providing adequate capacity to manage the clinical pathway, GTT tests undertaken each day in the fetal and maternal assessment unit (FMAU) and the screening midwife coordinating GTT's and liaising with community midwives.
- We viewed the results of the 2016 national neonatal audit (NNAP). We saw that the trust met the NNAP standard for all babies having their temperature taken within the first hour after birth. The NNAP standard was 98-100%. The trust was achieving 99%. The NNAP standard was 100% of eligible babies receiving their first retinopathy of prematurity (ROP) screening within the time specified in guidelines. The trust was meeting the standard with 93% of mother's receiving a dose of antenatal steroids. The NNAP standard was 85%. The trust was below the standard for documented consultation with parents by a senior member of the neonatal team within 24 hours of admission. The standard was 100% the trust achieved 99%.

Maternity and gynaecology

- The maternity dashboard had a threshold of 2% third or fourth degree tears per month. The service had met its threshold every month between November 2015 and October 2016.
- The maternity dashboard indicated that the trust's normal (non-assisted delivery) rate between April 2015 and March 2016 was 62.5% this was better than the England average of 60%.
- Between April 2015 and March 2016 national average for ventouse (vaccum) deliveries was 5.6%. The trust was below the national average at 4%.
- The modes of delivery were similar to the national average. For example, elective caesarean sections accounted for 11.1% of the service's deliveries compared to the England average of 11.3%; other emergency caesarean sections were 16.7% compared to 15.3%; breech deliveries accounted for 0.2% of deliveries compared to the England average of 0.4%.

Competent staff

- All staff we interviewed told us that they had timely and productive annual appraisals and personalised support for their roles. At appraisal, all mandatory training attendance among others was planned and discussed. However, when we viewed appraisal rates provided by the trust dated November 2016, we found some staff groups had not achieved the trust target of 95%. These were fetal medicine (92%); maternity nursing staff (94%); maternity and gynaecology administrators (91%); Ocelot Ward (93%); and women's health management (50%).
- We viewed the medical staff job plan review sheet and found 100% of consultants had received a job plan review in the previous 12 months.
- Junior doctors we spoke with told us they were all allocated supervisors. Revalidation of doctors was planned at annual appraisal and the nursing team were aware of the date their revalidation was due.
- 100% of midwifery staff had up to date clinical supervision. The Local Supervising Authority (LSA) Audit Report for 2015/16, is a report on how the service was meeting the Nursing and Midwifery Council (NMC) rules and standards for the function of the Local Supervising Authorities (LSA) and the supervision of midwives. Women's services were meeting all the standards with the exception supervisors of midwives (SOM) attending at least 75% of SOM meetings and the uploading of SOM supervision records onto the LSA database.
- Maternity and gynaecology's services were supportive of post qualifying nurse education. Nursing staff had access to a range of modules and courses. The need for post qualifying education was identified at the annual performance reviews and prioritised according to need. Funding was available to support staff undertaking advanced neonatal nurse practitioner (ANNP) masters programmes and neonatal intensive care courses.
- All pre-registration nursing students had 5 induction days, and staff nurses attended mentor preparation programmes.
- Doctors we interviewed told us that maternity and gynaecology's services provided good training for medical trainees.
- Temporary staff had relevant and appropriate training and experience and provided evidence of being a registered midwife or a registered nurse. The maternity and gynaecology service kept records of temporary staff inductions.
- We saw there was a weekly teaching rota in place for midwives and medical staff. Some of the session topics included a training session 'in-situ simulation of a major obstetric haemorrhage in the obstetric theatre.' This was a rehearsal to give staff skills in dealing with an obstetric haemorrhage. Staff used the session to identify and implement good practice and learning points.
- We viewed labour ward meeting minutes and saw that the meetings provided updates for staff on new policies, procedures and guidelines.
- Nursing were supported with their revalidation. This meant the service ensured nurses were competent to provide safe and effective care. Management used a revalidation spread sheet to record when staff needed to update their professional registration.
- Junior doctors received educational supervision and consultant staff took an active interest in their teaching. For example, there was a rota for registrars to teach and assess learners and weekly training sessions that were facilitated by senior medical staff.

- The midwifery staff had access to a programme of in-house training and continuous professional development (CPD) updates programme, this included recognising the deteriorating patient and patient group directives (PGD) and medicines management.
- The trust target for completion of staff appraisals was 95%. Between April 2015 and March 2016, the trust reported a staff appraisal completion rate for maternity and gynaecology of 72.5% and between April 2016 and September 2016, the appraisal rate was 93.6%. Appraisal rate data was not provided by staff group. However, only four out of nine departments had met the trust target for staff appraisal completion between April 2016 and September 2016. These were: gynaecology outpatient department (100%); gynaecology medical staff (95.8%); community maternity nursing (100%); obstetric ultrasound (100%).

Multidisciplinary working

- The Birth Place and Delivery Suite had twice-daily safety 'huddles' to promote effective communication across the service. The obstetrics consultant, midwife and nurse in charge from neonatal intensive care unit (NNU), Kent Ward, Pearl Ward, maternity care unit and the Birth Place attended these meetings. Staff told us communication with staff on the NNU had improved since the introduction of safety huddles.
- Multidisciplinary team (MDT) board rounds had been introduced on each maternity and gynaecology ward to ensure each patient was discussed by the consultant and the clinical team, including therapists and a hospital social worker on a daily basis.
- Community midwives provided flexibility in the midwifery staff team, with community midwives providing occasional support on the Delivery Suite when it was busy and Delivery Suite staff attending home births when community midwifery services were stretched.
- The Windmill Clinic was a joint midwifery and substance misuse clinic. A specialist midwives in substance misuse; drug and alcohol keyworkers; specialist midwives in substance misuse; safeguarding and mental health staff; as well as staff from the service attended a weekly multidisciplinary meeting at the clinic.
- We viewed the monthly minutes from the labour ward meeting. The minutes were structured along the lines of the CQC key lines of enquiry (KLOE). Midwifery and medical staff, including consultant obstetricians and gynaecologists, theatres manager and the anaesthetic lead for the delivery suite attended the meetings.
- Team Aurelia was a MDT, working with women identified as requiring a caesarean section. Team Aurelia worked closely with the obstetrics theatre team, obstetricians, anaesthetists and postnatal staff. The elective caesarean pathway had a list five days a week. This was supported by three dedicated part time midwives and two maternity care assistants, who prepared women undergoing a surgical birth, took them to theatre and looked after them in recovery.
- We spoke with anaesthetists and obstetric theatre staff. They told us there was good multidisciplinary working with maternity services staff and the communication between maternity and surgery was good. All women who were having a caesarean section spoke with the anaesthetist prior to their procedure.
- Staff we spoke with told us there was close liaison between the community midwives and the hospital service. The maternity service was an integrated service which included community midwives that were employed by the trust. Staff in the hospital were positive about the relationship with the community midwives, as well as the health visiting team which was operated by Medway Community Healthcare.
- The service had two specialist screening midwives for downs syndrome and fetal medicine.

Seven-day services

- The Delivery Suite, Birth Place, Kent Ward, Pearl Ward, and Ocelot Ward operated a 24-hour service, seven days of the week. However, due to a lack of sonographers there was no weekend scanning at the maternity unit. This meant women did not have access to diagnostic ultrasound scanning at the weekend. The head of midwifery was applying for funding to train further nurse sonographers.

- Obstetricians, paediatricians and anaesthetists were available 24 hours a day. Consultants provided cover for the maternity unit labour ward between 8.30am and 10.30pm seven days a week. There was an on-call rota for out of hours medical emergencies.
- The MCU was open 24 hours of the day, seven days of the week. The MCU was on a different level of the hospital to the delivery suite. This meant women who were assessed as in labour would need to be transferred to the delivery suite. A member of staff on the Delivery Suite carried a bleep at night to alert them when a woman needed to be transferred from the MCU.
- OOH's imaging was available 24 hours of the day, but if any special tests were required OOH's, such as MRI or CT, the obstetrics and gynaecology consultant would contact the on call radiographer.
- The pharmacy department was open seven days a week. Pharmacy had an emergency cupboard for supplies. Staff could call the on call pharmacist for advice OOH's.
- Physiotherapy and occupational therapy had an on call service; but these services were normally only contacted during office hours.

Access to information

- All maternity teams had access to computers for booking of appointments. Leaflet and guidelines could be accessed on the computers and sent electronically to women. Midwives were able to access patient records electronically. All NHS protocols and guidelines, NICE guidelines, and Trust leaflets were available on the intranet. However, we were told agency staff did not have access to the trust's computer system and were reliant on staff to access information from the intranet.
- Staff could access policies on the trust's shared drive. Staff were able to demonstrate how they used the shared drive. There were adequate numbers of computer terminals for staff to work at.
- Staff told us there was no 'fail safe' officer for tracking women's screening results electronically, as the screening team used a hand written system due to the trust's electronic records system not interfacing with the system use by community teams. Staff told us there had not been any incidents in regards to screening systems, but they considered the system of hand collating results a risk to women due to the reliance on people to collate information. Staff said a band 7 midwife collated the results as the team did not have dedicated administrative support.
- Staff had access to the trust's health library and information service. The library had a stock of books and journals. Staff could request information if the item they wanted wasn't stocked by the trust and it could be sourced from other libraries.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All Deprivation of Liberty (DoLS) training at the trust was delivered under the mandatory adult safeguarding modules. As of 18 October 2016, 83.8% of staff had completed adult safeguarding level 1, which was above the trust's target of 80% and 78.7% had completed adult safeguarding level 2 which was below the trust's target. As of 18 November 2016, 90.1% of staff in women's services had completed Mental Capacity Act (MCA) training.
- Staff we spoke with on Ocelot Ward told us told us that the ward took a 50/50 ratio of patients with gynaecological and general health care needs. Most of the staff we spoke with on Ocelot Ward demonstrated understanding of the principles of MCA and of their responsibilities under DoLS. Staff told us a mental capacity assessment was undertaken if a patient refused treatment, or if staff had a concern that a patient might not have capacity to consent to care or treatment. Staff told us there were no women receiving care on the ward, at the time of our inspection, who required an assessment under the MCA.

Are maternity and gynaecology services caring?

Outstanding ☆

At our last inspection we rated the service as good for caring. Following improvements in key areas, we now rate the service as outstanding. This was due to the caring culture embedded in the service and demonstrated by the team winning an 'Excellence in maternity care' award at the annual Royal College of Midwifery (RCM) national awards.

Maternity and gynaecology

Staff listened and responded to women's needs as shown by the introduction of the 'Induction of Labour Team' and the 'Patient Satisfaction Following Emergency Caesarean Section' project.

We rated maternity and gynaecology services as outstanding for caring because:

- There was a strong, visible person centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted dignity.
- The relationship between women who used the service, their families and staff was caring, supportive and professional, which was promoted by the management team.
- Women who used services were active partners in their care. Staff were fully committed to working in partnership with women and empowered them to have a voice.
- Women's individual preferences and needs were always reflected in how care was delivered. Staff supported them and their families to ensure those needs and preferences were met.
- Women's emotional needs were recognised and valued by staff and were integral in their care and treatment.

Compassionate care

- Maternity services participated in the national Friend and Family Test (FFT). The FFT is a survey, which gives patients an opportunity to feedback on the quality of the care they received. This gives hospitals a better understanding of their patients' needs, enabling them to make improvements. We found that FFT results at Medway Maritime Hospital were consistently high across maternity and gynaecology services and better than England average. In January 2017, 100% of patients who completed the test would recommend the service.
- The trust performed "better than" other trusts in the CQC maternity survey 2015, for example the question, "Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations that you needed?" scored 8.1 out of 10. The question, "During your labour, were you able to move around and choose the position that made you most comfortable?" scored 9 out of 10.
- We observed staff consistently delivering compassionate care across maternity and gynaecology services. Staff were always considerate and empathetic towards women, their partners, relatives and other people. We were told of many cases where staff had gone above and beyond which reflected the caring culture embedded in the service. We saw relationships between staff, patients and their families was caring, professional and supportive.
- The maternity team were awarded the Johnson's Excellence in maternity care award. This was presented to the team during the annual Royal College of Midwifery (RCM) national awards. This award is for an individual or group of midwives who have pioneered an innovative development providing an excellent, compassionate standard of care to women, their babies and families.
- Women we spoke with advised us that staff on Ocelot, Kent, and Pearl Wards treated them with respect and compassion and praised staff for their attitude and approach. They reported overwhelmingly positive experiences of care. Throughout our inspection, we found the approach staff used was consistently appropriate and demonstrated compassion and consideration for women, their babies and families.
- Staff interacted with patients and relatives in a respectful and considerate manner. For example, we saw tea and coffee being offered to women and their families in the antenatal waiting room due to delays in the clinics appointment times.
- There were 504 ratings of maternity services on the NHS Choices website. These awarded maternity service a 3.5/5 star rating. We saw that trust staff had taken the time to address people's feedback on the website and had apologised where people had reported that the service had not met their expectations.
- There were notices on bays in Pearl Ward to remind staff to draw curtains when providing care and treatment, these protected women's privacy and dignity. We saw staff observing the notices and drawing curtains when providing care and treatment.
- Birthing rooms had privacy curtains within them to maintain dignity and respect, which was used whenever the room was in use.

Maternity and gynaecology

Understanding and involvement of patients and those close to them

- All women we spoke with told us they felt actively involved in planning and making decisions about their care. We spoke with 15 women, partners and relatives during our inspection. They told us they were very satisfied with the information and advice they had been given; leading up to and during labour; following the birth of their baby; or whilst receiving care and treatment.
- Women always had a named midwife who was responsible for their care and the women we spoke with knew who their midwife was and who to speak to regarding any questions or concerns. We observed staff demonstrated good communication skills during the examination of patients and gave clear explanations without the use of medical jargon, staff always checked patients understanding.
- Women we spoke with told us nurses and midwifery staff always involved them in decisions about their care and they were actively involved in their own care planning.
- The Birth Place provided women with an 'app' where they could get information and advice about pregnancy, birth and postnatal care. Women we spoke with advised us they found this to be a useful tool when they needed reliable information but were away from the hospital site.
- Since our last inspection the trust had launched a 'Patient Satisfaction Following Emergency Caesarean Section' project. The project was introduced in line with National Institute of Health and Care Excellence (NICE) guidance updates and the significant number of women requesting a discussion following emergency caesarean sections.The project assessed the satisfaction of patients who had undergone an emergency caesarean over the course of a month. Consultants wrote directly to women asking for feedback on their experiences and the letters were followed up with a telephone call. Responses included "I found the letter useful. It was written in language I could understand" and "I didn't know why I had an emergency caesarean section until I got this letter".
- Across the maternity and gynaecology services women, their partners, friends and relatives had access to a wide variety of information leaflets.

Emotional support

- Staff demonstrated an excellent understanding of patients' emotional wellbeing. Patients' emotional and social needs were highly valued by staff and were embedded in their care and treatment.
- The service had a speciality bereavement midwife for women needing higher levels of emotional support after the birth of a stillborn baby. The bereavement midwife told us the service signposted women to support services such as the local Kent Stillbirth and Neonatal Death Charity (SANDS).
- The addition of Abigail's Place, improved the care and support provided to families of stillborn children.
- The trust had a speciality midwife for mental health. We saw there was a robust process in place for supporting women with mental health needs and consultant obstetricians facilitated referrals to antenatal clinics.
- Women living with mental health needs during pregnancy or after birth were referred to the specialist mental health midwife who offered women a one hour appointment to discuss their mental health needs, advise them on the support available locally, and make referrals to specialist services if needed. There was a clear pathway to refer postnatal women to the obstetric lead and mother and infant mental health service (MIMHS).
- We saw that information was available on the Maternity enhanced care (MCU) and antenatal ward for the pregnancy anxiety group (PRANX). The trust offered this weekly support group to pregnant women with anxiety disorders.
- Since our last inspection, an 'Induction of Labour Team' had been introduced. The team supported a care pathway which prepared women for induction and ensured they had enough information to feel part of the decision making. The same midwife who met the women at the pre induction of labour clinic also supported them during the induction process. This ensured continuity of care but also meant women received emotional support from a member of staff they already knew.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Good

At our last inspection we rated the service as good for responsive. On this inspection we maintained a rating of good, however we saw improvements regarding the introduction of Abigail's Place, which was a new bereavement suite.

We rated maternity and gynaecology services as good for responsive. This was because:

- Services were planned and delivered in a way that met the needs of patients. For example, The maternity services delivery plan provided clear guidance on the pathways for mothers and babies from antenatal to postnatal care.
- The needs of different people are taken into account when planning and delivering services. Translation and advocacy services were available to meet the needs of patients with language barrier needs.
- Access to care was managed to take account of people's needs, including those with urgent needs. The ante-natal appointments system was easy to use and supported patients to make appointments. People are kept informed of any disruption to their care or treatment.
- Abigail's Place was a new bereavement suite at Medway Maritime Hospital for families who had lost a baby. The suite rooms gave parents somewhere they could grieve and say goodbye when a baby was stillborn or died soon after birth. The new suite gave parents more time and space to be with their babies away from the maternity ward.

However, we also found:

- The maternity unit had closed on seven occasions between April 2015 and July 2016. However, the service had followed the trust's procedures in regards to unit closures.

Service planning and delivery to meet the needs of local people

- Maternity and gynaecology served a population in Medway and Swale of over 400,000 people. 21% of children in the area lived in low income households. The diabetes rate was 6.9% of the population; the rate of obesity was 26.5% and 22% of adults smoked. There were 5,063 births at the hospital from April 2015 to April 2016, with 3% of women choosing home births; 97% of women giving birth received a one to one midwife to mother ratio in accordance with NICE guidance.
- Gynaecology provided inpatients ambulatory and emergency access pathways. There were 12 inpatient beds including a gynaecological assessment unit (GAU). The service offered planned and emergency gynaecology care. Referrals were from primary care and the emergency department (ED).
- In the year 2015/16 obstetrics and gynaecology day surgery provided care for 883 inpatients, 9,995 outpatients, completed 7,741 outpatient procedures and 22,724 ultrasound scans. The caesarean section rate was 27% compared to a national average of 30%.
- In 2015/16 the service had 488 multiple pregnancies, 824 preterm, 1,496 placental disorders, 264 invasive tests, 1,604 fetal abnormalities, 744 ward emergencies and 72 perinatal losses.
- The head of midwifery attended meeting with the maternity services liaison committee (MSLC). This was a group that aimed to ensure parents' views of local maternity services were taken into account when commissioning services. The group liaised regularly with the services commissioning group.
- The Maternity Enhanced Care Unit (MCU) provided an intermediate level of care for women or those in the postnatal period requiring a higher level of care above that readily available on the antenatal or postnatal ward. It included step-down care from the intensive therapy unit (ITU) or high dependency unit (HDU) environments and enabled women to stay with their babies. The intrapartum anaesthetic lead provided training to the midwifery staff to ensure competence and safety.
- The neonatal unit secured funding from a charity to refurbish Pearl Ward transitional care unit. This provided a comfortable space for mothers and their babies.

Maternity and gynaecology

- The antenatal department had a multidisciplinary team approach to the provision of maternity care. As part of the department's routine clinical service, women's first visits were between 11-13 weeks and included an early ultrasound examination of the fetus as part of the antenatal screening programme to assess the risk for Down's syndrome and other chromosomal defects. A further appointment was made for 22-23 weeks for a full anomaly scan to examine the growth of the baby and determine the position and health of the placenta. The department provided a maternity care unit which allowed women from 18 weeks gestation onwards to attend for a variety of reasons be it routine testing for diabetes in pregnancy, to monitoring of the fetal heart if concerns arose. Obstetric consultant led antenatal clinics took place in this department. These clinics were for pregnancies that were identified as high risk from the outset, or for review and management when a pregnancy was seen to be deviating from the expected course. Many specialist midwives were based in the department. Specialties ranged from fetal medicine; safeguarding; screening; diabetes and obesity and mental health. A specialist consultant in fetal medicine was also based within the department.
- The maternity and gynaecology service had introduced 'Ask, Respond, Evaluate' communication care rounds, every two hours. This involved staff in asking women about their care needs, responding to these, and evaluating the services response to patients identified needs on a two hourly basis.

Access and flow

- Between November 2015 and April 2016 bed occupancy in maternity was consistently higher than the England average. There was however a downward trend in bed occupancy over this period, with the trust reporting an occupancy rate of 62.6% compared to the England average of 61%.
- The maternity unit had 17% midwifery led births in the previous 12 months.
- The maternity unit had closed on seven occasions between April 2015 and July 2016. These were 17 hours in April 2015, six hours in October 2015, 43.5 hours in January 2016, 33 hours in February 2016, 37.25 hours in March 2015, 5.5hours in June 2016, 6.25 hours in July 2016. The head of maternity told us there was an increase in the rate of closures in January to March 2016 due to the neonatal unit (NNU) reaching capacity and closing. Each closure was investigated as a serious incident. We viewed records of the maternity unit closures and saw that the stages of closure, (green, red, black) had been followed and the senior maternity team had been involved in the decision making around closures. The procedure around closure of the maternity unit had also been changed to include NNU capacity. The actions taken by staff to be consistent with the trust policy entitled 'Trust escalation of emergency closure of the maternity unit'.
- The maternity services delivery plan provided clear guidance on the pathways for mothers and babies from antenatal to postnatal care.
- Women were able to self-refer to the service via: an online referral form; phone; or via their GP. All bookings were undertaken in community settings by the community midwives. Women from outside the area were booked and cared for in the hospital based antenatal clinic. Women had a choice as to where they gave birth. For example, from November 2015 to October 2016, the service had a 3% home birth rate. Women could also choose to give birth at the Birth Place or on the delivery suite. Women's choice would be influenced women's risk status, which was continually assessed and reviewed throughout pregnancy.
- The service had an antenatal access pathway with a flowchart. Antenatal appointments were given to women in accordance with NICE guidelines 'antenatal care; routine care for the healthy pregnant woman', 2009. If a woman required an appointment with an obstetric consultant, they would be referred according to the specialist area that was required for example, diabetes, cardiac problems or obesity. The trust's fetal medicine service was provided by a sub-specialty trained fetal medicine consultant. The antenatal unit could provide cardiac scans, in-utero blood transfusions and offered a genetic outreach clinic.
- The antenatal pathway included pre-pregnancy awareness; pregnancy testing; and booking a first appointment with the antenatal clinic. The flowchart gave women information on where they could access services as well as information and advice.

Maternity and gynaecology

- Women booked with their community midwife at ten weeks gestation, when blood samples were taken and follow-up appointments were made. Blood results were usually received and reviewed within ten days of being taken. Risk assessments were completed to ensure that each woman was placed on the appropriate antenatal pathway according to their individual needs.
- At twelve to fourteen weeks women received their first trimester scan as part of the combined screening programme. This was the first screening scan provided by the fetal medicine department. The fetal medicine consultant was available Monday to Friday. Fetal medicine midwives arranged follow up appointments as necessary to provide continuity. Routine scanning appointments were made in accordance with the trust's maternity services delivery plan.
- Intrapartum care, this is care provided during a woman's labour and delivery, was either consultant led on the Delivery Suite; or midwifery led at the Birth Place. The consultant led unit was primarily used for women with complications identified in their previous medical history, previous birth experiences or their current pregnancy or labour. The midwifery led unit was designed for women experiencing low risk pregnancies.
- There were three wards that provided postnatal care: The Birth Place accommodated low risk mothers following uncomplicated deliveries: Kent Ward accommodated the majority of postnatal women from the Delivery Suite. Pearl Ward admitted women and babies who required extra care in the postnatal period. There was a transitional care unit located on Pearl ward, staffed by the special care baby unit (SCBU), for babies who required extra treatment but didn't need intensive care and could remain with their mothers. There were also two obstetric theatres available for elective and emergency lower segment caesarean section (LSCS).
- There were guidelines in place for transitional care, as well as criteria for discharging women and babies. Women and their babies were transferred into the care of the community midwives at the appropriate point in their care pathway. Guidelines for transferring women and babies to the community teams were in place.
- Team Aurelia was staffed by a team of midwives. The team followed the elective caesarean pathway from pre-assessment to discharge home from the postnatal ward. Mothers and babies did 24 hours enhanced recovery following their caesarean section prior to discharge.
- The Delivery Suite had 16 Delivery Suite beds which included maternity enhanced care and bereavement facilities and an obstetric triage. Inpatient provision included 23 high-risk antenatal and post-natal beds, including eight transitional care beds and 24 low risk postnatal beds.
  Ocelot Ward had clear procedures and guidelines for patients to access services and for their discharge. The procedures for the gynaecology emergency clinic provided a treatment pathway for stable women with early pregnancy or gynaecological problems requiring urgent assessment and treatment. This provided women with a clear pathway when using services. The discharge policy for Ocelot Ward had five key principles; one of which was patients and/or their representatives would be encouraged to engage and participate in the process of discharge as equal partners. The paramountcy of the needs, wishes and rights of the patient and/or their representative was highlighted in the discharge planning process. Staff we spoke with told us patients' were always asked about their views and involved in discharge planning.
- Discharge summaries were sent to patients GPs within 24 hours of discharge. The summaries were also copied and pasted into women's hospital based notes.
- We saw there was a long wait in the antenatal clinic waiting room. People in the waiting room told us they had been waiting for over an hour. However, one person told us they had visited the clinic on 13 occasions during their pregnancy and waiting times varied, sometimes there were long waits and sometimes they were seen immediately. A visiting professional told us there had been an emergency at the clinic and this had caused delays. They added that the staff usually put a notice up or announced it in the waiting room.
- The maternity risk register recorded a risk of increased perinatal morbidity and mortality at weekends due to the inability to detect a decrease in fetal movements via a scan due to a lack of sonographers at the weekend. The service were taking actions to mitigate the risk, including the head of midwifery requesting the funding to train a nurse sonographer to cover weekends.

- A further risk on the maternity unit was staff failing to recognise a deteriorating patient due to capacity and patient flow. In mitigation the service had completed a multidisciplinary review of the service. Specific guidance was being drafted so that community and hospital staff were clear which women should be assessed in triage and which ones in the fetal medicine assessment unit (FMAU).

Meeting people's individual needs

- The maternity service offered antenatal clinics to support women who were at risk of obesity and to support bariatric women, as well as those with gestational and chronic diabetes.
- All of the maternity and gynaecology policies we viewed had equality impact assessment statements. This meant there was a process in place designed to ensure that practice did not discriminate against any disadvantaged or vulnerable people.
- Across maternity and gynaecology services, women and their partners had access to a variety of information leaflets in the five most commonly used languages in Medway.
- The service had established a weekly clinic led by a specialist consultant to follow up women who had experienced third or fourth degree perineal tears or any significant major perineal trauma that needed review during the post-natal period. There was a rapid access facility for women needing assessment or follow up through an urgent referral.
- The smoking status of parents was assessed at booking and updated throughout pregnancy. The effects of smoking on the fetus and new born baby were discussed with both parents. Carbon monoxide (CO) levels were assessed at booking since and smoking cessation clinics were offered to both parents in collaboration with Medway Public Health. A risk perception tool was used to assess the levels of CO in the mother's blood. Smoking cessation training was part of the annual midwives training programme.
- The trust had an obesity clinical midwifery specialist who ran an obesity clinic with an obstetrician. The service also offered an obesity support group with assistance from Medway Public Health.
- There was no bariatric equipment on the Delivery Suite or the Birthplace. The Birthplace did not accept women with a body mass index BMI >40. All birthing beds could take women up to the weight of 178 kg. The theatre table could take women weighing up to 300kg.
- The clinical negligence scheme trust (CNST) requires the provision of support services for all women with a body mass index (BMI) of 30kg/m2. In response the trust held a healthy living clinic for women with a BMI of 35-44kg/m2 with no medical conditions.
- We spoke with an agency translator and advocate that was working on the antenatal ward. They told us they regularly worked for the service and provided support to people who did not speak English to explain procedures and consent.
- The service had a bereavement midwife who was responsible for educating midwives to deliver an appropriate standard of care to parents and ensure a sensitive pathway was in place for bereaved parents. Families were offered a 45 minute perinatal appointment and could speak with their consultant to understand their situation better. The bereavement midwife could refer families for a six week counselling course on loss and bereavement. The bereavement midwife had contacts with a variety of religious organisations that could minister the trust's ethnically diverse population.
- Abigail's Place was a new bereavement suite at Medway Maritime Hospital for families who had lost a baby. The suite rooms gave parents somewhere they could grieve and say goodbye when a baby was stillborn or died soon after birth. The new suite gave parents more time and space to be with their babies away from the maternity ward. The suite was soundproof so parents could grieve, without the sound of newborns and other families nearby.

Learning from complaints and concerns

- Between August 2015 and July 2016 there were 35 complaints about maternity and gynaecology services. The trust took an average of 48 days to investigate and close complaints. This was not in line with the trust's complaints policy, which states that the target response

time is 30 days, unless the complainant agrees to a longer period in which case the response should be sent. However, the trust was taking action to address the backlog of complaints.

- There were procedures and staff responsibilities for managing and responding to complaints. The complaints procedure included a flowchart to guide staff. The divisional office dealt with complaints. The matron and governance leads were notified of a complaint. The matron was given a timescale for investigating the complaint and sending a response. The governance lead reviewed the matron's investigation. The response was forwarded to the divisional office who responded to the person who had raised the complaint in writing. The governance lead was sent any changes to practice for approval. Ocelot Ward had also introduced a procedure whereby any woman or relative raising an issue was telephoned within 24 hours to see if the issue could be resolved prior to becoming a formal complaint.
- Women we asked said they had not raised any complaints with the service and they found staff approachable if they wished to raise issues.
- Information regarding complaints and concerns was available on all the wards and units we visited. Leaflets in the five main languages used by women and their relatives detailed how to make a complaint and were freely available. Leaflets in other languages could be requested from the hospitals accessible communications team. Information leaflets provided the contact details of the local advocacy service and explained that people could receive support from the advocacy service in making a complaint. The leaflets also advised that support for non-English speakers and people who needed support with communication was available via the advocacy service.
- Complaints and concerns were discussed at the monthly divisional governance meetings. Complaints were a standing agenda item at the meetings to ensure the quality of services improved. Learning from complaints was shared at team meetings and across services where applicable.
- The most frequently complained about specialty was obstetrics with 18 complaints and the most frequently complained about ward was the Delivery Suite with 11 complaints. There were also five complaints relating to 'other' areas.
- The most frequently occurring themes for complaints were lack of care/attention and treatment, mentioned in 13 complaints; and the attitude of nursing staff, mentioned in four complaints. Managers told us staff attitude and attentiveness had been discussed with team leads and disseminated at shift handovers.

Are maternity and gynaecology services well-led?

Good

At our last inspection we rated the service as good for well-led. On this inspection we maintained a rating of good as the service being well-led had been maintained.

We rated maternity and gynaecology services as good for well-led. This was because:

- Leaders at every level prioritized safe, high quality, compassionate care and promote equality and diversity. Leaders modelled and encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.
- Candour, openness, honesty and transparency were the norm. There was a culture of collective responsibility between teams and services.
- The service proactively engaged staff. However, in the staff survey 2016 some staff responded not feeling fully engaged with service developments. A culture where the benefit of raising concerns was valued. Staff actively raised concerns.
- Information and analysis were used proactively to identify opportunities to drive improvements in care. Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. For example, the maternity services vision and strategy outlined the direction of services for the next five years.
- There was a focus on continuous learning and improvement at all levels of the service. Safe innovation

was supported and staff have objectives focused on improvement and learning. For example, the bereavement suite Abigail's Place was an innovation, providing a "gold standard" provision of care for parents and families who experienced a stillbirth.

- Staff were encouraged to use information and regularly take time out to review performance and make improvements. For example there was a clearly defined and embedded system of governance meetings in place where service risks were regularly reviewed.

Leadership of service

- Oversight of the maternity service was by way of: a non-executive director at trust board level; a director of operations, the head of midwifery and a specialist clinical lead for women's services. The service had an interim governance lead midwife; this position was due to be reviewed in December 2016.
- Ward managers told us that they felt well supported in their roles and understood their governance responsibilities. The head of midwifery told us they liaised frequently with the director of operations for midwifery services. The head of midwifery services had been promoted internally from the midwifery team and liaised regularly with the supervisors of midwives. Staff we spoke with told us the women's management team were visible and the head of midwifery services frequently visited the wards. Staff we spoke with said the senior management team were approachable. Staff knew the director of operations as they were formerly the head of midwifery.
- Staff told us that communication between the midwifery and medical teams was good. Maternity services had daily safety huddle meetings.
- A number of the senior medical staff were members of Royal Colleges and the lead obstetrician was the lead regional lead for fetal and maternal services.
- Midwives told us they had a named supervisor of midwives with whom they had an annual review. There was a range of evidence to demonstrate that supervisors of midwives were in frequent contact with the Delivery Suite in regards to operational issues or concerns that might have an impact on the quality of services women received.
- In the Picker staff survey 2016 91% of staff in the women and children's division that responded to the survey responded that they always knew what their work responsibilities were. 75% of staff that responded across the division responded that there immediate manager encouraged team working. 87% of staff responded that they knew who their senior managers were; but 39% of respondents responded that senior managers acted on staff feedback.

Vision and strategy for this service

- Staff were aware of the trust's new vision and values, which had an acronym of BEST. This stood for: bold, every person counts, sharing and open, together. The new values were embedded in the corporate induction and appraisal process. Staff we spoke with were able to articulate what the values were and how these influenced their practice.
- Staff were also aware of the trust's 'bold' values. Staff were able to tell us about being bold in practice and most said the trust's vision of being bold involved staff challenging poor practice or inappropriate behaviour from colleagues or other staff.
- The divisional strategy and business plan for 2016/17 outlined the main challenges to the service as delivering efficiency and productivity gains that aligned with the trust's five year sustainability and transformation plan 2016/21 and the two year operational plan 2015/18. There had been a directorate 'away day' which had been attended by clinical and managerial staff in September 2016, which outlined how the plan would impact on services with the intention of delivering safe and cost effective women and children's service.

Governance, risk management and quality measurement

- There was a clearly defined governance system in place. This included a fetal, MCU, and antenatal medicine group; weekly incident reporting system group; labour ward forum; gynaecology forum. These groups fed into the women's health governance group, which was part of the divisional core team with children's services. This fed into the divisional board meetings; who fed into the board of directors' chief operating officer.
- We reviewed minutes from the women's speciality governance meetings. The monthly divisional

governance meetings and monthly divisional board meetings acted as regular review points for all: incidents; risks and complaints. Groups were conducted in accordance with the women and children's governance group terms of reference (TOR). We saw that the meetings were well attended by managers, medical and nursing staff.

- The trust had a maternity risk strategy in place. This included: risk identification; evaluation; control of risk; review and monitoring of risks/incidents at a local level; communication and sharing of successes, failures and lessons learnt.
- Maternity and gynaecology services had a risk co-ordinator who specifically looked at risks in the services. Staff recorded risks to maternity and gynaecology services on the divisional risk register. We viewed the risk register and saw this contained five identified risks to service provision. We saw that risks on the risk register were reviewed and updated on a monthly basis.
- Managers introduced safety huddles to identify and address risks on a daily basis.
- The 'Super 7' was an audit designed and implemented by the Deputy Director of Nursing (DDON) and Matrons, this was based on the 'principles of care.' The audit measured the quality of nursing care provision on each ward on a monthly basis to patients in the Women and Children's Directorate. The audit was based on the concept of seven aspects of fundamental care, with seven patients care being measured on the seventh day of each month by a band 7 nurse, with each patient being asked seven questions. Patient responses were monitored by the matron and DDON and themes from the audit were fed back to staff at handovers and board meetings.
- The service had a programme of clinical and internal audits in place. The women's health division had a quarterly women's health audit meeting. The meeting reviewed the progress and results from national and local audits the division had undertaken. For example, the trust had completed an audit for the LSA on the supervision of midwives where the outcome was that the SOM required improvements. An action plan was in place to address the areas identified as requiring improvement.
- The service had a monthly clinical risk newsletter 'Lessons Learned', which was disseminated to all staff. The newsletter included a trigger list for staff that acted as a prompt for staff in recording incidents by identifying what should be recorded on the trust's electronic incident reporting system.

Culture within the service

- Staff morale was high across the service. Staff we spoke with told us they felt respected and valued. We saw multiple examples of staff working collaboratively and sharing responsibility to ensure women received good quality care. Midwifery staff described the culture as: hardworking, friendly, open and reflective.
- Staff were committed to ensuring women who used maternity and gynaecology services received high quality care. Staff we spoke with told us the culture in the service encouraged openness and honesty. Staff we spoke with were aware of the Duty of Candour and their responsibilities in regards to this. There were information leaflets across all wards on the Duty of Candour.
- The Picker staff survey 2016 94% of staff that responded to the women and children's division survey responded they had not experienced discrimination from managers or other colleagues.

Public engagement

- The head of midwifery attended a meeting with the maternity services liaison committee (MSLC). This was a group that aimed to ensure parents' views of local maternity services were taken into account when commissioning those services. The MSLC had been reinstated following a period of inactivity in 2015. The MSLC met in October 2016 to confirm the terms of reference (TOR) for the group and determine the group's priorities of work for the forthcoming year.
- The service offered home birth and positive birth support groups on the second Tuesday of every month. Both groups offered birth pool hire. Each group had a Facebook page that women could join. People could access information from the page, as well as contacting the group facilitators.
- The Delivery Suite had postcards and post boxes people could use to post their FFT responses.

Maternity and gynaecology

- The trust took part in the NHS 'Wow' awards patient experience scheme. This is a national initiative to recognise and reward good service and best practice. The scheme relies on people who have used services nominating teams or individual staff members they have received care or treatment from.
- The nurse in charge on Pearl Ward was not wearing a badge to denote their position; this made it difficult for patients, temporary staff and visitors to know who was responsible for coordinating the ward.

Staff engagement

- The trust produced a weekly 'Friday's News' newsletter and monthly 'Lessons Learned' newsletter staff to provide practice and organisational updates for staff, including new developments.
- The head of midwifery told us there was a monthly briefing with staff, 'what's happening in the trust.' Staff from all grades attended the briefings.
- Whistleblowing information was available in numerous locations across the maternity and gynaecology service. For example, we saw a 'razing concerns' route map, this provided staff with step by step guidance on raising issues within the trust.
- The antenatal clinic staff room had a 'stand up – speak up' poster on the wall with contact details of the director of operations, this meant staff could directly and easily report any incidents of discrimination.
- Staff told us there was a rotational policy to add flexibility to the system, whereby staff would rotate around the services to meet surges in demand. However, staff said this had caused some unrest with some midwives who were not part of a core team, as it tended to be the same staff that were asked to rotate.
- Staff were involved in a Picker staff survey in 2016. The results of this were recently available in January 2017. We found results generally positive in the women and children's division. However, there was a theme in some responses to indicate that staff did not feel fully engaged in service developments. For example, 35% of staff responded that senior management involved staff in important decisions; and 39% of staff responded that senior management acted on staff feedback.

Innovation, improvement and sustainability

- The trust had introduced the 'Stop Oasis Morbidity Project' (STOMP). The project was introduced following the service recognising that some first time mothers were suffering more third degree perineal tears than expected. The project won the Royal College of Midwifery Award 2017, Johnson's Award for Excellence. Staff told us prior to the use of STOMP there had been frequent perineum tears. However, since its introduction these had reduced to an average of one per month.
- Team Aurelia was a multidisciplinary team. Staff referred women identified in the antenatal period as requiring an elective caesarean section to Team Aurelia. Team Aurelia consisted of a team of two midwives and a maternity care assistant based on Kent Ward that provided continuity of care for women undergoing elective caesarean section. The team undertook the pre-operative review prior to admission for elective caesarean section. Women were seen by an anaesthetist prior to surgery and an enhanced recovery process was followed to minimise women's hospital stays following surgery.
- The bereavement suite, Abigail's Place, opened in November 2016 and provided the "gold standard" in the provision of care for parents and families who experience a still birth. A stillbirth's charity and local business contributions funded the suite. Staff created a realistic home environment in the suite for parents to spend time with their child.

Services for children and young people

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

Information about the service

The services for children and young people include diagnostic, treatment and care facilities for children and young people from birth to 16 years of age. The needs of young people aged 16 to 18 years of age are considered on an individual basis with most being admitted to adult facilities within the hospital. Where a young person has particular needs, such as a learning disability or a life limiting condition may be admitted to the children's unit if more appropriate.

Between April 2015 and March 2016, there were 9,588 admissions to the children and young people services at the trust. The largest proportion in relation to age was the four to 15 age group (4,292), followed by one to three (2,482) and under ones (2,171). During this period, there were 643 admissions for 16 to 17 year olds.

The hospital had a dedicated children's emergency department, which was located next to the adult emergency department. The children's emergency department had a dedicated waiting and treatment area for children under 16 years of age. Young people between 16 and 18 years old attend the adult emergency department.

There are two wards, Dolphin ward, and the Penguin assessment unit. Children attend for day surgery at the Sunderland Day unit and the Oliver Fisher neonatal unit caters for the needs of pre-term babies. There are parent facilities and play areas on the ward. A specialist community support service is available on site. The children's outreach and specialist team (COAST) consists of specialist nurses, carers and a specialist social worker who are based at Medway Maritime Hospital. It is a hospital-based team providing a service to children outside hospital with life threatening and life limiting illnesses, aiming to keep them out of hospital as much as possible.

There is a dedicated children's outpatient centre providing outpatient support for children and young people.

We rate 'effective', 'caring', 'responsive', and 'well led' on our previous inspection as good, however we rated 'safe' as requires improvement, this gave the service and overall rating of Good. We rated safe as requires improvement because there was a lack of a safeguarding flagging system in the emergency department, which was identified as a risk to children who were seen or admitted, as staff could not be easily alerted to any safeguarding concerns. The inspection team also witnessed lapses recognising and managing child protection. It was also identified the services for children and young people should enhance play specialist provision in line with national guidance. On this inspection, we found a new electronic flagging system had been introduced into the children's emergency department (ED). However, the system was not fully embedded into practice. We also found that the play specialist provision had not been enhanced on the wards and departments, except for in the Children's ED, where a play specialist had recently been appointed.

During our inspection, we visited all clinical areas including theatres, ward areas, the children's emergency department, neonatal unit, and the outpatient centre.

Services for children and young people

We spoke with 14 parents, two young people, and 25 members of staff, which consisted of a clinical director, doctors, nursing staff, a non-clinical support worker, and administrators.

As part of our inspection, we looked at hospital policies and procedures, staff training records and audits provided by the trust and observed a 'huddle' between the paediatric and children's emergency department nursing staff. We inspected five sets of medical records and five prescription charts and the environment and equipment.

Summary of findings

At our previous inspection in 2015, we rated the services for children and young people overall as good. On this inspection, we have maintained the overall rating as good, as the overall standard and quality of care has been maintained.

At this inspection we rated this service as good because:

- Risk was managed and incidents were reported and acted upon with feedback and learning provided to staff.
- There were effective systems in place to report incidents. Incidents were monitored and reviewed and staff gave examples of learning from incidents. Staff understood the principles of Duty of Candour regulations, were confident in applying the practical elements of the legislation.
- Treatment and care were effective and delivered in accordance with National Institute of Health and Care Excellence (NICE) guidelines and other best practice guidelines. There was effective multidisciplinary team working within the service and with other agencies. The service also participated in national audits and implemented local audits such as infection control audits.
- Staffing levels and skill mix were planned, implemented, and reviewed to keep children and young people safe at all times.
- We found all clinical areas visibly clean and the equipment was fit for purpose and well maintained.
- We saw that parents were fully informed prior to consent being obtained and that nursing and medical records had been completed appropriately and in line with each individual child's needs.
- Staff skills and competence were examined and staff were supported to obtain new skills and share best practice.
- We observed good team working both within the services for children and young people and externally with other wards and departments that children had contact with.

Services for children and young people

- All parents and young people spoke highly of the approach and commitment of the staff that provided a service to their children. We saw good interactions between staff and children, young people and their families. The caring attitude of all staff was obvious in every department we visited. Staff had expertise in caring and communicating with children and young people. Support and equipment was also provided for mothers on the neonatal unit to assist with breast-feeding.
- There were clear governance arrangements in place that monitored the outcome of audits, complaints, incidents, and lessons learned throughout the service. Staff were positive about the culture in children's and young people's services and felt supported by senior managers in the trust.

However:

- A recommendation from the previous report was there should be an electronic flagging system for safeguarding arrangements in the children's emergency department. On this inspection, an electronic flagging system had been implemented but was not yet fully embedded into practice.
- There was no flagging system to identify Looked after Children (LAC) in the children's emergency department, as staff in children's emergency department told us they relied on children or their parents/carers to inform them.
- A recommendation from the previous report was children's services should enhance play specialist provision in line with national guidance. The play specialist provision had not been enhanced since the previous inspection.
- Safeguarding documentation was on yellow paper along with other documents including consent forms and day care unit documentation for paediatric surgery; this made it difficult to distinguish safeguarding documentation in children and young people's notes.
- Neonatal and ear, nose and throat medical staff were not meeting the trust compliance rate for Safeguarding Children Level three training.
- Staff working in recovery in main theatres and nursing staff on Sunderland day unit did not have Safeguarding Level three training in line with the 'intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014'.
- The service was not complying with National Institute for Health and Care Excellence (NICE) Quality Standard (QS) 94, as children were not given a menu to read, and we told the meal choices. This did not allow children and young people or their parents and carers to make informed choice when choosing meals, as they are not provided with the details about the nutritional content. Children and parents we spoke with told us they had a low opinion of the quality of meals provided.
- There was no dedicated paediatrics recovery area in theatres. There was no segregation of children from adults in the recovery areas of the theatres. This meant children were directly opposite adult post-operation patients, other than a drawn curtain. In addition, parents were not always able to be with their children in the recovery room due to adult post-operative patients being present. This was not in accordance with The Royal College of Surgeons, standards for children's surgery.
- We saw children's names and ages on a white board, which was visible to the public. This did not comply with the trusts 'Code of conduct for Employees in Respect of Confidentiality' policy.
- Fridge temperatures on medicine fridges were not consistently recorded.

Services for children and young people

Are services for children and young people safe?

Requires improvement

At our last inspection in 2015, we rated the children and young peoples services for safe as requires improvement. On this inspection we have maintained a rating of requires improvement, but have seen improvements with the implementation of a flagging system in the paediatric emergency department, although this had not been full embedded into practice.

At this inspection we rated the children and young people services for safe as requires improvement because:

- A recommendation from the previous report was there should be an electronic flagging system for safeguarding arrangements in the children's emergency department. On this inspection, it was implemented but was not yet fully embedded into practice.
- Safeguarding documentation was yellow along with other documents including consent forms and day care unit documentation for paediatric surgery. This made it difficult to distinguish safeguarding documentation in children and young people's notes.
- There was no flagging system to identify Looked after Children (LAC) in the children's emergency department, as staff in children's emergency department told us they relied on children or their parents/carers to inform them.
- Neonatal and ear, nose and throat medical staff were not meeting the trust compliance rate for Safeguarding Children Level three training.
- Staff working in recovery in main theatres and nursing staff on Sunderland day unit did not have Safeguarding Level three training in line with the 'intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014'.
- We saw damaged flooring on Dolphin ward and Sunderland day unit. Flooring that is damaged can harbour dirt and dust and make the cleaning difficult.
- Generally, staff were cleaning their hands appropriately. However, staff were not cleaning their hands at 'point of care', and chose to use the central sink on the ward. We observed times when hand hygiene had not been undertaken.
- Staff did not consistently record medicine fridge temperatures.
- We saw children's names and ages on a white board, which was visible to the public. This did not comply with the trusts 'Code of conduct for Employees in Respect of Confidentiality' policy.
- Patients with infectious conditions are not always isolated in side rooms with ensuite facilities, in compliance with the Department of Health (2008) "Isolating patients with healthcare associated infection: A summary of best practice".

However:

- There were effective systems in place to report incidents. Incidents were monitored and reviewed and staff gave examples of learning from incidents. Staff understood the principles of Duty of Candour regulations and were confident in applying the practical elements of the legislation.
- Management planned and reviewed staffing levels and skill mix to ensure children and young people were safe at all times.
- We found all clinical areas were visibly clean and the equipment was fit for purpose and well maintained.

Incidents

- There were no never events reported from September 2015 to August 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In the same reporting period, the service reported two serious incidents. Both serious incidents were related to delays in treatment and of the two, one included the failure to act on test results. We saw the incidents raised at the July 2016 clinical governance and management meeting minutes. The incidents were thoroughly investigated and actions were taken to change practice,

which was shared with all staff in the service. The consultants, doctors, and nurses we spoke with as they described details of both the incidents and explained a change in practice to minimise any recurrences supported this.

- There were a total of 95 incidents reported via the trust's incident reporting system from June to August 2016 for children and young people services including the community. None of these incidents were classified as serious incidents. Eighteen of the incident reports were attributable to medication errors with no injury or harm reported.
- Eight of the incident reports were related to the readmission of babies to the neonatal unit. We saw the 2015 to 2016 paediatric incident report that there were eight incidents related to the re-admission of babies to the neonatal unit, primarily because of jaundice or weight loss. This was better than the previous quarter where there were 16 readmissions.
- Eight incidents were related to medical equipment during the same reporting quarter, primarily with no medical equipment in stock. These incidents reported no injury or harm caused as equipment replacements were found. This was due to the equipment breaking down and the actions taken by this service was to ensure there were either spare equipment in store or be able to loan equipment from local health services.
- Six incidents were related to staffing levels, primarily planned agency staff did not attend. The incidents reported no injury or harm caused to patients as staff followed the trust escalation policy.
- We spoke with a range of medical and allied health professionals and nursing staff and they were able to describe the incident reporting system. This has not changed since the last inspection. Staff members were able to explain their roles and responsibilities related to incident reporting. Staff explained recent incidents and provided examples of how lessons learnt were shared. They gave us two examples on Dolphin ward; one was when medication was not administered to a patient. The matron spoke to the staff who then completed a reflective statement. This was shared at the ward meeting. The second example was about an incorrect dose being prescribed. Both staff involved in prescribing and checking the prescription were spoken to and learned to check the British National Formulary (BNF) carefully for all prescriptions and were able to challenge each other if concerned or escalate to a senior or pharmacy staff if unsure. Both incidents resulted in no injury or harm to the patients.
- The matrons monitored the electronic reporting system closely, a continued practice since the last inspection. They discussed incidents with staff members and shared information on duty and at ward meetings.
- Staff who had reported incidents described recent examples of incidents, actions taken and how they had received feedback. We saw in the minutes from the paediatric, children's emergency and neonatal clinical governance meetings that incidents were discussed as a standard agenda item.
- Twice weekly morbidity and mortality meetings and monthly joint meetings with safeguarding were held in this service. The meetings were well attended by staff. We saw in the meeting minutes that managers identified and shared examples of good practice with staff and action plans were reviewed and updated regularly.
- Between Monday 24 to Sunday 30 October governance and learning from incidents was the 'theme of the week' on the trusts website, which could be accessed by staff and members of the public. The themes included patient safety incidents, learning from serious incidents and duty of candour.
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened. We observed posters displayed on walls of clinical areas within children's services, which clearly explained the duty of candour for visitors to the areas.
- We reviewed the records of two incidents graded as serious. We noted that the trust had met its obligations regarding the duty of candour when managing these.

Safety Thermometer

- Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer

provides a 'temperature check' on harm that can be used alongside other measures of harm to monitor local and system progress in providing a care environment free of harm for patients. Safety thermometer data was submitted from the trust and reported at divisional level via a clinical safety dashboard.

- There were no pressure ulcers, falls or catheter related urinary tract infections in children's or young people's services reported under the Safety Thermometer between August 2015 and August 2016.

Cleanliness, infection control and hygiene

- There were infection prevention and control policies and procedures readily available to staff on the trust's intranet, as well as the public via the trust's main website.
- In the CQC children's survey 2014, the trust scored 8.33 out of ten for cleanliness for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.
- All areas of the wards and departments we visited appeared to be visibly clean. Some areas of Dolphin ward, Penguin assessment unit and recovery on the Sunderland day unit, had flooring that had tape present or had marks in places. Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment, says, "Flooring should be seamless and smooth, easily cleaned and appropriately wear-resistant". Flooring that has tape in place or is damaged can harbour dirt and dust and make the cleaning difficult. Therefore, the hospital was not meeting this requirement.
- We observed all staff in the wards and departments we visited were 'bare below the elbow', this was in line with the trusts 'hand hygiene guidelines' (dated October 2015).
- There were sufficient handwashing sinks and alcohol hand sanitising gel within the wards and departments we visited. On the whole staff cleaned their hands in accordance with the WHO 'five moments for hand hygiene', however staff predominately cleaned their hands at the central sink in the main corridor opposite nurses station, despite handwashing sinks and alcohol hand sanitising gel being located closer to their point of care. This meant staff did not always clean their hands in accordance with the guidance, which recommends hands should be cleaned at the point of care. A poster on hand washing technique was displayed above the sink.
- We looked at six sharps bins during our inspection, and found them correctly put together and labelled; they were out of reach of children. This was in accordance with Health Technical Memorandum (HTM) 07-01: safe management of healthcare waste.
- The toilet in the children's emergency department appeared visibly clean and the hand wash sink had a hands free operated tap. According to the Health Building Note (HBN) 00-09: Infection control in the built environment, this enabled the ease to turn on and off the tap without contaminating the hands.
- All waste bins we saw were foot-operated and clean, waste was separated in different colour bags to signify different categories of waste. This was in accordance with the HTM 07-01, control of substances hazardous to health (COSHH) and health can safety at work regulations.
- Between April 2016 and November 2016, there had been no Meticillin Resistant Staphylococcus aureus (MRSA) blood stream infections, within children and young people's services at the trust. MRSA is a type of bacterial infection, is resistant to many antibiotics, and has the capability of causing harm to patients.
- Between April 2016 and November 2016, there were thirteen cases of Clostridium difficile (C.diff) at the trust; however, none were in the children and young person's services. C.diff is a type of bacteria, which can infect the bowel and cause diarrhoea.
- Babies on the neonatal unit (NNU) were screened on admission for MRSA and then on a weekly basis if they remained in hospital. Data received from the trust showed that between April and November 2016 the compliance rate was consistently 100% for both admission and weekly screening, except in July where the weekly compliance was 96%. This meant the NNU unit identified babies with MRSA and ensured the appropriate infection prevention precautions were in place.
- Children admitted to Dolphin ward were also screened for MRSA on admission and then on a weekly basis if

they remained in hospital. Data received from the trust showed that between April and November 2016, the compliance for screening on admission was variable. The ward was 100% compliant in May, June, August and November. However, the compliance rate in April and October was 50%, 75% in June, and 60% in September. This meant that Dolphin ward could not be confident it identified children with MRSA and ensure appropriate infection prevention precautions were in place.

- We saw audit scores displayed prominently on the entrance wards and departments. For example, we saw on the entrance to Dolphin ward and Penguin assessment unit that their hand hygiene compliance as well as their commode cleanliness scores was 100%.
- Data received from the trust showed the commode cleanliness score between April 2016 and November 2016 was consistently 100%. We checked one commode during out visit and found it to be clean.
- Data received from the trust showed on Dolphin ward the hand hygiene compliance rate between April 2016 and September 2016 was consistently 100%; however, the ward did not submit data for October and November 2016. This meant the ward could not be confident all staff were cleaning their hands as per trust policy.
- During the inspection, we undertook a 20-minute observation of staff hand washing at the central sink, during the 20 minutes we saw there were 10 times when hands should be cleaned. We saw that on seven occasions staff cleaned their hand in accordance with the trusts hand hygiene guidelines. However, we saw on three occasions staff were interrupted prior to cleaning their hands by parents. The three members of staff did not clean their hands prior to dealing with the request. This meant there was the potential for cross infection as staff did not clean their hands correctly
- Data received from the trust showed on NNU the hand hygiene compliance rate between April and November 2016 was 100%, except May and August where the compliance rates were 89% and 92%. However, the NNU did not submit data for October 2016. This meant the ward could not be confident all staff were cleaning their hands as per trust policy.
- There was a dedicated infection control link nurse for the department. Link nurses are members of the department, with an expressed interest in a specialty; they act as link between their own clinical area and the infection control team. Their role is to increase awareness of infection control issues in their department and to motivate staff to improve practice.
- Infection control training was mandatory for all staff groups, and was undertaken yearly. Data indicated that 84% paediatric medical staff, 99% of paediatric nursing staff, 89%) neonatal medical staff, 85% neonatal nursing staff and 100% of paediatric surgery staff had completed their level 2 mandatory infection control training., All staff groups were better than the trust target of 80%. This meant the trust could be confident all members of the children and young people service were aware of their roles and responsibilities to keep patients safe.
- Dolphin ward had seven side rooms, four with ensuites, but only two of the ensuites had toilets. Staff told us they tended to use these side rooms for children who had a weakened immune system. If staff placed a child with a weakened immune system in a room without a toilet, staff closed a toilet nearby and allocated this for the sole use of that child to use during their stay.
- If children or young people were found to have an infectious condition or had a poor immune system, single side rooms were used to reduce the risk of cross infection. We saw signs were placed on the doors informing staff and visitors to see the nurse in charge before entering the room.
- During our inspection, we saw two patients who had isolation precautions in place. Staff placed signs on their doors appropriately. One case was due to an infectious condition and the other was being barrier nursed due to a weak immune system. However, staff placed the patient with the infectious condition in one of the side rooms without an ensuite. “Isolating patients with healthcare associated infection A summary of best practice”, says ‘The most effective form of isolation is in a single room with a self-contained toilet and its own hand basin. This should always be the first choice for placement of an infected patient’. Therefore, the trust was not working in accordance with the recommendation.

- Regular cleaning of toys took place. We saw the play specialists cleaning toys that had been used. The play specialists confirmed they regularly check the toys, to ensure they are intact and safe to use.
- Equipment was identified as being clean by using labels, which included the date of cleaning and the person responsible. We randomly selected 10 pieces of equipment and found all to be clean and labelled.
- We saw the infection control audit for Dolphin ward and the NNU were both undertaken in June 2016, and included inspection of the cleanliness of the environment and equipment, management of sharps, waste and linen and hand hygiene and the use of PPE. We saw a completed action plan for any issue that did not meet the required standard. Action plans were monitored and had been completed within the required timescales.
- We saw between Monday 14 to Sunday 20 November infection prevention and control was the 'theme of the week' on the trusts website, which could be accessed by staff and members of the public. The themes included hand hygiene (including 'five moments), use of antibiotics, flu, and clean environment.

Environment and equipment

- The ward and neonatal unit we visited had controlled access on both external doors and to treatment or utility areas. There were signs in place to warn parents and staff when entering the secure area of tailgating, and to make sure they do not let people onto the ward. Parents could access an external courtyard during the summer, with their children. We found the area was secure, as other buildings and CCTV surrounded it. The CQC team were asked to provide identification on arrival at the ward. We did not see anyone allowing people onto the wards without permission from the nursing staff. This ensured the safety of children and young people and their visitors.
- The children's emergency department had a shared entrance and reception with the adult emergency department. However, children and parents were directed to a separate waiting area after being checked in at the reception. The double door entrance to this separate waiting area was secured and access was gained with the use of the staff key card or staff automated system. There was also a secured separate entrance for children when they arrived by ambulance and access was through a CCTV system operated by staff in the children's emergency department.
- There was one toilet with enabled wheelchair access, which had baby changing facilities in the waiting area of the children's emergency department.
- Dolphin ward consisted of 19 beds, including large bays and seven side rooms. Some side rooms had ensuite and there were multiple separate bathrooms available on the ward. However, in the bathrooms used by patients there was noted to have a pull cord that was a ligature risk. Staff explained that the hospital was aware and this was on their risk register. A ligature risk or point is anything that could be used or used to attach a cord, rope or other material for the purpose of strangulation. There was also the four-bedded Panda high dependency unit on dolphin ward.
- There were separate dedicated areas for younger and older children. The ward also had direct entry to a large outdoor playing area accessed via the playroom. Patient bedrooms and bays were well equipped with either beds or cots, seating and bedside lockers for personal belongings. A range of toys and activities were available. Sensory equipment was available for children with special needs.
- Penguin assessment unit was attached to the ward and had ten rooms, which were used for assessment of children and young people. Parents and children were able to use the play areas on Dolphin ward.
- The trust's electronics and medical engineering (EME) department serviced equipment. Maintenance was generally undertaken using two methods: planned preventative maintenance (PPM) or reactive maintenance. PPM was undertaken on a regular programme (weekly, monthly, quarterly, yearly) to meet statutory requirements, legislation, manufacturer's guidance, and industry good practice. Reactive maintenance was undertaken on an as required basis to address damage, breakdowns, or failure.
- During our inspection, we saw 22 pieces of equipment in the children's emergency department and Dolphin ward. All were safety checked and in service date with the exception of one piece of equipment on Dolphin

ward. We raised this with staff who immediately removed the equipment from use and put an 'out of use' label on. We observed faulty equipment, which were clearly labelled 'out of use'.

- The neonatal unit had eight intensive care, four high dependency, 12 special care and eight transitional cots. We found that each bed space had the necessary equipment. Machines with internal batteries were plugged into the mains to keep them charged.
- Staff we spoke with in the children's emergency department and Dolphin ward felt there was always enough equipment when required.
- In the CQC children's survey 2014, the trust scored 8.75 out of ten for the question 'Did the ward where your child stayed have appropriate equipment or adaptions for your child?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Medicines

- We saw medicines were stored securely and handled safely. On Dolphin ward, we saw that medicines were stored in a locked room. Only trained nursing staff had access to the room using their trust identity badges. In the room, medicines were stored in the locked cupboards with keypad access.
- Staff told us every week a senior member of staff checked the medicines to ensure they are all in date, during our inspection we randomly checked medicines and found not all of them to be in date.
- We saw the controlled drug (CD) cupboard securely locked in a room on the children's emergency department. Nursing staff had access to the room with their trust identity badges and the nurse in charge had access to the locked CD cupboard. There were five stock medicines in the CD cupboard, all of which were in date. The CD register showed that all five medicines had the correct balance recorded and dated with two staff signatures. We saw records of daily checks carried out to ensure this was correct.that staff under took spot checks on balances showed that contents of the cupboard matched the register.
- We reviewed four prescription charts on Dolphin ward and one on the neonatal unit. All five charts were legible. Staff documented the age, weight, and allergies of children where appropriate. Staff prescribed antibiotics according to the trust guidelines. One chart documented the reason for a medication being omitted or not administered where required. In addition, our CQC pharmacy team reviewed four prescription charts and found these were legally valid and contained information about people's allergies. There were no gaps in medicines administration on these charts.
- Medicines administration times were bespoke to each child to help continue with routines from each child's home.
- A copy of the national formulary was accessible in all children and young people's services to support prescribers (both hard copies and online). The national formulary provides guidance on prescribing, monitoring, dispensing, and administering medicines, as well as uses, cautions and side effects.
- A dedicated pharmacist visited the unit on a daily basis. They checked ward stocks and reordered medicines as necessary. They also provided advice and support to staff regarding audits and reducing medication errors. However, staff told us that the clinical pharmacy service was very "thinly spread" over several wards and they would like more support with medicines.
- Processes were in place to ensure the safe issue of medicines at the point of a patients discharge. We saw staff checking medicines before giving them to patients. Staff told us they would go through the medication with the parents to ensure they were aware how they were to be taken.
- All staff we spoke with had knew how to handle medicines waste appropriately.
- Paediatric physical health monitoring was completed and documented as requested by doctors on the ward.
- At the time of the inspection, the service's protocol was for two nurses checking intravenous medications prior to administration. Only staff who have undertaken the trust's mandatory training for administration of intravenous drugs were able to check and administer. Intravenous drugs are medicines that are given directly into the blood stream.
- Staff on Dolphin ward did not regularly monitor the temperature of the medicines and chemotherapy fridges. For example, we found in October 2016 the

chemotherapy fridge only had temperature recordings for 16 out of 30 days, and 13 out of 28 days for November 2016. The medicines fridge had recordings for 17 out of 28 days for November, however we saw in October there was only one missed recording. This meant the trust could not be confident that medicines stored in these fridges were kept at the correct temperatures. However, we did not find evidence that either of the fridges operated with temperatures out of range.

- Prescription forms were stored securely and the serial numbers were recorded when prescribers issued them to patients. However, there was no record of the serial numbers of the stock of prescriptions held on the ward. So whilst serial numbers were logged out when items were prescribed. This meant it would not be possible to ascertain if any had been removed from the cupboard.
- We saw between Monday 10 to Friday 14 October 2016, medicines management was the 'theme of the week' on the trusts website, which could be accessed by staff and members of the public. The themes included controlled drugs, drug storage in rooms, cupboards, and focus on drug charts. Staff told us they had found this useful, and were able to use it as a quick reference guide.

Records

- Staff managed patients' records in accordance with the Data Protection Act 1998. Records were kept confidential on the wards in lockable trolleys in the multidisciplinary office. We did not see any unattended notes during our inspection.
- Records within children's services were maintained through paper records with separate medical allied health professional and nursing records. The neonatal records were multidisciplinary.
- Patients were identified on white boards by the nurse's station on Dolphin ward, showing full name and ages. This was visible to people visiting the ward and could have compromised patient confidentiality. This did not comply with the trusts 'Code of conduct for Employees in Respect of Confidentiality' policy, which says staff, should 'make sure that any computer screens, or other displays of information, cannot be seen by the general public.'
- We reviewed five sets of medical records on Dolphin ward. All of these had the relevant information recorded such as patient details, diagnosis and management plan, observation charts and assessment of nutritional status where applicable. Staff were therefore able to obtain the correct information and provide the plan of care to the patients. However, we saw loose filing in one of the five sets of medical records. This meant staff may have difficulty quickly accessing relevant notes.
- Data indicated that 94% of paediatric medical staff, 97% of paediatric nursing staff, 95% of neonatal medical staff, 86% of neonatal nursing staff, 82% of administration staff, and 100% of paediatric surgery staff had completed their information governance training. All staff groups were better than the trust target of 80%. Staff working in neonatal transport and children's health management were below the trust target. However, the overall compliance rate was 85%, which meant the trust could be confident the majority staff members within the children and young people service were aware of their roles and responsibilities to keep patient information safe.
- Leaflets explaining how patient's personal information will be protected were available. The trust website had information on handling patient information as well as a section explaining patients' rights to access their medical records under the data protection act.
- All nurses were given their own personalised signature stamp, we found evidence of this being well used in the medical records we reviewed, and this was the same as our previous inspection finding.
- The children's emergency department completed a documentation audit monthly. Results of the audit were communicated to staff. We saw this in the November 2016 children's emergency department newsletter. Staff we interviewed confirmed this and told us they had improved in documentation.

Safeguarding

- The trust had a safeguarding children policy and dedicated sections on the main trust website for both safeguarding children and for looked after children, and could be accessed by both staff and members of the public. Both sections contain contact details for the teams, where to find them and about the service, they provide.

Services for children and young people

- Between September 2015 and August 2016 there were 164 child-safeguarding referrals made by the trust.
- Staff we spoke to knew who the nursing safeguarding leads for the trust were, and could explain the actions they would take if they had any concerns. However, staff did not know the named safeguarding doctor. Named professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals.
- The last inspection in August 2015 identified there was lack of a flagging system for safeguarding arrangements in the children's emergency department. Since then, the trust had implemented an electronic flagging system. However, we found the processes were not fully embedded into practice. Nursing staff we spoke with, told us they did not always check the flagging system, however the reception staff were fully aware of the system and would check for each child as they booked in.
- Staff used safeguarding paperwork, which was 'yellow' in colour for easy identification. However, this was the same shade of yellow as the consent form and the day care unit documentation booklet for paediatric surgery. We looked at four sets of notes with yellow paper in them. We counted 12 pieces of yellow paper, which included five-day care paediatric surgery documentation, six consent forms, and one safeguarding referral. This meant staff were not able to immediately recognise whether the child or adolescent required safeguarding arrangements.
- There was no flagging system to identify Looked after Children (LAC) in the children's emergency department (ED), as staff in the children's ED told us they relied on children or their parents/carers to inform them. This meant that LAC would not always be identified in the department. National Institute of Health and Care Excellence (NICE) quality standard QS31, Looked-after children and young people, quality statement 2, says Looked-after children and young people receive care from services and professionals that work collaboratively. It goes on to say that feedback form looked-after children and young people that they do not have to re-tell their life and medical history when using services.
- Data indicated that 100% of paediatric medical staff, neonatal medical staff, neonatal transport staff, and paediatric surgery staff and 98% of paediatric nursing staff had completed their safeguarding vulnerable adults training level 1, which was better than the trust target of 80%. Staff working in neonatal administration, neonatal nursing staff, and paediatric administration staff were below the trust target. However the overall compliance rate was 86%, this meant the trust could be confident the majority staff members within the children and young people service had the necessary up-to-date training to keep patients safe.
- Data indicated that 100% of neonatal transport staff, children's health management and paediatric surgery staff, 90% of neonatal nursing staff, 88% of paediatric medical staff, 97% of paediatric nursing staff, had completed their safeguarding children level 3 training, which was better than the trust target of 80%. Thirteen out of 19 (68%) of neonatal medical staff had completed this training, which was below the trust target. However the overall compliance rate was 95%, this meant the trust could be confident the majority staff members within the children and young people service had the necessary up-to-date training to keep patients safe.
- We looked at the training data supplied to us by the trust, for staff working in recovery in main theatres and nursing staff on Sunderland day unit. The data showed that 94% of staff working in recovery in main theatres and 89% of Sunderland day unit nursing staff had completed safeguarding children Level two mandatory training. This was better than the trust target of 80%. However, none of the nursing staff had undertaken safeguarding level three training. This was not in line with the 'intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014'. The document says, that level three training is required of "Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns".

- Data indicated that 100% of anaesthetic medical staff had completed level three safeguarding training, which was better than the trust target of 80%. However, 43% of ear, nose and throat medical staff had completed level three training, which was below the trust target.
- We saw in between Monday 3rd and Sunday 9th October 2016, safeguarding was the 'theme of the week' on the trusts website, which could be accessed by staff and members of the public. The themes included understanding the needs of vulnerable patients, how to assess for mental capacity, how to raise a concern and child sexual exploitation. The safeguarding team described that they saw an increased in safeguarding enquiries from staff during the week where safeguarding was promoted through the weekly message. The safeguarding team felt it improved staff awareness.
- Staff we spoke with had a good understanding of female genital mutilation (FGM). All staff we spoke with knew how to raise FGM as a safeguarding concern.
- The safeguarding lead nurse monitored safeguarding supervision of nursing staff. Staff were able to access the trust safeguarding supervision policy on the trust intranet. However, the policy date was September 2015 and has therefore expired. The trust safeguarding policy was up-to-date, for the period July 2016 to 2019.
- A doctor we spoke with was able to describe the actions he would take related to a safeguarding concern and would escalate the concern where appropriate.
- There was a dedicated safeguarding link nurse for the department. Link nurses are members of the department, with an expressed interest in a specialty; they act as link between their own clinical area and the safeguarding team. Their role is to increase awareness of safeguarding issues in their department and to motivate staff to improve practice.
- Young people aged 16 to 17 year old attended the adult's emergency department. Staff told us they completed a checklist related to safeguarding, for all 16 to 17 year olds who attend the department; they told us they were actively encouraged to do this by the trust. At the time of our inspection there were no young people in the adult emergency department, however staff showed us the checklists and explained how they would be completed.
- In the CQC children's survey 2014, the trust scored 9.64 out of ten for the question 'Did you feel safe on the hospital ward?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Mandatory training

- Mandatory training for all staff groups was comprehensive. The training was a mixture of face-to-face and on line learning system. Mandatory training modules included equality and diversity, information governance, fire training, infection control and manual handling. Other training was role specific for example, consent, newborn life support, and blood sampling.
- There was a trust wide electronic staff record where all training attended was documented. Managers were informed of training completed and alerted to those staff requiring updates for mandatory training.
- Data provided by the trust showed as of October 2016, staff within children's and young people's services had completed the majority of their mandatory training, with most staff groups achieving compliance greater than the trust target of 80%. However, five out of 17 modules fell below the trust target. These modules were adult life support 64%, manual handling, every 5 years 75%, newborn life support 64%, safeguarding adults level 1 76% and safeguarding children level 2 76%.
- The trust held central mandatory training records for all wards and departments in the hospital. We looked at the training records for the wards and departments we visited which showed staff were either up to date with training, know if their mandatory training date had expired or had training days scheduled.
- Staff we spoke with told us they felt their training was good. However, they sometimes had difficulty in accessing face-to-face modules. This was due to limited dates released and conflicts with their rota. For example, basic life support training is both an online learning and face-to-face package, rotas for nursing staff are completed 12 weeks in advance, however dates for basic life support were only eight weeks in advance. Staff told us this made it difficult to complete both parts

of the training. The practice development nurse and matron told us they were working with the resuscitation team to get extra dates in order for staff to complete their training.

- We saw a mandatory and statutory training chart displayed on the wall in the neonatal intensive care unit office. This meant staff had easy access to view their compliance against other staff, and ensure they were able to stay up to date with their training.

Assessing and responding to patient risk

- We saw Paediatric Observation Priority Score (POPs) charts displayed in all seven areas of consulting rooms and treatment bays within the children's emergency department. This included escalation information and described a clear process for staff to follow. However, one of the seven charts we saw did not display any escalation information. We raised this with staff who immediately removed the poster and replaced it with one that contained escalation information.
- As we found at our previous inspection, there remained a process in place for referring children who were deteriorating via the South Thames Retrieval Service (STRS), and the Children's Acute Transport Service (CATS), which specialises in the inter-hospital transfer of critically ill children in South London. The resuscitation team within the high dependency area of Dolphin ward cared for children requiring intensive care management prior to retrieval. The neonatal unit at Medway is a dedicated level 3 neonatal intensive care unit and caters for all babies except those requiring very specialist services or surgery.
- The children's emergency department had arrangements for the transfer of critically ill children to specialist centres in London via the Children's Acute Transport Service (CATS) retrieval service. Doctors and nurses we spoke with told us that these arrangements continued to work well since the last inspection and they could access the policies for the transfer of patients electronically.
- Paediatric life support training was mandatory for all staff groups, and was undertaken yearly. Data indicated that 100% of neonatal nursing staff, 82% of clinical support workers and 88% of paediatric medical staff had completed paediatric life support, 96% of trained paediatric nursing staff had completed paediatric advanced life support training, which was better than the trust target of 80%. However, data showed only five out of 19 neonatal medical staff had completed paediatric life support training. However the overall compliance rate was 92%, this meant the trust could be confident the majority of staff members within the children and young people service had the necessary up-to-date training to keep patients safe. Four members of the senior nursing team within children and young people services had recently undertaken training for advance paediatric life support, so they were able to deliver this training within the service.
- We looked at the training data supplied to us by the trust before the inspection, for staff working in recovery in main theatres and nursing staff on Sunderland day unit. The data showed that 81% of staff working in recovery in main theatres had completed paediatric life support training. This was better than the trust target of 80%. However, 51% of nursing staff in sunderland day unit had completed this training.
- Resuscitation trolleys in the children's emergency department and Dolphin ward had completed daily checklists. Both checklists were completed, dated, and signed. All equipment against the checklists was in date and available on the trollies. We saw child-sized masks were available on the trolleys.
- The resuscitation trolleys in theatres had completed daily checklists. Both checklists were completed, dated, and signed. There was a paediatric difficult intubation tray, which contained equipment to be used when a patient's airway was difficult to manage. This meant staff could be confident the correct equipment was available. However, we found the paediatric airway trolley was not clearly labelled as paediatric specific, and we found one airway out of date.
- The Paediatric Early Warning Score (PEWS) system was used. Details of the escalation required, depending on the scores, were in place on each PEWS chart. Four different PEWS charts were used for different children of different age ranges. Each chart recorded the necessary observations such as pulse, temperature, and respirations. We saw four records that included PEWS on Dolphin ward, and all were completed fully. Early warning scores have been developed to enable early recognition of a patient's worsening condition by

grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points. We saw the Paediatric Early Warning Score (PEWS) system also recorded pain scores

- Neonatal unit nurses used newborn Early Warning Trigger Score (NEWTS) on transitional care wards. Staff on the neonatal unit and high dependency unit carried out observations hourly. We looked at one record the included NEWTS on the neonatal unit, and found it to be completed correctly.
- We observed a 'safety huddle' between the nursing staff from the children's emergency department and paediatric wards where updates were exchanged such as staffing levels, bed availability on the ward and equipment. The huddles took place twice daily, which meant staff were provided with support and were able to escalate any issues and take prompt actions as required.
- We saw a 'safe to care checks' folder in the children's emergency department. This contained audit checklists such as the wall oxygen and suction in working order, controlled drugs, emergency call bells, play area and toys cleaned and clinical fridge temperature within range. Audits from July to November 2016 for these were completed, dated, and signed. Staff we interviewed told us they would check the folder daily and it was easily accessible to all staff.

Nursing staffing

- Staffing levels were adjusted as required on a daily basis using bank nurses and when necessary agency nurses. Staff we spoke with said they did not use formal acuity tools to balance patient dependency with staffing levels. Staff told us they felt they had enough staff on the wards to provide good nursing care. This was no different to the last inspection.
- Nursing rotas for Dolphin ward, PAU, Sunderland day case unit, and Magpies Centre were planned twelve weeks in advance and reviewed weekly by a senior nurse to identify shortfalls and proactively seek cover. The matron and senior nurses oversaw daily nursing allocation to ensure that appropriate skill mix was in place and that temporary staff were sought for planned or short notice shortfalls in the rota. This included utilising staff on non-clinical duties to fill vacant shifts.
- Two band five nurses were responsible for the development of the rota, which could automatically allocate staff to areas, based on skills and qualifications, including Panda HDU. This meant the trust could be confident the right staff were in the right places to keep patients safe.
- A safe staffing and escalation procedure was in place, which was used daily to check the adequacy of staffing levels. For example at the daily huddle meeting between paediatric emergency department and dolphin ward, we saw any shortfalls in staffing was discussed.
- Between November 2015 to October 2016, 97% of women received 1:1 care, this was slightly below the trust target of 100%.
- Nurses we spoke with in the children's emergency department and Dolphin ward felt there was enough staff at each shift. Bank staff were used to cover sickness and holiday absences. Between April 2015 and March 2016, the trust reported a nursing bank and agency usage of 4% for services for children and young people.
- The staffing establishment for children's emergency department was 12.8 children's nurses and 3.6 clinical support workers whole time equivalent. At the time of inspection, there were four vacancies; one band six (who will be interviewed shortly), two band five commencing in April 2017.
- The nursing staff establishment for general paediatrics was 63.64 whole time equivalent (WTE), with 47.78 WTE in post as of August 2016. For the neonatal nursing staff the establishment was 93.22 WTE, with 69.86 WTE in post as of August 2016. This meant the nursing staffing level was at 75% of the WTE establishment.
- Information provided by the trust before our inspection showed that as of July 2016, the vacancy rate for nursing across children and young people services was 25%, against a trust target of 8%. However, during our inspection we were told nursing staff had increased as 6 WTE staff had been appointed.
- Nursing rotas for Dolphin ward, PAU, Sunderland day case unit and magpies centre were planned twelve weeks in advance and reviewed weekly by a senior nurse to identify shortfalls and proactively seek cover.

Medical staffing

Services for children and young people

- There were 51 doctors working within children and young people services. This was broken down into 15 consultants (10 in paediatrics and five on the neonatal unit), 27 speciality registrars (16 in paediatrics and 11 on the neonatal unit), three speciality doctors on the neonatal unit, and one speciality doctor in paediatrics. There were four foundation year one and one foundation year two doctors (junior doctors) in paediatrics. Data showed in July 2016 the proportion of consultant staff working at the trust was lower than the England average and the proportion of junior doctors (foundation year one and two) was higher. This meant, there were sufficient numbers of doctors with the qualifications, skills and experience to meet the need of children and their families who used the service.
- Information provided by the trust before our inspection showed that as of July 2016, the vacancy rate for medical staff across children and young people services was 13%, against a trust target of 8%.
- Staff told us on the neonatal unit there were 22% vacancies for junior doctors. We saw staffing levels for junior doctors on the risk register and agency staff were used to fill the current gaps. In addition, staffing for the next day was discussed on a daily basis to ensure the required staffing was adequate. This service was recruiting, including from overseas.
- There were well-structured medical handovers, which made sure important information was passed onto each other, including all known risks, and any incidents that may have occurred. Consultants were present at, at least one of the handovers; this is in line with the Royal College of Paediatrics and Child Health (RCPCH) guidelines. Consultants undertook daily rounds on the ward, and a consultant saw all children and young people within 24 hours of admission.
- The consultant of the week was readily available to discuss referrals for outpatient or inpatient care with local primary care physicians.

Major incident awareness and training

- There was a paediatric business continuity plan, which included clear instructions on what to do should there be an electrical failure, loss of water, IT systems failure, staffing shortage and loss of documentation. The instructions also showed instructions on what to do. Staff we spoke with on Dolphin ward and the children's emergency department described that they would refer to the plan when required.
- Scenario based training was held jointly with paediatric emergency department and the paediatric wards, this ensured staff responded appropriately to emergencies. For example, staff told us these included, life support scenarios, and safeguarding training.

Are services for children and young people effective?

Good

At our last inspection in 2015, we rated children and young people services as good for effectiveness. On this inspection we have rated as good as the effectiveness of the services had been maintained. However we found areas for improvement such as providing children and young people with a menu, as well as improving the variable appraisal rates across the service. In addition, the provision play specialists within the department requires improving, although an additional play specialist had been recruited for paediatric emergency department. This was also a recommendation of the previous report.

At this inspection we rated the children and young people services for effective as good because:

- Children and young people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice, and legislation.
- There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services and service accreditation.
- Staff skills and competence were examined and staff were supported to obtain new skills and share best practice.
- We observed good team working both within the services for children and young people and externally with other wards and departments that children had contact with.

- The majority of services were offered seven days per week with the exception of the outpatients department, which was a Monday to Friday service.
- We saw that parents were fully informed prior to consent being obtained. Nursing and medical records had been completed appropriately and in line with each individual child's needs.

However:

- A recommendation from the previous report was children's services should enhance play specialist provision in line with national guidance. The play specialist provision on the wards had not been enhanced since the previous inspection.
- The service is not complying with National Institute for Health and Care Excellence (NICE) Quality Standard (QS) 94, as children were no longer given a menu to read, and are told the meal choices. This does not allow children and young people or their parents and carers to make informed choice when choosing meals, as they are not provided with the details about the nutritional content. Children and parents we spoke with told us they had a low opinion of the quality of meals.
- The number of staff that had an up to date appraisal was variable across the service, with children's outreach and specialist team, neonatal medical staff, neonatal and paediatric administration, neonatal nursing staff and paediatric medical below the trust target.

Evidence-based care and treatment

- Policies and guidelines had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. For example, we viewed the trust guidelines for post-partum haemorrhage, August 2015.
- Frequent audits were completed in paediatrics, such as epilepsy, diabetes, asthma, and infection control compliance. We were provided with copies of the joint paediatric and neonatal clinical audit plans for 2015/16 and 2016/17. The audit plan was devised based on audits required nationally as well as to assess compliance with NICE about paediatrics and neonatology and local priorities and issues identified through complaints and incidents.
- The service held audit meetings, such as the neonatal (sub-group) audit meeting, we saw the minutes for February, May, and June 2016 they were well attended by members of the multidisciplinary team. We saw the meeting discussed outcomes of audits and audit action plans and audit streams.

Pain relief

- Children received adequate pain relief and there were systems appropriate systems for assessing pain in children in use, is required.
- A variety of assessment tools were used to assess pain depending on the age of the child. Staff assessed pain using recognised methods based on observation (the FLACC scale that is based on observation of a child's face, legs, activity, crying, and consolability) or children's own reporting of pain, for example, the Wong Baker FACES pain rating scale. We saw these tools effectively used on patients on Dolphin ward. Staff used the visual analogue pain score, where zero meant no pain and 10 meant severe pain for older children.
- Children and their parents received clear explanations regarding medication and analgesia. For example, we spoke with one adolescent, who was undergoing an investigation for a stomach problem and was given limited pain relief. This had been fully explained and the reason why, both the patient and parent were happy with the explanation and knew they could seek further help from the nursing staff if required.
- Analgesia and topical anaesthetics were available to children who required them in the ward and outpatients department.
- Staff we spoke with told us they had access to the hospital pain team, if needed as well as other pain management strategies from the children's outreach and specialist team (COAST).
- Clinicians in the neonatal unit used oral sucrose analgesia, administered pre-procedure, for newborn infants undergoing painful procedures. The use of sucrose as an analgesia is common practice across internationally.

Services for children and young people

Nutrition and hydration

- The NNU had improved its breast-feeding rates between 2014 and 2016. Breastfeeding rates at discharge were monitored as part of the National Neonatal Audit Programme (NNAP), which showed that between January to December 2014 the rates were 34% of mothers were breastfeeding on discharge, which was below the national average of 60%. However, the unit had made improvements to their breastfeeding programme and facilities such as, the introduction of a dedicated infant feeding team, improving education of nurses to help mothers express breast milk, and the development of dedicated facilities, including provision of reclining chairs, to make it more comfortable for mothers to express or breastfeed. As a result, between January to March 2016 the NNAP data showed that 69% of mothers were breastfeeding on discharge, which was better than the national average of 59.
- The service gave children and young people a choice of meals on Dolphin Ward. Hot food was now available at lunchtime and in the evening. At the last inspection, we found the menus to be imaginatively designed, however the children were no longer given a menu to read, and were told the meal choices. This is not in line with National Institute for Health and Care Excellence (NICE) QS94: Obesity in children and young people: prevention and lifestyle weight management programmes, which says 'Children and young people, and their parents or carers, should see details of nutritional information on menus at local authority and NHS venues. Providing details about the nutritional content of food will allow children and young people (and their parents or carers) to make an informed choice when choosing meals. This information will help people achieve or maintain a healthy weight by enabling them to manage their daily nutritional intake'. One patient we spoke to, told us they would "Prefer to read a menu", a parent told us "Staff tell them what the food is on offer".
- Children and parents we spoke with told us they had a low opinion of the quality of meals; this was different to the previous inspection where parents told us that the food for children was good. One parent told us the food on offer was "not very good"; another told us "food is a bit hit and miss". However, we were told children could request food that was not on the daily menu, for example, a parent told us staff would make beans on toast, if their child did not like what was on offer. Staff told us, parents were able to take their children to the canteen, if they wished, or were able to bring in their children's favourite food in from home.
- There was a milk room available on Dolphin ward. This provided alternatives to breastmilk and formula, for example, if a baby was lactose intolerant or had allergies. Fridges used to store expressed breast milk, were labelled and information on safe storage was provided. All expressed breastmilk was labelled with name and date, and would be discarded after five days. The fridge temperatures were recorded daily.
- We saw breast pumps in the main room and breast pump room, which allowed easy accessibility and could potentially encourage mothers who may not have wanted to breastfeed. Breast pumps were loaned to parents; this acts as an enabler for breastfeeding and made it as easy as possible for parents.
- The neonatal unit offered a breast milk bank service. Donors were recruited and donated milk was tested and pasteurised before being offered to parents. We saw all fridges and freezers to store the donated milk were checked daily and were within temperature range. We saw recordings of the temperature for one fridge was out of range and was put out of use. The fridges and freezers were securely locked. All the pasteurised milk had green tops and batch numbers, donor's details, and expiry dates were clearly documented. Frozen milk after pasteurisation were stored for no longer than six months. This followed NICE guidance February 2010 'Donor breast milk banks; the operation of donor breast milk bank services'.
- The 2015 neonatal unit annual report showed 92 babies in 2015 and 78 babies in 2014 benefitted from pasteurised donated breast milk. It was also reported that 30 new donors were recruited in 2015 and 26 in 2014. The amount of pasteurised donated breast milk in 2015 was 44,439 ml in 2015 and 40,590 mls in 2014.

Patient outcomes

- The neonatal unit staff participated in the National Neonatal Audit Programme (NNAP), which was implemented to assess whether babies admitted to neonatal units in England, receive consistent care in relation to key criteria such as the proportion of babies receiving breast milk at discharge.

Services for children and young people

- The trust performed well in elements of the 2015 NNAP audit. For example, the audit showed the trust achieved the standard of 99% (against a standard 98-100%) of babies of less than 28 weeks gestation had their temperature taken within one hour of delivery. A low admission temperature on admission for pre term babies has been associated with an increased risk of illness and death. For mothers of premature babies 93% (against a standard of 85%) received antenatal steroid. Steroids are given to mothers prior to pre-term birth in order to reduce the chance that their baby is affected by breathing difficulties. The percentage of babies that received retinopathy of prematurity (ROP) screening was 99% (against a standard of 100%). ROP is an eye condition that can affect babies born weighing under 1501g or 32 weeks gestation. A documented consultation with parents within 24-hours of admission to the neonatal unit was 99% (against a target of 100%). This ensured that parents have a timely explanation of their baby's condition and treatment.
- There were no emergency readmissions, following an elective admission of children aged one and under between March 2015 and February 2016.
- There were readmissions, following an elective admission, for children aged one to 17, for the same period., This was arate of 0.8%, which was slightly worse than the England national average of 0.6% for this age group.
- There were 43 readmissions, following an emergency admission of children aged one and under, between March 2015 and February 2016. This readmission rate of 2.4% was better than the England national average readmission rate of 3.4%, for this age group.
- There were 144 readmissions following an emergency admission of children aged one to 17, between March 2015 and February 2016. This readmission rate of 3.2% was worse than the England national average readmission rate of 2.8%, for this age group.
- Between April 2015 and March 2016 there were too few admissions to measure the trust performance for the percentage of patients under the age of one who had multiple admissions for asthma, diabetes, and epilepsy.
- The rate of multiple (two or more) emergency admissions within 12 months among children aged one to 17 with asthma was 15.4% between April 2015 and March 2016, which was better than the England average multiple admission rate of 16.6% for this age group.
- The rate of multiple (two or more) emergency admissions within 12 months among children aged one to 17 with epilepsy was 40.5% between April 2015 and March 2016, which was worse than the England average multiple admission rate of 29.3% for this age group.
- The National Paediatric Diabetes Audit 2014/15 found the trust was an outlier at 21% for a measurement related to HbA1c monitoring compared to a national average of 19%. This meant the trust performed better as there were more patients having an HbA1c value of less than 58 mmol/mol compared to the England average. HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The NICE Quality Standard QS6 states "People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)".
- Staff told us the service had very few child deaths. Children's and young people's services had a specific end of life care policy. All child deaths whether expected or unexpected were discussed at the Child Death Overview Panel for Kent, as part of the service's governance arrangements.
- The "Mothers and babies: reducing risk through audit and confidential enquiries" (MBRACE) showed the neonatal unit was in the top 10% for lowest neonatal mortality in the country.

Competent staff

- All staff had specialist knowledge and skills to treat children with their presenting conditions.
- Healthcare assistants and play specialists complimented paediatric nurses on the children's ward. All trained nurses who worked on Dolphin ward, Penguin assessment unit (PAU), and Sunderland day case unit were nurses registered in paediatrics, apart from one nurse, who had over 40 years' experience working within the service.

- All trained nurses working in the paediatric emergency department, were registered nurses (RN)in paediatrics, with the exception of one nurse, who was an RN in adults
- On the neonatal unit, nursery nurses who were specifically trained to care for this group of babies supported nurses. All staff on the neonatal unit had appropriate training and were certified in neonatal resuscitation and neonatal intensive care, including 60% of the ten staff who were recently appointed from overseas. The remainder of the staff were due to complete their training.
- The trust had a newly appointed practice development nurse who had developed a comprehensive preceptorship programme for newly qualified nurses. This was a structured period of transition for the newly qualified nurses when they started their employment at the hospital. Staff we spoke with were very complimentary about the new practice development nurse and felt they had already made a difference, with training and education.
- There were 16-trained members of staff working on Dolphin ward with an additional qualification in specialty for looking after children and young people on Panda high dependency unit (HDU). A further ten were set to attend a course in June 2017.
- The trust target for completion of staff appraisals was 95%. Between April 2015 and March 2016, the trust reported a staff appraisal completion rate for children and young people's services of 68%, however between April 2016 and September 2016, the appraisal rate had increased to an average of 92%. Data provided by the trust showed that between April to September 2016, 100% of child health, neonatal medical staff and paediatric surgery staff, 96% of paediatric nursing staff and 95% of neonatal nursing staff, had all had an up to date appraisal. However, data showed 93% of neonatal medical staff, 89% of neonatal administration staff, 88% COAST staff, 75% paediatric administration staff, and 50% neonatal transport had, had an appraisal, which was below the trust target of 95%. Lack of appraisals for staff may have meant the service did not address any potential staff performance issues.
- Nurses were supported to keep themselves up-to-date professionally. Regular study days were provided. Nurses told us these provided opportunities to further their education to support revalidation and progress in their careers. They told us they were also encouraged and supported to develop areas of interest and act as a source of advice and training for the team. For example, there were link nurses in infection control, tissue viability, moving and handling, health and safety and safeguarding.
- Staff received training in end of life care. Data received from the trust showed that 37% of the children's outreach ad specialist team (COAST) had attended training at either Great Ormond Street Hospital or Royal Marsden. The bereavement team on the neonatal unit attend yearly update training, which is run by BLISS and the Child Bereavement Trust. The neonatal bereavement team ran study days for maternity and neonatal teams at the hospital. Data received from the trust showed 100% of the bereavement team had attended this training.

Multidisciplinary working

- We observed that staff worked well together during our visits to the various wards and departments. They also worked well with multidisciplinary teams (MDT) within the hospital and with other outside services in order to provide the best care possible for children and young people.
- Reviewing five medical records, talking with 28 members of staff, 14 parents, and two young people, confirmed there were effective multidisciplinary working practices, which involved nurses, doctors, physiotherapists, and pharmacy. Staff told us they felt supported and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe.
- All nurses we interviewed told us there was good MDT working between the children's emergency department and wards.
- There were two play specialists employed at the trust, 1.72 WTE in total, with no vacancies. Play specialists are an important part of the ward and department teams, as they work with children to make sure the hospital environment is welcoming and fun. At our last inspection, we found play provision for sick children was inadequate as children's services employed only two play specialists to cover all the clinical areas. This did

not meet best practice as stated in 'Getting the right start: National Service Framework for Children Standard for Hospital Services' (2003), which says all children staying in hospital must have daily access to a play specialist and the use of play techniques should be encouraged across the multidisciplinary team caring for children. We found at this inspection that there had been no increase in play specialists on the ward. However, there had been a new appointment for a play specialist in the children's emergency department.

- Staff used play specialists in providing distraction techniques when a child required a procedure that may be painful or upsetting. For example, we spoke to the parent of a child receiving treatment who was having distraction therapy provided by the play worker. The play worker engaged with the child through age appropriate play, which allowed the nurse to take bloods without the child being in distress. The parent was very happy with the support the play worker provided.
- The trust had good links between children and young people's services and the child and adolescent mental health service (CAMHS). Staff told us they had rapid access to this service. CAMH's is Staff reported they had a good working relationship and spoke with the CAMHS service daily. as offered to 16 to 18 year olds who attended the adult emergency department.
- Staff in the children's emergency department had access to Children and Adolescent Mental Health Services (CAMHS). This service was previously available from 8am to midnight and had been reduced with accessibility now from 8am to 8pm, covering two sites. This meant that CAMHS may not respond to cases quickly and so may have to admit children or adolescents up to 16 years' of age. Over the age of 16, mental health support services were available for young adults who attended the adult emergency department.
- There were qualified play specialists available on Dolphin ward and Penguin assessment unit seven days a week.
- The children's ward had established links with other specialist children's services. Staff could attend training through this network. There were strong working links in place to support staff, children, and young people.
- The children's outreach and specialist team (COAST) is an outreach team in place to support children and young people at home and reduce re-admissions into hospital. Staff told us they had excellent working relationships with this team. For example, we saw emergency boxes for children who have tracheostomies (an opening in the neck in which a tube is placed into a person's windpipe. This allows air to enter the lungs), who may be admitted to the ward. These boxes were labelled with the individuals name and ensured that if they are admitted, staff on the ward had the correct patient specific equipment, including tracheostomy tubes to hand. The COAST team maintained the boxes.
- The neonatal networks functioned well together with good relationships between the unit and the Kent neonatal transport service.
- Nurses told us that team working with physiotherapists was good across the children's services and they felt supported by their colleagues in the MDT.
- On the neonatal unit, an eight-bed transition ward was available for women and their babies, for women to get used to the additional care their babies might need whilst having the reassurance that a qualified nurse was on hand to advise and support and help prepare for the babies discharge home.

Seven-day services

- Dolphin ward, penguin assessment unit, paediatric emergency department, the neonatal unit and the radiology department provided seven-days services for children and young people at the trust.
- Outpatient appointments were scheduled Monday to Friday, with no clinics run at the evenings or weekends. This meant that children and young people and their parents or carers could not always access outpatient appointments at times that suited them. This resulted in children having time out from school and parents or carers taking time off from work in order to attend appointments.
- There was a facility to provide high dependency care for children and young people at the trust. However if any children required intensive care management and ventilation, they would be stabilised within Panda high

dependency unit before being transferred to the anaesthetic department of the operating theatres prior to retrieval by either the South Thames Retrieval Service (STRS) or Children's Acute Transport Service (CATS).

- A single paediatric pharmacist provided specialist cover to the service Monday to Friday.

Access to information

- Staff told us they could access information they needed to deliver effective care and treatment in a timely and accessible way. For example, blood results and other investigations such as x- ray and scan results were available as soon as they were ready and on the system.
- Policies, protocols, and procedures were kept on the trust's intranet and staff were familiar with how to access them.
- There were enough computers available to allow staff to have quick access to trust policies, guidance, and the staff rostering systems. In addition, we saw each ward and department had a number of computers on wheels (CoWs) which allowed staff to access patient information as well as request diagnostic tests, and inputting information whilst on ward.
- GP's were informed of patients discharge on the day of discharge. Care summaries were sent to a patient's GP on discharge to ensure continuity of care within the community. GP's could telephone consultants and registrars for advice following discharge.
- The service used the 'personal child health record' (PCHR), referred to as the "red book", and encouraged parents to bring these to hospital if their child attended an appointment or received treatment. Medical records, for children and young people who regularly attend, were kept on the ward and were accessible to all staff that were involved in the child's care.

Consent

- Staff obtained consent from patients and parents appropriately in relation to care and treatment. Staff were able to explain how consent was sought and how they involved both the child and the person with parental responsibility in obtaining consent where appropriate.
- Consent forms for surgical procedures included an explanation of any risks to the child from receiving treatment.
- Parents described the process of giving consent. This included receiving detailed information from doctors and nurses in a way that could be understood so an informed decision was made.
- Parents also confirmed that staff explained what they were going to do and asked verbal consent whenever they were present. Staff also described care that had been provided in their absence.
- Staff used the principles of the Gillick guidelines, when making decisions about the ability of a young person to consent to procedures. 'Gillick Competence' refers to any child who is under the age of 16 who can consent, if he or she has reached a sufficient understanding and intelligence to be capable of making up their own mind on the matter requiring a decision.
- We reviewed three consent forms for three children who underwent surgery. All were dated, timed, legible and documented the patient's details, procedure, with benefits and risks explained. They were signed and the names of doctors were printed and included their grade. This meant that a patient, parent, or guardian's agreement to undertake the procedure was sought in line with the trust consent policy and procedures.

Are services for children and young people caring?

Good

At our last inspection in 2015, we rated children and young people services as good for caring. On this inspection we have maintained this rating.

At this inspection we rated the children and young people services for caring as good because:

- Parents, carers, children, and young people's feedback was mainly very positive about the care provided from all the staff within children and young person's services.

Services for children and young people

- Medical and nursing staff were caring, calm and kind when delivering care and interacting with patients and families. They were described as "excellent", "very helpful" and "attentive", by both patients and their parents.
- Parents and children were involved in their care and independence was encouraged. Parents, children and young people were kept up to date and fully informed on what was happening to them.
- Children and young people, their families and carers were supported by staff and treated with dignity and respect.
- Staff responded compassionately when parents, children or young people who needed help and supported them to meet their basic personal needs as and when required. Staff were highly motivated to offer care that promotes people's privacy and confidentiality was respected at all times.
- Good interactions were observed between staff and children, young people and their families. The caring attitude of all the staff was obvious in every department we visited. The staff had expertise in caring and communicating with children and young people.
- There was access to specialist play worker, who was able to use play as a therapeutic tool to help children understand their illness and treatment.

Compassionate care

- All staff we spoke with were very passionate about their roles and were dedicated to making sure children and young people received the best patient-centred care possible.
- We saw and heard staff delivering kind and compassionate care to the children and young people in their care.
- Children and young people, their families and carers told us they felt well supported by staff. We saw young people being treated with dignity and respect, and observed staff providing child centred, compassionate care. Parents, children, and young people told us that they were kept up to date with plans about their care verbally.
- During our inspection, we observed very good interactions between staff, children, young people, and their parents. Staff treated patients with kindness, dignity, and respect. Staff interacted with patients in a positive, professional and informative manner. This was in line with National Institute for Health and Care Excellence (NICE) QS15.
- Staff protected the privacy and dignity of patients by using children specific bays and curtains used to screen children from other patients when needed. For example, the day surgery unit had two bays used for children in an area where adults were also cared. Staff drew curtains to protect children from witnessing adult care and protect the child's privacy.
- Staff were skilled in communicating with children and young people; we observed this on every ward and department we visited. Most staff introduced themselves with "my name is".
- We spoke with 14 parents and two young people on the wards and departments we visited. All parents and patients we spoke with were very positive about their care. One patient told us "The care is very good". Another parent told us "The staff are excellent, always asking if everything is alright of if we need anything". Parents and young people told staff were "Excellent", "Very helpful", "Kind", "Very caring", and "Attentive".
- We received three negative comments from patents, which related to the Magpies Centre, and a lack of communication.
- In the 2014 CQC children's survey for all 14 questions relating to care were about the same as other trusts. This was the most recent data available at the time of inspection.

Understanding and involvement of patients and those close to them

- As at our previous inspection, we found staff interacted with children and their parents in a polite and friendly manner. Children, young people and their families were given the opportunity to speak with staff, to ask questions and were kept informed of what was happening. A parent told us "I feel like I am able to ask any questions, no matter how silly".
- Parents and children told us that the doctors and nurses kept them informed as to what is happening. One parent told us "everything is explained, so I know exactly what is happening".

Services for children and young people

- We observed staff explaining to families the care their child was receiving and the purpose of the equipment helping them to do this. Staff did this in a compassionate way, allowing families to ask questions.
- We observed members of staff talking with children and young people. We heard them using language appropriate to their age and level of understanding.
- Children and young people told us how staff involved them in their own care. One young person told us that they were able to do most things for themselves but that the staff were there whenever they needed additional help or support.
- Older children we spoke with felt they were kept updated about their care by staff and could be involved in making decisions as appropriate.
- On each ward and department, it was clear which nurse was looking after each child or young person. The children and young people we spoke with all knew who was looking after them.
- We saw that support mechanisms were in place for parents of babies in the neonatal unit. We saw thank you cards from parents in appreciation of the support given. Staff told us that parents would often bring their babies back to see them to show the staff how well they were doing.
- In the 2014 CQC children's survey for all 19 questions relating to understanding and involvement of patients and those close to them, were about the same as other trusts. This was the most recent data available at the time of inspection.

Emotional support

- Parents told us they felt able to leave the ward or area in which their child was being cared for and felt their child would be safe.
- There was a community nursing team based on site that provided support for children and young people with learning disabilities, who were able to help parents with emotional support. Additionally, there was a children's outreach and specialist team (COAST) that provided support for inpatient children with life threatening and life limiting illness.
- The child and adolescent mental health services provided by other NHS trusts supported children with mental health problems.
- Play therapy services included preparation for invasive/ non-invasive procedures, distraction therapy, emotional support, and pain management. There was a specialist play worker able to Staff and families stated play therapists were a valuable support service for young people.

Are services for children and young people responsive?

Good

At our last inspection in 2015, we rated children and young people services as good for responsive. On this inspection we have maintained, as good as the responsiveness of the services had been maintained. However we found areas for improvement such as improving the lack of dedicated recovery areas for children and young people, in sunderland day unit and recovery in main theatres.

At this inspection we rated the children and young people services for responsive as good because:

- Services were tailored to the meet the needs of individual children and young people.
- There were good facilities in place for children to occupy their time during their inpatient stay and facilities for parents to stay with their child.
- Single sex accommodation was provided, for young people where possible
- Access to, and flow within, the service worked well. Staff responded well to complaints and knew the procedure so could direct parents appropriately.
- Interpreting services were available when required.
- End of life care support was available and where possible, parents' wishes, cultural and religious requirements were followed.

However:

- Complaints were not always responded to within the trust's response time scales, the service had recently cleared the back log.

- There was no dedicated paediatrics recovery area in theatres, as there was no segregation of children from adults in the recovery areas of the theatres.

Service planning and delivery to meet the needs of local people

- We found that the children's service had good links within the trust, commissioners, the local authority, and other providers. This ensured services were planned and delivered in order to meet the needs of the local population. For example, a paediatric consultant told us they were working with the local clinical commissioning group to review the children attending the children's emergency department to reduce the amount of inappropriate attendances. Another example given was the service told us they were currently working with community nursing and emergency department on an attention deficit hyperactivity disorder (ADHD) pathway.
- Outpatient appointments took place in dedicated paediatric facilities. The environment was child friendly with toys available and access to a play specialist if required. Specialist consultants from other trusts held clinics at the trust to support the care of children with complex health needs, for example, for children with cystic fibrosis.
- A framework was available for all healthcare professionals to enable them to deliver a well-planned transitional process for young people with long-term health conditions and complex health needs as they moved from child-centred to adult-orientated services. We noted that young people up until the age of 16 were cared for within the service. Staff consulted with young people over the age of 16 about whether to remain on a children's ward or whether an adult ward would be more suitable.
- Formal transition processes were in place for children moving to adult services who had conditions such as Diabetes Mellitus or Cystic Fibrosis. There were formal networks available for transition to adult services with other NHS trusts for conditions such as cystic fibrosis, cardiac or renal conditions. Diabetes, irritable bowel disease and sickle cell transition clinics were held at the trust in partnership with adult medical colleagues.
- We saw the transition policy for diabetes, which set out best practice principles to ensure that all young people from aged 14 and their families are informed of the transition process. Staff invited patients aged 18 to a transition clinic, which were held every two months by the adult diabetic team, to allow patients and families to ask questions about the move to adult care. Additionally there was a meeting between paediatric and adult diabetic services, held quarterly, to discuss any patients about to transition to adult services or those who recently have. This meant the trust could be confident that a high quality service that was coordinated, uninterrupted, and patient-centred, age, and developmentally appropriate.
- The trust provided nearly 50% of all paediatric day cases within Kent. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD), 'Are We There Yet? A review of organisational and clinical aspects of children's surgery' (2011) recommends Hospitals that have a large caseload for children's surgery should consider using dedicated children's operating theatres, and where this is not possible to there should be designated time for children on adult operating lists should be scheduled, ideally at the start of such lists.
- However, the hospital did not have a dedicated paediatric operating theatre. The Royal College of Surgeons, "Standards for children's surgery" (2013) recommend minimising any distress that children and young people should not be cared for alongside adults in recovery areas and parents should be allowed to visit their child in recovery.
- We were told there were dedicated paediatric lists that took place in Sunderland day unit. Children or young person were initially been recovered from surgery, in the same recovery area as adults. We were told if adults were present, they would draw the curtain around the child or young person. They would be moved to a dedicated recovery bay for children. Parents are able to stay with their children, in this dedicated area.
- For surgery that took place in main theatres, we were told there were no dedicated lists. Children were put in the same recovery room as adults with a curtain to separate them. Only once they were fully recovered from the anaesthesia, would they be transferred back to the ward. Guidance on the Provision of Anaesthesia Services for Pre-operative Assessment and Preparation 2016 states, "Children should be separated, ideally visually and audibly from adults and should be managed and

treated in child-friendly areas, including waiting rooms, pre-assessment clinic rooms, and theatre areas, including anaesthetic and recovery areas, as far as possible".

- However, the recovery bay in the main theatres was staffed by appropriately qualified nursing staff and operating department practitioners (ODPs)s. Staff told us where possible, providing there were no adults in recovery they would try to allow parents into recovery in a timely way following an operation and would not be left for lengthy periods unsupervised in a recovery bay.
- On our previous inspection, we were told that plans were being submitted to the board in October 2015, for a separate children's recovery area in sunderland day unit. This was not in place for this inspection, and we were not told of any plans for this. however, we did see on the risk register that the lead nurse was in discussion with the estates department to build a solid wall, to fully separate children and young people and adults in the recovery area. We were not made aware of any plans to rectify the lack of separation in the main theatres recovery area.
- There were facilities for parents to be able to stay overnight with their children both on Dolphin ward and the neonatal unit. On the neonatal unit, there were three bedrooms available with ensuite facilities. All three rooms allowed two people to stay. There was access to Wi-Fi and televisions, along with toys and books for siblings.
- There was access to a shared sitting rooms and kitchen facilities with a fridge, toaster, microwave, and hot water dispenser, which allowed parents to prepare food and drinks for themselves. This facility allows parents to be in close proximity of their babies and the staff caring for them. In addition, the neonatal unit also provided financial assistance for travel costs to low income families.
- There was self-contained accommodation within the hospital grounds, which included shower and kitchen facilities, which was available for parents to use.
- On Dolphin ward, folding beds were available for parents who wished to sleep next to their child. Only one parent was able to stay over at any one time. However, staff said this is based on individual basis, and gave us an example where two parents were able to stay overnight, due to one parent suffering from depression and it was safer to allow both parents to stay. Parents had access to shower facilities on the ward.
- There was also a room with comfortable seating with tea and coffee making was available. A drink and snack machine was available in the room.
- In the CQC children's survey 2014, the trust scored 7.3 out of ten for the question 'for parents and carers who stayed overnight saying facilities were good?' This was about the same as other trusts. This was the most recent data available at the time of inspection.
- In the CQC children's survey 2014, the trust scored 8.9 out of ten for the question 'for parents and carers being able to access hot drinks when in hospital?' This was about the same as other trusts. This was the most recent data available at the time of inspection.

Access and flow

- There had been 9,588 children and young people admissions to the trust between April 2015 and March 2016. For children aged one and under the most common diagnosis was acute bronchitis (15%). This was below the England national average of 18%. The most common diagnosis for children aged one to 17 was viral infection, (9%), which was below the England average of 11%.
- Children and young people were admitted to the ward via a planned admission process, through emergency admission from a direct referral from their GP, via the Penguin assessment unit, or through the children's emergency department. Neonates were admitted via maternity as a planned or emergency admission.
- The neonatal unit had transfer and admission policies in place, this gave staff clear clinical guidelines and explained the criteria for a baby being admitted to the unit.
- Guidelines were in place for some babies, children, and young people to have direct access to the ward. This meant that, should any problem arise with their child's condition, the parents could bring them directly back to the ward without having to go to their GP or the emergency department first.

Services for children and young people

- The hospital had a children's emergency department that was located beside the adult emergency department. The children's emergency department had a dedicated emergency waiting and treatment area for children under the age of 16 years. Children's nurses with the support of doctors staffed it. An administration clerk supported both the children and adult emergency departments. Children aged 16 to 17 years were seen in the adult emergency department.
- The Magpies Centre was a dedicated paediatric outpatient facility and was a child friendly environment.
- The average length of stay for children young people service at the trust was 2.22 days (6,456 stays), between September 2015 and August 2016. This is made up of 0.81 days (5,373 stays) for paediatric patients and 9.27 days (1083 stays), for the neonatal unit.
- There remained in place arrangements for the transfer of critically ill children and young people to specialist centres.
- Children and young people attended preadmission clinics before being admitted for surgery. During the clinic, staff explained the procedure to children and their parents and consent forms would be signed. Staff we spoke with told us if the treatment needed to be cancelled or delayed, they would contact the parents or carers and explain the reason for cancellations. Staff offered a new appointment at the earliest opportunity.
- Paediatricians provided clinical oversight of their outpatient waiting lists, to ensure children received appointments based on their clinical needs. Parents and children who were waiting to attend outpatient appointments told us they were usually seen very quickly.

Meeting people's individual needs

- At the last inspection in August 2015, the neonatal unit (NNU) was seeking full United Nations International Children's Emergency Fund (UNICEF) accredited baby friendly status. At this inspection, the unit continued working towards this. The trust was currently level 2 UNICEF Baby Friendly accredited. The Baby Friendly Initiative is based on a global accreditation programme of UNICEF and the World Health Organization. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.
- We judged children and young people services at the trust had a warm, family-friendly atmosphere despite the clinical setting.
- Staff explained that they tried to nurse male and female children and young people in separate bays from ten years of age upwards. We saw they were able to allow children to be segregated by gender, by separating young people either into different bays or into side rooms. There were multiple bathrooms available on Dolphin ward. However, it was difficult to designate a toilet to either male or female.
- On Dolphin ward, there were facilities available for parents to make drinks and have snacks. All parents we spoke with were happy with the facilities provided. There was a quiet room away from the main ward, and main parent room, where parents could go to get away from the ward environment.
- Breastfeeding mothers on Dolphin ward were offered food from the same menu as the children. On the NNU breastfeeding, mothers were offered vouchers to use in the canteen. This is in line with National Institute of Health and Care Excellence (NICE) CG37: postnatal care up to 8 weeks after birth, which recommends breastfeeding mothers, should be offered food and drink on demand.
- Staff had developed a sensory room on Dolphin ward. This was used for calming anxious children and some procedures could be performed there such as the passing of nasogastric tubes if the child found it easier.
- There was 'quiet' room available to allow staff to break bad news to children and young people or parents.
- The X-ray department did not have a dedicated paediatric waiting area however; staff liaised with the ward staff to ensure, where possible, children were seen quickly.
- Staff told us that the three largest ethnic minority groups who attend were Polish, Slovakian, and Russian. The trust offered face-to-face, telephone and written translation services, as well as sign language using an

outsourced company. The doctors and nurses we spoke with were able to fully describe how to organise translation services for families. We did not observe any interpreters being used during our inspection.

- The mother of a breastfeeding baby reported she had been well supported to breast feed and had been given all the equipment she needed to assist her in doing so. Breast feeding pumps were accessible and breast-feeding pump hire was available for mothers.
- We observed a range of information leaflets across the service to help inform families about care and support services available to them. Leaflets were available in the children's waiting area of children's emergency department and were child appropriate. Examples of this were 'head injury advice for parents and carers' 'burns injury (child)' and 'swallowed foreign bodies', which were produced by the trust. There were in English language and staff told us leaflets with different languages could be made available when requested.
- We saw all areas visited had noticeboards displaying current and relevant information. We also found a suitable range of information leaflets were readily available for families and children; these were easily accessible. Most of the leaflets were also available on line, staff told us they would always print off information for parents.
- The learning disability team were available to support families with inpatient children with learning disabilities and the Coast Team with patients with complex illnesses. Patient passports were in use for patients with a learning disability, which were completed by their relative or carer. The passports were used so that patients could outline their care needs, preferences, and any other information the staff would find useful to assist with their care.

End of life care

- Staff provided families with emotional support during bereavement, they were aware of how to sensitively handle the situation. At the time of inspection, no patients were requiring end of life care.
- The trust had an up to date end of life care policy, which were children and young people specific. Staff were able to explain how they would support parents in the event of a child death at the hospital. We saw that Dolphin ward had a 'bereavement box' on the ward, and staff would be able to give parents 'keepsakes' of their child, this included, take a lock of hair and take casts of foot and hand prints, and anything else the family chose if it was possible. Staff told us, not all parents would want this initially, but they still took these 'keepsakes', as this was often requested later. The 'keepsakes' were kept with the child's notes. All wards and departments within children and young people services were able to provide 'keepsakes' for parents.
- Parents did not accompany their child to the mortuary, but the nursing staff took time to explain to the families, what would happen, and that they would accompany their child there. Staff told us, parents did not request to accompany their children. There was a facility in place, where a child following their death could be sent to a 'bereavement suite' at a nearby local specialist child hospice. The 'bereavement suite', is a specialist bedroom, where a child can lay at rest, allowing their family to say goodbye in a familiar, supportive, and sympathetic environment.
- Staff told us; where possible they will try to accommodate parents wished as well as religious and cultural needs. For example, staff told us about a child who had spent the majority of their life in hospital, and their parents wanted to take them home after they died. The ward were able to make this happen.
- Staff at the hospital liaised closely with COAST and was aware of any children or young people in the community who may require end of life care. Children who required end of life care had an advanced care plan in place, including a preferred place of death and symptom control. The hospital had a dedicated trust chaplaincy service, the multi faith chaplaincy supported families in a way suitable for the faith of the family and to meet their wishes.
- There were processes for supporting the parents, carers, and siblings of children receiving end of life care.
- There was no link nurse for end of life care in the children and young people services. This meant staff in children and young people services would not always receive up to date information form the main trust end of life team.

Services for children and young people

- A face-to-face appointment with a consultant and midwife was offered to families who suffered the loss of a baby, either during pregnancy or after the birth of their child. This included a bereavement counselling service.
- The bereavement nurses team conducted a local patient bereavement survey to seek feedback to enable them to improve their services. Responses we saw from the survey included, "The team were absolutely lovely considering the traumatic circumstances, and couldn't do enough for myself and my partner". Others told us, "We were given all the literature to enable us to make a very difficult decision", "The support was very good both at the time and subsequently", "We were provided with meaningful information that was appropriate for our circumstances" and "We were looked after very well, with the right level of support".
- The bereavement nurse team offered an annual remembrance service to families who had suffered the loss of a baby. The hospital chaplain led the service.
- The bereavement service team sought feedback from bereft families using an invite letter, which parents could use to provide feedback.

Learning from complaints and concerns

- Between August 2015 and July 2016, there were 30 complaints about children and young people services at the trust. The trust took an average of 49 working days to investigate and close complaints. This was not in line with their complaints management policy, which stated the target response for all complaints was 30 working days. However, at the time of inspection children and young people services had managed to clear the backlog of complaints responses.
- The common themes for complaints related to a lack of care of attention and treatment (37%). Paediatrics speciality had the highest number of complaints (24, 80%), followed by ear, nose and throat (2, 7%), orthopaedics (2, 7%), dermatology (1, 3%), and urology (1, 3%). By location, outpatients department had the highest number of complaints (11, 37%), Dolphin and Penguin assessment unit (4 each, 13%), Pearl, and theatres (1 each, 3%). The remaining nine (30%) were 'other' services within children and young people.
- We saw information was displayed in wards and departments explaining how parents, children, and young people could raise their concerns or complaints. In addition, we also saw the number of complaints received for October 2016, prominently displayed on the entrance to wards and departments. For example, we saw on the entrance to Dolphin ward and Penguin assessment unit that they had received no complaints in October 2016.
- Staff were aware of the complaints process. Staff told us they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process. Staff were aware of any complaints made about their own ward or department and any subsequent learning.

Are services for children and young people well-led?

Good

At our last inspection in 2015, we rated the children and young people services as good for well led. On this inspection we have maintained a rating of good.

At this inspection we rated the children and young people services for well-led as good because:

- There was evidence of good clinical leadership within the medical and nursing teams. We saw examples of innovative developments to improve the patient outcomes and experience.
- Staff felt proud to work for the trust and supported the trust shared vision and values.
- Staff believed that they continued to strive to improve safety for patients after the last inspection.
- It was apparent from parents that they felt confident in the care their children received, and supported the trusts vision of providing safe, clean and personal care.
- Leadership of individual aspects of the children's services was good as staff spoke positively about their immediate team managers and leaders.
- Staff felt they culture has improved within the trust following the last inspection.

Leadership of service

- There was effective nursing leadership at all levels in the children and young people services, with the matrons and head of nursing being visible and approachable, supporting the staff and families. We witnessed good interaction between medical and nursing leadership.
- Staff told us they felt well supported by their immediate line manager. They felt there was a clear management structure within the team and leaders and senior staff were very approachable. If there were any conflict within the service, they would go to their line manager and seek support.
- Since the last inspection, staff who worked with children and infants told us that clinical leadership continued to be good and they received timely and appropriate support from their immediate line managers on a daily basis.
- Emergency staff, nursing and medical, felt supported by their immediate line managers and described they were visible and approachable.
- Medical staff felt that the new senior management team listened to suggestions and were more visible since the last inspection.

Vision and strategy for this service

- Staff remained positive since the last inspection when they spoke about providing high quality care, which supported the trust-wide vision of ensuring patients received safe, clean and personal care.
- Staff were able to describe the trust shared vision and values, and spoke about how they continued to work towards the same goals when caring for children and young people.
- The all-encompassing vision and strategy that attributed to the overall provision of children's services at the trust was identified at the last inspection, which continued at this inspection. We saw staff embraced the vision and strategy in the provision of neonatal intensive care, acute care and day care provisions, and outpatients and community paediatric services.
- All the staff we spoke with told us the communication strategy developed by the Chief Executive since the last inspection continued to be successful. However, some staff said that whilst the weekly messages were helpful, the daily messages created too much information that they did not pay attention to.

Governance, risk management and quality measurement

- An analysis of the 2016 children's risk register summary provided by the trust prior to this inspection showed this service was able to continue the implementation of action plans and controls to reduce risks, as identified at the last inspection. We saw that the risks were being reviewed and updated regularly.
- We saw register that the lack of dedicated children's recovery areas had been identified as a risk on the risk register. From our review, we saw that that some risk reduction strategies has been put in place, for example, the use of screen to separate children and young people from adult patients in recovery. We also saw for sunderland day unit the lead nurse is liaising with estates department to build a solid wall to separate children and young people from adults in the department. However, there was limited mention about any risk reducing strategies for recovery in main theatres, other than reference to the main theatres project of 2015/2016.
- We saw, as at our last inspection, arrangements were in place for governance, risk management, and quality measurement associated with the care of children and infants across the trust. We found the arrangements continued to enable them to measure their performance and service quality.
- Regular governance meetings in the children's services were held where topics such as incidents, education and training, risks, audits, referrals, policies, complaints, guidelines and research were considered. These meetings were well attended with minutes that showed actions taken and learning shared with staff.
- Doctors and other health care professionals told us the meetings across children's services continued to be an effective strategy to escalate risks where required. These meetings and the associated quality board meetings facilitated monitoring of action plans, and to consider and reflect on situations when the delivery of care had

not gone according to plan. Topics considered were serious incidents, safeguarding concerns, reviews of existing and new risks, reviews of policies and medical pathways, financial, and human resource performance.

- Clinical governance meetings were held regularly across the children's services and these were well attended. These meetings discussed standard agenda items such as incidents, safeguarding, care pathways, risk register, complaints, and compliments received. Prior to our inspection, we saw the minutes of the paediatric governance and management meetings held in July and August 2016, which confirmed this.
- Staff regularly monitored the neonatal care accountability scoreboard on the neonatal unit, which displayed quality standards. The quality standard covered the care provided for babies in need of specialist neonatal services including neonatal special, high-dependency, intensive or surgical care services and transfer services. Some examples of the care covered were health outcomes, skills and multidisciplinary staff, needs assessment, transfer arrangements, encouraging parental involvement in care and breastfeeding. The scoreboard was visible to all staff, patients, parents, and visitors. This provided them to view the definitions of high quality care and was a way for staff to maintain those quality standards. This followed National Institute for Health and Care Excellence (NICE) guidance 'neonatal specialist care: quality standard (QS24), October 2010'.

Culture within the service

- Staff talked positively about the service they provided: they enjoyed working at the trust. Some members of staff had worked there for many years. They felt part of the team and felt staff worked well together and supported each other. Morale appeared good.
- Between October 2015 and September 2016, the average sickness rate within nursing staff working in children and young people services was 5%, which was higher than the trust target of 4%. In the same period, the average sickness rate for medical staff within children and young people was 0.1%, which was lower than the trust target of 4%. This gave an indicator the departments were well run, and staff morale was high among medical staff.
- Most staff we spoke with remained feeling good working for the trust, with many of them having worked there for many years. They also felt the overall culture of the trust has improved since the last inspection as staff were encouraged to raise concerns.
- Staff and parents we spoke with praised the good care their children received. This was no different to the last inspection.
- There was an open and honest culture within the children and young people services at the trust. Staff we spoke with were candid throughout our inspection about their service and the areas were they wanted to do better. Staff felt valued and respected.
- Between October 2015 and September 2016, the average sickness rate within nursing staff working in children and young people services was 5%, which was higher than the trust target of 4%.
- Between October 2015 and September 2016, the average sickness rate for medical staff within children and young people was 0.1%, which was lower than the trust target of 4%. This gave an indicator the departments were well run, and staff morale was high among medical staff.

Public and Staff engagement

- The children's services held a monthly forum 'The Listening' where all unit staff were able to share their views about the impact of caring.
- The neonatal unit had plans to refurbish the transitional care unit to provide a more comfortable space for mothers and their babies in response to patients' feedback. The refurbishment would also provide mothers and babies privacy and dignity in a temperature-regulated unit.
- At the last inspection, staff confirmed that a '15 steps challenge' had been undertaken. The 15 Steps Challenge is a tool to help staff, patients and others to work together to identify improvements that will enhance the patient experience and was part of the NHS Institute for Innovations and Improvements productive ward series. During this inspection, the children and young people services across the hospital wards had adapted and expanded the 15 Steps Challenge by participating in the 'Perfect Ward challenge'. Staff we interviewed confirmed they used this web-based audit

tool to assist the wards to improve the quality of care by engaging with staff and patients at ward level. The tool audited areas such as friendly atmosphere, privacy and dignity of patients, completed patient assessments and observations, clear fire exits, tidy ward, staff challenging bare below the elbow, secure medical records, secure equipment when not used, fully secure doors, and medication with dates. We saw the audit reports for the children's wards, Penguin assessment unit, and neonatal unit between September and December 2016, which primarily scored over 90%. The reports clearly displayed the results in a simple format and areas requiring attention were clearly displayed.

- The neonatal unit had recently introduced a 'positivity tree', where staff could write thank you messages for staff who had gone 'above and beyond'. We saw the tree and noted there were multiple messages for staff who had been flexible with staying late on shift, to cover. Other messages included 'thank you' to staff that had supported them, during a difficult shift.

Innovation, improvement and sustainability

- The neonatal unit has introduced the use of an 'omnibed' care station. This was a portable power source that connects the 'omnibed', the incubator and radiant warmer in one device, and carries a ventilator to facilitate the movement of babies between the delivery suite and neonatal unit. This reduced the potential for clinical problems that result from interrupted patient thermal regular, which is vital in the first few hours following the birth of a very premature baby.
- The trust held an annual 'Celebrating Excellence Awards' to celebrate staff achievements and dedication. Several staff in the children's services had won awards such as employee of the year, hospital hero, and excellence in care. Some staff we spoke with told us that this was a good way of recognising staff that went the extra mile to improve patients' experience.
- The children and young people services at the trust had a strong culture of research and demonstrated the effectiveness of its care and procedures through research. We saw that the service was involved in various local and national research and innovation development projects. These included: Probiotics in pregnancy (PiP) study, Magnetic Resonance Biomarkers in Neonatal Encephalopathy **(**MARBLE) and MARINEX study.

End of life care

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

Information about the service

End of Life Care (EoLC) encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in the trust and it consists of essential nursing care, bereavement support and mortuary services. The EoLC team provided support to any hospital inpatients whose death was recognised as imminent, along with their families and hospital staff responsible for their care. The EoLC team comprised of a Consultant in EoLC, a head of nursing, clinical nurse specialist and a sister/charge nurse.

At Medway Maritime Hospital (MMH), the palliative care team was separate to EoLC. While palliative care also includes caring for people nearing the end of life, the palliative care team at MMH was primarily responsible for helping people living with and controlling complex symptoms related to their terminal or progressive illness. In comparison to EoLC patients, those referred to the palliative care team could be managed for many months in the community (at home, nursing home or hospice) and only attend hospital during the more acute phases of their illness.

Specialist palliative care and residential hospice services were arranged by Medway clinical commissioning group (CCG) through another provider, and were therefore not included in this inspection. The CCG had commissioned a team of two consultants in palliative care, a clinical nurse specialist, a sister/charge nurse and an administrator. The palliative care team had office accommodation at the hospital but in a separate area to the EoLC team.

Both the EoLC and palliative care teams aimed to treat or manage pain and other physical symptoms as well as help patients and their families with any psychological, social or spiritual needs. Support with the legal aspects of last offices was provided by the patent affairs department, which employed a team leader and two administrators. An inter-faith spiritual care team was available at all times and comprised three Chaplains and 50 chaplaincy volunteers.

Mortuary and portering services

Mortuary care was delivered by a manager, three anatomical pathology technologists and an assistant. The department provided mortuary services to the trust, HM Coroner and external agencies such as the police authority and tissue donation services. The department was a public mortuary as well as the hospital mortuary and received community deaths referred by the Coroner from Medway, Swale and Maidstone. The mortuary received all hospital deaths pending release of the body to a designated funeral director. Mortuary staff facilitated viewings and formal identifications for all cases at the request of the bereaved or the Coroner's Office.

The mortuary also facilitated cases referred to the Coroner for post mortem examination. While the Mortuary did not undertake hospital-consented post mortem examinations, the Human Tissue Authority (HTA) licence enabled consent to be taken prior to transfer to another facility in the region. The majority of hospital-consented post mortem examinations resulted from pregnancy loss or neonatal deaths. As the mortuary was not equipped to deal with increased risk cases, those that had been identified or

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suspected as a risk of infection from 'category three' pathogens (types of bacteria, virus or other agents capable of causing specified diseases) were transferred to another facility in Kent.

The hospital portering team, led by two supervisors, supported a number of ward and mortuary activities related to EoLC and after death. The role focussed on the active transfer of deceased patients from hospital wards to the mortuary department, but it also included additional tasks and responsibilities out of working hours and when dealing with external agencies.

Background

At our last full inspection in 2015, we rated EoLC as requires improvement. At the time, we had concerns about governance, resources and equipment, training, procedures and policy. In particular, the trust had to improve compliance with anticipatory medication, provide EoLC training to staff and full seven-day EoLC services.

We conducted this inspection to follow up on these issues as well as progress against the trust action plans that were in place. Our inspection took place over two days (29 and 30 November 2016), when we visited wards and departments concerned with EoLC and reviewed information supplied prior to our visit and provided during the inspection. We considered feedback from the staff focus groups and written communications from stakeholders. We observed care, watched staff interacting with people using the service and made checks on the care environment and equipment.

We examined 14 sets of patients' notes and we spoke with three patients and their families along with 38 members of staff, including doctors and nurses at varying levels of seniority, allied healthcare professionals, hospital chaplains, managers, health care assistants, administrative and portering staff. In addition, our report took account of the latest staff survey results published in January 2017.

Summary of findings

At our last inspection in September 2015, we rated end of life care (EoLC) overall as requires improvement and said the trust had to improve compliance with anticipatory medication, provide EoLC training to hospital staff and full seven-day services.

On this inspection we have EoLC as requires improvement, because:

- While there had been considerable work done to improve the service, we found the governance structure was not well established. It remained unclear that EoLC governance could be fully demonstrated at this stage and we concluded it was too soon to tell if the measures being implemented translated to established systems that effectively monitored and managed clinical quality and performance.
- Senior managers readily and transparently acknowledged this and stated EoLC was on an improvement 'journey', which was consistent with our own observations and comments made to us by staff and patients.
- Side rooms and interview rooms were not always available for patients at the end of their lives or their families. Facilities were not available for relatives to stay by the bedside and the hospital did not always provide the appropriate surrounding and privacy relatives required.
- Patients did not have face-to-face palliative care services seven days a week.
- It was unclear if actions and discussions from the EoLC steering group were shared widely across teams.
- Death certificates were not always issued in a timely way.

However,

- We found that the EoLC team had significantly increased in size and demonstrated a high level of

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specialist knowledge. There was a newly implemented leadership structure that had resulted in improved policy, procedures and a daily presence on the wards.

- There were sufficient staff with the right skills and staff had been provided with mandatory and additional training for their roles. Completion rates for mandatory training were better than trust targets.
- There was openness and transparency about safety. Staff understood and fulfilled their responsibilities to report incidents and near misses and were supported when they did.
- The departments we visited were visibly clean and there were appropriate systems to prevent and control healthcare associated infections. There was sufficient equipment available to meet patients' needs.
- Mortuary services had received investment that resulted in increased capacity and improved facilities.
- In the majority of patients' medical records, we found 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) orders prominently presented at the front of the record folder.
- Medicines were managed safely in accordance with legal requirements and anticipatory prescribing was utilised effectively.
- EoLC staff were sensitive, caring, and professional. Patients' complex symptoms were controlled and patients and those close to them were supported.
- Spiritual and religious support was available through the interfaith spiritual care team. The chapel, recuperation rooms and viewing suite in the mortuary were suitable to meet the needs of service users and their families.

Are end of life care services safe?

Good

At our last inspection, we rated safe as requires improvement. On this inspection we have changed the rating to good. This reflects improvements in incident coding, staffing levels, equipment provision and mandatory training compliance.

At this inspection we rated end of life care (EoLC) as good because:

- There was openness and transparency about safety. Staff understood and fulfilled their responsibilities to report incidents and near misses and were supported when they did.
- There were sufficient staff with the right skills and staff had been provided with mandatory and additional training for their roles. Completion rates for mandatory training including key topics such as safeguarding was better than targets set by the trust.
- The departments we visited were visibly clean and there were appropriate systems to prevent and control healthcare associated infections. We saw that areas were equipped with sufficient and suitable equipment.
- We saw that medicines were managed safely in accordance with legal requirements and anticipatory prescribing was utilised more effectively compared to our last inspection.

However,

- While we saw a number of strategies implemented to improve the way lessons were learned and communicated, it remained unclear if actions resulted from steering group discussions or if the discussions were shared more widely across teams.
- In the majority of patients' medical records, we found 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) orders prominently presented at the front of the record folder, however, some forms were harder to locate in the file and this had caused problems during the year.

Incidents

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- Clinical and portering staff reported incidents on a trust-wide electronic reporting system. They confirmed they had received training and felt confident using the system. Incidents logged on the system were shared throughout the hospital and discussed at ward or team meetings and we saw minutes confirming this. Mortuary services utilised an additional electronic incident system that was part of pathology services quality management. This helped show compliance with standards set by licencing bodies such as the Human Tissue Authority (HTA) and the software included processes for reporting and investigating quality incidents as well as documentation controls and equipment records.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between September 2015 and August 2016 the trust reported no incidents which were classified as never events for end of life care (EoLC).
- The trust reported no serious incidents (SIs) in EoLC which met the reporting criteria set by NHS England between September 2015 and August 2016.
- Twenty-seven incidents were reported for EoLC between September 2015 and August 2016. Of these, 12 resulted in 'no harm' and 12 resulted in 'low harm'. The most frequently reported incident type was delay in treatment or failure to monitor, which correlated with complaints themes such as lack of care and privacy, delay in pain relief or delay in medication). While higher incident numbers were reported in February, April and July 2016, there was no correlation with months recording higher number of complaints.
- Three incidents resulted in moderate harm. These were resuscitation attempts against a valid DNACPR or pursuing active treatment prior to consultation with a palliative care consultant. Two occurred in late 2015 and one in August 2016.
- The incident total had reduced since our last inspection and we saw that a number of strategies had been implemented to improve the way lessons were learned and communicated. For instance, EoLC was one of the topics of a 'theme of the week' introduced by the trust to improve internal messaging. Improved notification of EoLC cases, the establishment of a link nurse network, a new education package and daily ward visits by the EoLC team had also addressed communications. We found evidence that the recently established end of life steering group routinely discussed incidents and complaints at their meetings, although it remained unclear if actions resulted from steering group discussions or if the discussions were shared more widely across teams.
- We saw an example of a 'near miss' recorded on the trust-wide system that indicated a good safety culture existed in the organisation. A porter checked the request for transport of a deceased patient with the on-call mortuary technologist prior to attending the ward when new instructions had been received by email after normal working hours.
- The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The trust had developed an e-learning DoC package directing relevant staff through the principles and concept. DoC was included in the template used by the incident reporting software, which automatically alerted investigating managers and blocked progress if the relevant section was incomplete. This facility meant the trust had assurance that DoC was being correctly applied by all involved in the reporting process.
- Departmental heads and clinical staff we spoke to had good awareness of the duty of candour and their responsibilities under it, although none could recall an incident occurring in EoLC of the severity required to trigger the duty. EoLC managers stated that 'moderate harm' incidents reported elsewhere in the hospital were processed be the relevant clinical manager in line with the duty of candour policy.

Cleanliness, infection control and hygiene

- We inspected EoLC facilities provided for the use of patients and their families, which included interview and recuperation rooms along with adjoining staff and public toilets, the chapel and the viewing suite in the mortuary complex. All areas were visibly clean and tidy.

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- Patient led assessments of the care environment (PLACE) are conducted by patient and staff representatives and national guidelines set out the areas of the hospital to be reviewed each year. In 2016, MFT scored 99% for cleanliness, which was an improvement over the 2015 and 2014 results and just better than the England average of 98%.
- Mortuary storage, receiving and transfer areas appeared clean and free from clutter. Flooring in the complex was made from seamless, smooth, slip-resistant material that complied with Health Building Note (HBN) 00-09: Infection control in the built environment (Department of Health, March 2013). The flooring had been improved since our last visit.
- We saw antimicrobial hand-rub dispensers mounted on the walls at ward and department entrances. All contained sufficient gel and we observed staff and visitors using the gel. We also saw information displayed above handwashing sinks in toilets. These demonstrated the 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines on hand hygiene in health care. Lever-operated taps were in place, with liquid soap dispensers and paper hand-towel dispensers nearby, which was in line with HBN 00-09.
- Ward and departmental staff wore clean uniforms and observed the 'bare below the elbows' policy. Personal protective equipment (PPE) was available for use by staff in all relevant areas. Porters described using gloves and gowns when transferring a deceased person from the bed to the trolley in the wards. PPE was then removed during transit and if necessary worn again on arrival at the mortuary.
- Guidance was available to reduce the risk of spreading an infection when providing care for people after death. We saw examples of this documented in the trust's Mortuary policy, training notes for porters and the 'End of Life Care – Nursing Care after Death' policy. We saw that policies included the wearing of gloves, aprons and the use of body bags. Staff we spoke with were familiar with the policy documents and we saw that adequate supplies of body bags were available.

Environment and equipment

- During our inspection, we visited six wards and the chapel, mortuary and patients affairs departments. Overall, the areas we observed supported the safe performance of procedures and delivery of care. Security of access was achieved where necessary by entry phone and keyless door locks. Rooms were well-lit, air-conditioned where required and supplied with sufficient equipment. The Chapel, interview, recuperation and viewing rooms were appropriately decorated and furnished with comfortable seating.
- The 2016 PLACE audit for the condition, appearance and maintenance of the hospital was 89%, which was better than the scores achieved in 2014 and 2015, but remained worse than the England average of 93%.
- Since our last inspection, the trust had changed to nationally recommended ambulatory syringe pumps. These devices delivered consistent infusions of medication to help patients keep pain and other symptoms under control. They offered improved safety features such as code-protected programmes pre-configured and locked into the pump memory. Staff were positive about the new equipment and managers told us that eight of the devices were "in store" and a further 10 were on order. Patients were usually discharged home with the syringe driver in place, which raised the risk that syringe drivers could be lost from stock. EoLC staff explained that they had received good support from community nurses and GPs and had recovered devices without problems.
- Ward staff told us they had access to equipment needed for caring for patients at the end of their lives including ambulatory syringe pumps, pressure relieving air mattresses and air cushions. These were readily available and there were no issues about securing equipment to support patients.
- The Medicines and Healthcare Products Regulatory Agency's Managing Medical Devices (April 2015) states that healthcare organisations should risk assess to ensure that the safety checks carried out on portable electrical equipment are appropriate and reasonably practical. These include pre-use testing of new devices and maintenance tests. We checked a sample of devices in each of the departments we visited. These had been labelled with the dates of the most recent electrical testing, which provided staff with a visual check that the items had been examined to ensure they were safe to use. We also saw furniture and equipment labelled with

asset numbers and service or calibration dates. These helped hospital managers identify, control and maintain equipment in accordance with manufacturer recommendations and hospital policy.

Environment and equipment

- We saw a number of improvements in mortuary facilities and equipment compared to our last inspection. Building work was underway in the viewing suite, which incorporated a new entrance and enhanced layout, utilising redundant office space. The refrigeration units had been upgraded with re-built refrigeration motors and more bariatric shelving provided. Mortuary capacity had been increased to 104 spaces using specialist mobile refrigeration units. We saw records confirming that fixed and portable equipment such as refrigeration units and hydraulic trolleys were regularly serviced. Staff there reported no issues replacing damaged equipment.
- Mortuary fridge temperatures were monitored and managed electronically and on-call mortuary staff were able to view the temperatures remotely. If the fridges were outside the range after a set time, the on call technician was paged. The premises were secured by keyless entry phone systems and CCTV cameras monitored key parts of the facility, including the private entrance and parking area reserved for community undertakers.
- The mortuary had a private ambulance to speed journeys across the hospital site. The department had also purchased a transport cover that was a three dimensional expandable cube that fitted over any size of hospital bed or patient trolley. This enabled the portering team to move the deceased discreetly and with more dignity than having to transfer the body onto a concealment trolley. The device could be quickly adjusted in size, which made it faster to employ and suitable for use with bariatric patients as well as children. Staff were positive about the device and said it also improved the capacity of the service they offered.

Medicines

- The EoLC team had produced a number of documents supporting safe prescribing and early intervention to help ensure distressing symptoms were controlled immediately. These included information leaflets designed for staff and families, which clearly set out expectations for the care to be provided and management of patients who had been recognised as dying.
- Anticipatory prescribing was utilised as part of EoLC. This prescribing technique recognises each patient has individual needs, but many events during the last days of life can be predicted and management measures put in place in advance. We saw anticipatory prescribing algorithms for the treatment of dyspnoea (breathlessness), nausea and vomiting, respiratory tract secretions, pain and agitation or restlessness. These documents were clearly presented and included phone and pager contact details. Medical staff we spoke to told us they were helpful.
- We reviewed the Medication Administration Record (MAR) charts for three patients who were receiving end of life care. These were legibly completed in line with trust policy. Managers stated that pre-printed labels were planned for use to assist with the anticipatory prescribing and it was hoped these would be introduced in 2017.
- Any EoLC patients discharged from hospital were dispensed with a ‘crisis medication pack’ and advice sheet. This ensured that patients had all their prescribed medication available to them on discharge, which helped maintain symptom control.
- We saw that anticipatory medication for end of life care was readily available. In addition to existing ward stock, reserve drugs was available in an 'EoLC emergency box' secured outside the hospital pharmacy.
- Those medications that were controlled drugs (CDs) were handled appropriately and stored securely, demonstrating compliance with relevant legislation. Staff working on the wards checked controlled drugs daily and when we looked through the contents of the CD cupboard against the controlled drug register we found they were correct. We observed locks were installed on all storerooms, cupboards, and fridges containing medicines and intravenous fluids. Nursing staff held medication cupboard keys.

Records

- Ward staff were completing the ‘Individualised Care Plan’ which included daily reviews that demonstrated a

minimum of four-hourly review of symptoms and comfort measures including food and oral care had been addressed. A new EoLC version of the form had been just introduced (November 2016) which was similar to the palliative care version we saw in earlier files.

- We saw there were appropriate reviews by the consultant and other healthcare professionals such as occupational therapists and physiotherapists as well as referrals made to speech and language therapists to ensure end of life patients received adequate nutrition and hydration.
- In the majority of patients' medical records, we found 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) orders prominently presented at the front of the record folder. This helped to ensure clinical staff were kept aware of the order. However, some forms were harder to locate and we noted two incident reports in the last year where CPR had been commenced when a valid order had been missed during handover. We checked resuscitation coded incidents over the last year and saw these were isolated instances.
- We saw the results of an audit undertaken on 'Do not attempt cardiopulmonary resuscitation' (DNACPR) orders that showed 94% of patients DNAR had forms at the front of their notes. This was consistent with our observations and we noted that the EoLC team continued to monitor compliance through daily ward visits.
- Ward staff we spoke to were clear on the DNACPR review policy and EoLC team members were well aware of the incidents and had addressed this in the EoLC educational programme and in routine monitoring.
- We saw that medical records were stored securely on the wards, and patient confidentiality was protected.
- We checked the mortuary register and records archive. The register was neatly and legibly completed and the archive room secure and well organised. In the register, we observed that deaths had occurred in a variety of ward and department locations, which was consistent with a normal pattern of patient outcomes.
- There were clear recording systems in the mortuary for the admission and storage of deceased patients and their discharge to the care of funeral services. Managers told us that a new electronic register was being trialled. They told us this was "working well" and was seen as a positive step in improving and automating the data management in the department.
- When we visited the patient affairs office we saw that effective systems were in place to process death, burial and cremation certificates.
- There was no electronic palliative or EoLC system to share information across providers in the region. Managers said that local GP's and the ambulance service used different systems, which dictated the use of paper handover notes and discharge letters.

Safeguarding

- We found that staff had safeguarding training at the appropriate levels for their roles and all those we spoke with were alert to any potential issues with adults or children.
- The trust had adopted a 'Quick guide to Safeguarding', which was clearly presented and included simple flow charts and key contact numbers to aid staff recognise and respond to any concerns. We also saw versions of the flow-charts and pathways for adults and children displayed on notice boards in ward and staff offices.
- Staff explained that they undertook on-line safeguarding courses as part of their annual mandatory training. EoLC staff met the trust target of 80% for both child and adult safeguarding course completion.

Mandatory training

- The trust had a programme of mandatory training which included Adult Life Support, Conflict Resolution, Equality & Diversity, Fire Training, Health & Safety, Infection Control levels 1 & 2, Information Governance, Manual Handling Practical & Theory, Safeguarding Adults levels 1 & 2 and Safeguarding Children levels 1 & 2.
- Managers demonstrated how they could access the system, which automatically "flagged" training completion. Training status was included in monthly divisional meetings and we saw reports generated using the system that showed the mortuary team had achieved 100% mandatory training compliance.

- This was significantly better than the target of 80% and the trust overall average of 89%. According to trust data, EoLC and 'Other' staff groups (including chaplaincy, portering and patient affairs) achieved 81% compliance, which was above the trust target.

Assessing and responding to patient risk

- The trust employed a number of strategies to guide and assist staff to identify and respond to patient risk. For example, physiological parameters such as pulse and temperature were monitored in line with National Institute for Health and Care Excellence (NICE) guidelines and a standardised early warning scoring system (called National Early Warning System or NEWS) was employed to identify patients whose condition may be deteriorating.
- To assist medical staff in responding to the assessed risk, the hospital resuscitation committee had approved a resuscitation treatment escalation plan (TEP), which was printed on the reverse of the DNACPR form. This was designed to record medical consideration of escalation of care in the event of deterioration and completion of the form was required for every in-patient within 24 hours of admission, excluding maternity and paediatric cases. This form helped ensure that all staff concerned with the patient understood the extent of their illness and who to involve in the escalation of their care.
- The TEP was reviewed a clinician if there was a change in the patient's condition that suggested that the TEP decision was no longer appropriate. For EoLC patients however, further review was considered unlikely. Patients deemed unfit for critical care or at end of life also had the DNACPR order (printed on the other side) completed. The original DNACPR was kept with the patient on discharge and a photocopy placed in the patient's notes. We saw examples of correctly completed TEP and DNACPR forms in the patient files we reviewed.
- For patients where the progression of their illness was clear, the amount of clinical intervention and observations were reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible at all times. Staff told us that any changes to the frequency of monitoring was discussed with patients and their families to ensure they understood and that this was recorded on the care plan.

Nursing staffing

- Nursing staff levels on the EoLC team had increased significantly since our last inspection. The EOLC nurses provided weekday advice and support to patients, relatives, and staff on all aspects of end of life care, including complex symptom control, patient involvement in decision-making and staff training.
- EoLC link nurses were available on each ward. We saw that 25 link nurses had agreed to take on the role and more were being sought for next year. We learned that ED did not have a link nurse. The matron was trying to find a volunteer and cited high turnover in the department as one of the barriers.
- The establishment and number of EoLC team nurses in post was reported at 2.8 whole time equivalent (WTE), compared to one person in 2015. The two EoLC nurse practitioners were seconded to the department until March 2017. The head of nursing stated that they had already commenced a business case to make the posts substantive and did not expect any problems in obtaining approval. This meant that staff cover was available for sickness or annual leave. No agency staff were employed.

Medical staffing

- Since our last inspection, medical staffing had also increased. A substantive EoLC consultant was in post, which was additional to the two consultants commissioned by the CCG as part of the palliative care team.
- Given the combined establishments of the palliative and EoLC teams, the trust met the 'commissioning guidance for specialist palliative care (2012)' minimum requirement of one WTE consultant and one WTE nurse specialist per 250 beds.

Other staff groups

- Three salaried chaplains were in post, supported by a pool of 50 chaplaincy volunteers.

End of life care

- Porters told us their team had been increased in size and the number of temporary positions had been reduced with staff being offered permanent positions. Some team members were allocated permanently to high-demand areas of the hospital.
- One of the mortuary technicians was about to complete their traineeship, which meant the department would be fully staffed. According to trust data, the mortuary services team performed better than trust targets for vacancy rates and turnover. Sickness was reported at 0.4%, which was better than the trust target of 4%. No locum or bank staff were used during the reporting period.

Major incident awareness and training

- The trust had business continuity plans in place which covered major incidents that could affect EoLC such as refrigeration failure, loss of staff or building services, flood or fire.
- Mortuary services contingency plans relied on the use of mobile mortuary refrigeration units, which could be leased from an established specialist supplier and mutual support agreements with other mortuary services in the region. The mortuary manager stated that two mobile units had already been leased as part of the trust's winter preparedness programme. The hospital had also purchased a private ambulance to facilitate transfer to the mobile units.
- All mortuary staff had read the policy and tested the policy using a 'table top' exercise annually.

Are end of life care services effective?

Good

At our last inspection in September 2015, we rated effective for end of life care (EoLC) as requires improvement. On this inspection we have changed the rating to good, as we saw significant improvements in key areas such as policy and processes, staff development and training.

At this inspection we rated EoLC as good because:

- New policies and documents had been introduced based on national recommendations and we saw that people had comprehensive assessments of their needs. Outcomes were identified and care and treatment was regularly reviewed and updated.
- Staff were qualified and had the skills they need to carry out their roles effectively.
- The learning needs of EoLC staff were identified and training provided to meet these needs. Staff were well supported to maintain and further develop their professional skills and experience.
- When people received care from a range of 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.
- EoLC staff and those from other disciplines worked collaboratively to understand and meet the range and complexity of patients and their relatives' needs at the end of life.

However,

- Access to face-to-face palliative care services were not available seven days a week.

Evidence-based care and treatment

- The individualised care plan was based on nationally recognised standards developed by NICE and other stakeholders such as the Leadership Alliance for the care of Dying People.
- We reviewed 14 sets of medical records and saw the EoLC team had provided evidence-based advice on key aspects of care such as symptom control and support for patients and their families as they passed along the care pathway. This meant that the trust had assurance that clinical expertise was effectively employed to ensure high quality care was delivered.
- Overall, we found that the trust policy and strategy utilised best practice and legislation to assist it develop the EoLC service and delivery of care. These included National Institute for Health and Care Excellence (NICE) quality standards and guidelines (QS13 and NG31) as well as other key references, such as 'Actions for End of Life Care 2014' (NHS England) and 'The 5 Priorities for Care of the Dying person 2014' (The Leadership Alliance for the care of Dying People).

End of life care

- The trust had responded to recommendations from an earlier review of the Liverpool Care Pathway, 'More Care, Less Pathway' (2013) and staff indicated this had been removed from practice some time ago. We saw confirmation in the EoLC policy documents (June 2016) and this showed the trust had responded to concerns regarding the pathway and informed staff of its removal.
- The EoLC team had just introduced a new individualised care plans based on the '5 priorities of care' recommended by the Leadership Alliance. This meant that there was more guidance for ward and departmental staff caring for end of life patients based on national recommendations and evidenced based care.

Pain relief

- Effective pain control was an integral part of the delivery of effective end of life care. We spoke to ward staff who confirmed that pain levels were reviewed four hourly, which was consistent with the 'symptom observation chart' provided as part of the EoLC individualised care plan. The trust had adopted a 1-3 scale for the assessment of pain and other key indicators such as agitation and distress. Each column represented a four-hourly period and clearly specified this as the minimum requirement for observations. Each column had space for the registered nurse and doctor to sign, which meant staff and managers could identify the individuals involved. The chart included clear instructions on escalation should a score of three occur (i.e. does not improve following medication). If the nurse recorded three consecutive scores of two, escalation to the medical team was also mandated. The form included daytime contact details for both EoLC and palliative care teams. We noted that some of the columns on the version we saw were misaligned, making it unnecessarily difficult to match signatures with time slots.
- We reviewed two sets of medical records that confirmed pain assessments levels were routinely noted together with vital signs and pain was promptly treated. In addition, we noted that 'intentional rounding' was employed by staff to help monitor key aspects of care including pain and comfort. We saw examples of completed forms that indicated the rounds were undertaken.
- We saw examples of laminated communication charts designed for patients with altered hearing or learning disability. These contained 'smiley faces' used to help evaluate pain patients may be experiencing and was used in conjunction with clinical observations including facial, vocal and behavioural signs.
- The trust had published a number of information leaflets designed for staff and patients or their relatives. The 'End of Life Care Information for Relatives and Carers' leaflet provided basic guidance on EoLC prescribing and medication. This was in line with NICE guideline QG31 and meant that patients and carers had adequate information when opioids were used
- We were unable to find information about the ambulatory syringe driver, but staff told us they could obtain suitable leaflets from the equipment store when the devices were required.

Nutrition and hydration

- We saw advice leaflets (dated March 2014) displayed on wards that contained helpful and clear information for relatives about diminished need for food and drink during EoLC. This included advice about the importance of mouth care as well as the use of artificial fluids (a drip). The leaflet also set clear expectations about how staff would discuss and review these aspects with relatives and carers during the end of life process.
- Nurses and support staff we spoke with understood the needs of patients they were caring for and the importance of ensuring they had adequate food and drink when appropriate. We saw that elderly or frail patients underwent risk assessments on ward admission, which included an evaluation using the malnutrition universal screening tool (MUST). This helped staff identify patients at risk of poor nutrition, dehydration and swallowing difficulties and prompted further referral to hospital dieticians if needed. We noted that the dietetic service was contracted to the same provider as the palliative care team.
- The EoLC 'Individualised Care Plan' also included prompts about nutrition and hydration along with advice on involving the patient and relatives in decisions about nutritional and fluid requirements. This is recognised as good practice to discuss the role of

nutrition and hydration with relatives of dying patients, as a perceived lack of adequate food and fluid intake can be a source of distress for relatives of a dying patient.

- In the notes we examined, we saw records of referrals and reviews by Speech and Language therapists if patients were identified as being at risk of poor nutrition, dehydration, and swallowing difficulties.
- We saw that a variety of foods was available to support patients including soft and pureed food on the wards we visited. Patients had drinks left within reach and wards had protected mealtimes, which meant that non-urgent clinical activity was stopped to allow patients time to eat and staff to offer assistance.
- Food and fluid intake was monitored using food charts and fluid balance charts. We saw these being used and completed accurately on the wards we visited.
- We also saw coloured meal trays and jugs being used to indicate patients who needed help eating and encouragement to drink. Patients who were unable to feed themselves were assisted by the nurses and clinical support workers.

Patient outcomes

- The trust participated in the 'ran by the Royal College of Physicians. Five key clinical performance indicators (KPIs) were measured, along with eight organisational KPIs.
- In the 2016 audit, the trust performed better than the England average for four of the five clinical KPIs. This was an improvement compared to our last inspection. The trust scored particularly well for KPI 3: 'is there documented evidence that the patient was given an opportunity to have concerns listened to?' with 93% of cases in the trust having such documentation. By comparison, the national average was 84%.
- The trust answered 'Yes' to two of the eight organisational indicators. The trust responded 'No' to 'between 1 April 2014 and 31 March 2015, did formal in-house training include/cover specifically communication skills for care in the last hours or days of life for medical staff?' This was worse than the national response (71%) and managers acknowledged the organisational KPIs needed to improve and cited a number of actions already implemented to address this.
- We saw evidence of local audits in progress. The EoLC team were auditing the new notification system in preparation for the first review scheduled for December. Mortuary staff were able to describe the last offices mortuary audit, which was performeddaily and included information such as patient's name, ward, date and time of death, mortuary arrival date and time, notification of death complete, identity bands present, incontinencepad present and one white linen sheet used over patient.

Competent staff

- The trust target for completion of staff appraisals was 95%. Between April 2015 and March 2016, the trust reported a staff appraisal rate for nursing of 73% and an average of 60% across other staff groups, all of which were worse than the trust target. According to local records, EoLC and mortuary services had achieved 100% compliance.
- Staff we spoke with in EoLC found the appraisal process was useful and an opportunity to identify learning and training needs. The trust had approved funding for both EoLC clinical nurse specialists to attend the MSc and BSc for Palliative and End of Life Care Symptom Management course, which demonstrated a commitment to developing these staff in their new roles.
- The EoLC team also utilised a network of 'link nurses' to help train and inform ward staff as well as being patient advocates. Twenty-five ward nurses had volunteered and had received education and support that helped them cascade training to colleagues. These topics included the 'Five priorities of care', new policies and documentation. Link nurses also helped staff identify the difference between palliative and end of life care patients.
- We saw records showing that each ward had at least one link nurse and EoLC team staff said they hoped to increase this number in 2017. A link nurse study evening had been held on 17 November and we saw copies of the agenda and presentation material delivered at the event. We spoke to presenters and link nurses who agreed the evening has been "very successful" and were positive about the impact of the training. Eighteen of the 25 link nurses attended and the EoLC team provided individual updates to those that missed the event. We saw steering group minutes that confirmed study

afternoons or evenings would be offered every three months with a pre-circulated agenda allowing the link nurses to request additional topics of interest. The next training evening was planned for February 2017 and would focus on bereavement support.

- The EoLC team had also prepared an e-learning package to support the implementation of the new care plan, which was due to "go live" on 5 December 2016. Further training had also been booked with the manufacturer of the ambulatory syringe pumps and a rolling programme was due to start on 2 December 2016.
- Portering staff attended biennial training sessions conducted by the mortuary manager and technical staff. The course was designed to give staff the skills to transfer deceased patients from hospital wards to the Mortuary department. The training also covered instruction for tasks carried out by porters outside of normal working hours. We saw examples of a newly revised course (October 2016) which had been prepared for the next training day scheduled for December 2016. The training days were run at intervals agreed between the mortuary and portering managers and portering staff were not permitted to lead a task until they had been 'signed off' on a register we viewed. Portering managers conducted their own 'in-service' training on the use of the new transfer device, based on material provided by the manufacture.
- Mortuary technical staff participated in additional skills training and peer competency assessments, which were mandated by the HTA and reviewed annually. We saw copies of recent assessments.
- Chaplaincy volunteers received trust orientation and mentoring for six weeks after commencement. They met weekly for administration and case-focussed learning as well as attending a conference arranged by the trust annually. The chaplains also attended nursing skills course and presented 'essential spiritual care in the NHS' to new starters every two weeks.
- The EoLC team itself was well regarded by the staff they supported. For instance, a nurse on Bronte Ward told us the team were "magnificent" and "always approachable". Another staff member on Lawrence Ward said "they are really knowledgeable" and "the doctors respect what the EoLC team have advised".

Multidisciplinary working

- Managers stated that communication between the palliative care and EoLC teams had been encouraged to help alleviate duplication of patient caseload and transfer patients between teams as necessary. The teams conferred each morning to discuss caseloads and exchange information.
- The mortuary manager and chaplain attended meetings of the EoL steering group and played active roles in the development of policy and procedure as well as problem solving.
- Porters, mortuary, patient services staff and ward staff all described good working relationships and were complementary about the EoLC team.

Seven-day services

- Since our last inspection, there had been no changes in the hours worked by the EOLC team, mortuary staff, patient affairs office or chaplaincy.
- A key recommendation of the National Care of the Dying Audit (2014) was that hospitals should provide a face-to-face specialist palliative care service from at least 0900 to 1700, seven days per week to support the care of dying patients and their families, carers or advocates.
- The trust did not meet this as EoLC services worked from Mondays to Fridays. According to trust policy, palliative care specialists (employed by another provider) were available seven days a week, but this was not known by staff we spoke with. They said the Wisdom Hospice provided telephone advice and support to hospital staff outside normal hours. The telephone service was not normally available to relatives of the EoLC patient.
- The mortuary was open 0800 to 1600 Monday to Friday. Staff provided a 24-hour on-call service seven days a week.
- The Chaplaincy service was available 0900 to 1700 Monday to Friday with an on-call service after these hours. Services were held on Sundays and Friday lunchtimes. We were told that the chapel was locked after hours following an incident of vandalism.
- The pharmacy was open seven days a week and an emergency drug cupboard was accessible to authorised

staff after hours. Pharmacists provided a ward service at the weekends as well as an on-call service for urgent advice. This meant that discharge medicines could be authorised and dispensed without undue delays.

- We saw arrangements in place to ensure key diagnostic services were available after hours such as imaging and pathology. Medical staff we spoke to were confident they could access services when they needed them.

Access to information

- Overall, we found that ward staff had access to the information they required to provide patient care to those at the end of life. This was better than our last visit and improvements included daily ward rounds by EoLC staff, the introduction of new policy and better communications such as the electronic notification system.
- We were shown the EoLC resource page on the trust intranet and staff demonstrated to us that the website was clear and easy to use.
- We saw that records for EoLC patients contained care plans, anticipatory medications and evidence of multidisciplinary input into their care and treatment. This also indicated that access to information within the trust was effective.
- The website replaced resource folders (called 'purple boxes') which had been located on each ward or department. However, we noted these had been removed just prior to our arrival and a small number of staff we spoke to were unaware of the change.
- EoLC and palliative care team staff told us that both teams conferred each morning by telephone or personal visit to discuss patients who had been admitted to the hospital or identified through the EoLC notification system. The teams had separate office accommodation and staff felt both groups would benefit from being co-located. This had been proposed to the trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had an in-date policy on consent, which incorporated the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) policy.
- The trust provided staff with DoLS training as part of the mandatory adult safeguarding modules.Staff completed DoLS and MCA training online using an internet-based training system. Staff confirmed the system was easy to use and convenient, as it was possible to access the secure website from any home PC with an internet connection. MCA training compliance was 87% and above target.
- We observed several occasions when doctors and nurses sought the consent of patients before an intervention and we saw patient notes that indicated this was also completed by allied healthcare professionals such as physiotherapists and speech therapists.
- Clinical staff were aware of the DoLS and we were shown the process followed and the forms used.
- The mortuary staff were able to describe the processes in place regarding consent for removal of human tissue which followed the NHS Tissue Authority recommendations.

Are end of life care services caring?

Good

We have maintained the same rating as we found on our last inspection. We rated end of life care (EoLC) as good because:

- We saw EoLC staff perform patient reviews and interactions in a sensitive, caring, and professional manner, engaging well with the patient. The patient's complex symptom control needs were met and the supportive needs of both the patient and relative were addressed.
- We saw staff who were respectful to patients and their relatives. Patient dignity and comfort was a priority and we saw this attitude reflected in the staff working for mortuary services, patient affairs and portering.
- Mortuary staff reported the nursing staff appropriately prepared deceased patients after death in line with hospital policy. Nursing and Mortuary staff confirmed hospital porters transferred deceased patients to the mortuary in a discreet and respectful manner.

End of life care

- Spiritual and religious support was available through the interfaith spiritual care team. The chapel was open daily for patients and families to visit and facilities for other religions and cultures were available.

However,

- Side rooms on wards could be prioritised for use by patients with infectious conditions, which meant that EoLC patients and their families did not always have their needs met in private and dignified surroundings.

Compassionate care

- According to the 2016 patient-led assessment of the care environment (PLACE) audit, the trust performed worse than the England average for privacy, dignity and wellbeing. Scores deteriorated by about 10% compared to the 2015 audit.
- The trust's Friends and Family Test (FFT) performance was consistently worse than the England average between November 2015 and October 2016. In the latest monthly period, October 2016, the trust performance was 85% compared to an England average of 95%.
- However, these indicators did not fully reflect our observations in End of Life Care (EoLC). We found that hospital staff provided individualised care to patients who were at the end of life. We saw compassionate and caring staff who were respectful to patients and their relatives. Patient dignity and comfort was a priority and we saw this attitude reflected in the staff working for mortuary services, patient affairs and portering. For instance, we consistently observed staff introducing themselves to patients and their relatives and knocking before entering treatment or side rooms.
- All wards we visited had side rooms that could be used to accommodate the dying patient and private contemplative areas were provided in the main hospital, mortuary and patient services office. However, side rooms on wards could be prioritised for use by patients with infectious conditions, which meant that EoLC patients and their families did not always have their needs met in private and dignified surroundings.
- Patients and their relatives were complimentary about the care and attention they had received. They felt involved in their care and provided adequate information at the times they needed it. They also felt they had time given to ask questions and that their questions were answered in a way they could understand. Relatives were encouraged to participate in the care of patients when this was appropriate. For example, we observed relatives assisting with feeding and personal care.
- The trust provided results of a recent survey that asked bereaved relatives a variety of questions to gain an understanding of the EoLC delivered across the trust. From the survey, 92% of respondents rated the overall service at "excellent" or "good".
- Nursing and mortuary staff confirmed that hospital porters transferred deceased patients to the mortuary in a discreet and respectful manner. The mortuary staff ensured, from the documentation, that any particular religious or cultural wishes were respected. Mortuary staff said the porters treated the deceased patients with respect during the mortuary processes.

Understanding and involvement of patients and those close to them

- We saw patient notes that indicated patients referred to the EoLC team were kept actively involved in their own care and their relatives involved in the management of the patient. This was supported in our conversations with relatives. Staff also commented that they liked to include families as much as possible in caring for their relative but only as much as they wanted to be involved.
- The resuscitation treatment escalation plan (TEP) was discussed with the patient unless there was a reason to believe that this would cause significant harm. Likewise, if a relative or friend had a Lasting Power of Attorney for Health and Welfare (LPA) they were consulted. The role of the LPA was to represent the views of the patient in the decision making process, and while they could not insist on resuscitation, the LPA could decline treatment on behalf of the patient.
- We were shown a copy of a 'family communication sheet', which was intended to enable relatives or friends to record observations, comments or suggestions for review by the EoLC team. We did not see a completed version in use at the time of our inspection.
- EoLC facilities provided by the trust to encourage the involvement of relatives included free car parking, unrestricted visiting hours and use of a communal quiet room. The communal rest area called the 'Cedar Room'

was located near the Chapel and available 24 hours a day. Entry was controlled by keypad and staff knew the entry code to give to families. The suite included a variety of soft furnishings, a kitchenette and telephone.

Emotional support

- The hospital EoLC team provided face-to-face care and support for patients at the end of their life and their relatives. Out of hours, the hospice could be contacted by frontline staff for telephone advice and support.
- We saw that referrals to bereavement services had been made through the person's GP or CRUSE bereavement services.
- The hospital Chaplains provided spiritual and pastoral support to people of all faiths including those who were unsure of their beliefs or had no preference. Chaplaincy Volunteers were assigned to wards and visited weekly to talk to any patients on request as well identify any who had specific needs that could be met by the team or by a representative of their own faith group. In addition, visitors or relatives could make a request for a chaplain to follow up with a further visit or contact a faith representative. Chaplains were on-call 24 hours a day and we saw contact details published in leaflets and displayed on noticeboards. The chaplaincy maintained a list of local interfaith contacts and the hospital switchboard held a copy of the details of faith leaders willing to be contacted.
- Patients, staff and visitors were encouraged to attend non-denominational chapel services held weekly and a visiting service made available on the wards. No facilities existed for services to be broadcast within the hospital. The Chaplin stated that the inter-faith spiritual care team received more referrals from Wakely, Keats, Byron, Tennyson and Pembroke wards compared to other parts of the hospital. This indicated that nursing and care staff were aware of the spiritual needs of patients in these areas.
- While no spiritual training was given to medical or nursing staff, the Chaplaincy worked to ensure all were aware of the spiritual support available and encouraged contact through forums such as the Schwartz rounds.
- The Chaplain spoke about the special needs of EoLC patients without relatives. In these cases, the chaplaincy offered last rites and helped coordinate arrangements with funeral directors contracted to the trust.
- We learned of other positive examples of meeting individual needs. These included the Chaplain officiating at funerals at the request of the bereaved and weddings arranged with the support of relatives and the EoLC team. Memory trees had been introduced into the Chapel and a visitor we met appreciated this feature. The trust also provided screens and prayer mats for Friday prayers, which were led by a consultant volunteer of the Muslim faith.
- Overall, we found that patients had their physical and psychological needs regularly assessed in line with NICE QS 15. Compared to our last inspection, we also found improvements in the way the trust supported EoLC patients and their relatives emotionally. Initiatives outlined already included the training and provision of link nurses, EoLC educational programmes, new policy and care plans. Staff were supported by the interfaith chaplaincy either as individuals or through forums such as Schwartz rounds.

Are end of life care services responsive?

Requires improvement

We have maintained the same rating as our last inspection although we acknowledge the improvements achieved in mortuary services and other areas. We rated end of life care (EoLC) as requires improvement because:

- Side rooms and interview rooms were not always available for patients at the end of their lives or their families.
- Facilities were not made available for relatives to stay by the bedside and the hospital did not always provide the appropriate surrounding and privacy relatives required.
- Death certificates were not always issued in a timely way.
- The end of life steering group routinely discussed incidents and complaints and we saw improved notification and daily monitoring of EoLC patents.

- Local audit programmes had been implemented to measure these responses, although it was too early to conclude that the lessons from sources such as complaints, incidents, audits and the EoLC feedback survey were shared widely across teams.

  However,

- We saw that mortuary services had planned and prepared for seasonal variation in demand and we found similar improvement in the way EoLC was planned and delivered to meet the needs of service users. This included active preparations for regional coordination, improved discharge arrangements and advance care planning.

Service planning and delivery to meet the needs of local people

- The EoL steering group was actively preparing a strategy scheduled for agreement by the trust and the newly established Medway and Swale End of Life Care (EoLC) programme board in March 2017. The Medway and Swale EoL programme board was formed by Medway and Swales CCGs and the board, chaired by a commissioner, was focused on delivering improved quality and outcomes, patient experience and effective use of resources as well as implementation of the national EoLC strategy. This showed the trust was collaborating with partners to meet the needs of the local population.
- The strategic objectives also included completion of monthly audits of all EoLC notification forms submitted by wards; an annual audit of 50 sets of notes of patient deaths, reviewing the use of the individualised plan of care and an annual audit of the rapid discharge home programme. We noted this process had started with the collation of the new notification forms in preparation for the next quarterly steering group meeting in December.
- While we acknowledge the progress made in EoLC service planning, the newness of policies, procedures and post-implementation auditing limited our ability to say that the practices were fully embedded. We saw that the provider was actively working towards accounting for how responsive their EoLC service is.
- Mortuary services showed us the preparations in place for winter, which included extra capacity, dedicated vehicle and mutual support agreements with other facilities in the region. This indicated the trust had planned and prepared for seasonal increases in death rates.
- When 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.
- The chapel, interview and recuperation rooms along with the viewing suite in the mortuary were suitable to meet the needs of service users and their families. However, we noted that 'camp beds' were not made available for relatives to stay by the bedside. Staff explained that families would use chairs available at the bedsides.
- On the wards, we saw that staff used the day room or nurse's office to provide a quiet place for relatives. These rooms did not always provide the appropriate surrounding and privacy relatives required at such a time.

Meeting people's individual needs

- Where the preferred place of death was known, staff endeavoured to facilitate this and utilised the rapid discharge home scheme when appropriate. We saw evidence of agreement with the local ambulance service for a two-hour response time to transport the EoLC patient home or hospice and staff told us this "worked well". We also noted that the rapid discharge home algorithm was integrated into the comfort plan for the dying patient used by the palliative care team as well as the individualised EoLC plan.
- The wards had side rooms where they could accommodate the dying patient. In practice, this depended whether it was appropriate and whether the room was available. For example, on occasions the side rooms were occupied by patients with infectious conditions and could not be moved. If a patient was nursed in a bay, privacy was maintained by keeping the curtains drawn, if requested by the patient or family.
- As part of its improvement strategy and action plan, the EoLC team had introduced an online notification system utilising the hospital intranet. Notifications were automatically logged and distributed ready for review each morning. EoLC CNS would then visit patients

during their daily ward round. The executive lead for EoLC said that auditing of the system has just commenced and the first audit was due to be published in December. Early indications were positive and this was confirmed by ward staff who demonstrated how they accessed the system to us.

- A number of faith groups among patients attending the hospital. Just over 40% or patients belonged to the Anglican or Protestant faith, 6% Catholic or Orthodox, and approximately 1% each representing Muslim, Sikh, Hindu and other faiths. The remainder either did not record a religion or stated they were atheist.
- In addition, the end of life Steering Group had recently introduced EoLC individualised care plans and on 3 October a new electronic notification. Some 70 notifications had been received since. We reviewed 11 EoLC notifications made over a week and found all had been completed by a senior doctor and were appropriate given the patient's diagnosis and circumstances.
- Based on the 'five priorities of care', the individualised care plan was designed to help ward staff identify common risks and document care delivered. We found two versions of care plan at the hospital: one for palliative care and a newly introduced version for EoLC. Both versions were clearly marked and staff knew of the difference between the two. We asked staff on Tennyson Ward to demonstrate obtaining the relevant guidance and leaflets available on the trust's EoLC webpage. Using a staff login, they were able to locate and print the relevant papers easily and rapidly. This indicated that the hospital had effective systems for secure dissemination of controlled documents.
- The front page of the care plan contained clear reminders on how to notify the EoLC team; when and how to contact the palliative care team and out of hours contact details for the Wisdom Hospice.
- Ward staff explained that under certain circumstances, the deceased would not be washed. This happened when the death was referred to the coroner and we saw this clearly explained in the relevant EoLC policy and instruction. Additionally, the mortuary did not have facilities available to relatives for washing of the deceased, which had been requested on occasion. All staff we spoke to were sensitive about the faith and cultural needs of service users at the end of life and told us they worked as flexibly as possible to meet these needs.
- The time taken to issue a death certificate was a concern to some families and this could be compounded by the fact that the certifying doctor was working night shift or a locum not based at the hospital. The patient affairs supervisor outlined the procedures in place to minimise delays and escalate concerns to senior medical staff for rapid resolution.
- We saw advice leaflets designed for relatives (dated March 2014) which contained clear information about the changes that occur when people are dying. These were on display in wards and other locations such as patient affairs, the chapel and the Cedar room.
- In addition, we saw leaflets explaining chaplaincy services, last offices and the role of the Coroners course in ward locations and the viewing suite in the mortuary.
- The leaflets we saw were written in English. Staff confirmed that other language versions were not generally provided, although telephone translation services were available if required.
- While visiting times to wards were controlled for the majority of service users, the needs of EoLC patients and their loved ones were also met through unrestricted visiting hours, free car parking and communal quiet room which was made available 24 hours a day on request.
- The hospital also participated in the Butterfly scheme. The result of work by a non-profit foundation, the national scheme focused on memory support for patients who opted to display a special butterfly symbol. Staff were trained and supported by colleagues acing as butterfly schemechampions with the aim of improved recognition and response to patients who have dementia or other conditions that may affect their mental capacity.

Access and flow

- Medway NHS Foundation Trust (MFT) had 1,332 deaths between April 2015 and March 2016 and of this number, 975 had been referred to the end of life care (EoLC)

team. Of this number, 95 patients had been diagnosed with cancer and 919 had other illnesses or conditions. Overall referrals had increased by 175 from the year before, which represented a 21% increase.

- All patients with complex symptoms within the trust who required end of life care had access to the palliative care or EoLC team from Monday to Friday (9am to 5pm). Outside these hours, frontline clinical staff could contact the Wisdom Hospice for advice and support. Treatment and care took account of the patient's individual needs and included. Working in conjunction with other specialist nurses to support patients with complex symptoms as well as those needs cared for by ward nursing teams.
- We saw that the EoLC was notified by the admitting or treating doctor using a newly introduced electronic notification system. The recognition that a person is dying was also indicated on the trust's electronic bed occupancy system. The trust specified that EoLC patients should not be moved to other areas unless under exceptional circumstances. Ward staff confirmed that this seldom happened in practice.
- If an EoLC patient was admitted to one of the short stay wards Wakely or Gundolph, we were told they were transferred to a ward as a priority unless they were assessed as showing signs that death was imminent.
- The trust had commenced a rapid discharge to home programme to facilitate the transfer of EoLC patients from the hospital to their preferred place of care such as their own home or hospice. This helped to ensure they were discharged with appropriate medication and documentation such as a valid DNACPR as well as community prescription sheets for all anticipatory medications. The programme included a priority service supplied by the local ambulance service with a timeframe of 1-2 hours from when the request was made.
- We saw policy and procedure documents that confirmed staff explanations about the process at end of life. Death was certified by a medial practitioner or in the case of an expected death a registered nurse authorised by the trust (such as the site nurse practitioner). Once completed, caring for the deceased then included personal hygiene needs, which incorporated the person's wishes and religious, spiritual or cultural preferences. Relatives or those important to the person were given the opportunity to stay and participate in the care with their loved one. Time was allowed for this and relatives were also given support and advice leaflets and contact numbers of the nurse in charge of the ward as they left the hospital.
- Relatives were provided with the contact details of the patient affairs office who would then confirm the details with them by phone and arrange an appointment to collect the deceased's belongings and the medical certificate of cause of death. Staff were instructed to inform relatives that it may take 48-72 hours to obtain the death certificate and that the patient affairs office would contact the relatives at the earliest of opportunity.
- At the patient affairs interview, the relatives were given written information providing help and advice about registering the death. They were also offered a copy of the Medway End of Life Care Survey should they wish to share their experience of EoLC.
- Two porters would convey the deceased person to the mortuary out of hours as per hospital policy and had key codes to access the premises.
- Mortuary viewings normally took place during working hours but could be arranged outside these times in exceptional circumstance. Viewings were supported by the mortuary administrator or manager.

Learning from complaints and concerns

- The EoLC service received relatively few complaints. Between August 2015 and July 2016, there were 16 complaints about aspects of EoLC. The most frequently complained about specialty was general medicine with 11 complaints. The most frequently occurring themes for complaint were lack of care or attention and treatment (mentioned in eight complaints) and delay in pain relief (mentioned in six complaints). The CQC received two enquiries relating to EoLC between August 2015 and November 2016. Of these, one was a complement and one was an adult safeguarding concern that was resolved by the trust
- The EOL steering group obtained agreement for the trust complaints manager in May 2016 to copy any EoLC complaints to the EoLC team CNS. We saw meeting notes that indicated the EoL steering group routinely

discussed incidents and complaints at meetings. Early responses from the steering group included improved notification and daily monitoring of EoLC patents by the CNS that focussed on issues such as pain relief and assurance processes such as comfort rounds. Local audits had also commenced to measure these responses and the first results were due to be presented at the December EoL steering group meeting.

- The complaint process demonstrated there were systems to respond to complaints and we noted the steering group was part of an improved governance structure with included multidisciplinary membership and was itself linked to a newly formed stakeholder body (the Medway and Swale EoLC group).

Are end of life care services well-led?

Requires improvement

At our last inspection in September 2015, we rated the service as inadequate. At the time, we found the end of life care (EoLC) service had significant governance issues. There was no governance framework to support delivery of care and it was unclear at the time what EoLC responsibility the chief nurse held. There was no comprehensive assurance system or service performance measures in place and staff on the wards were unsure about their roles in delivering EoLC.

At this inspection we have changed this to requires improvement, because:

- We saw examples of the draft EoLC strategy that was due to be agreed by the trust and the Medway and Swale EoLC programme board in March 2017. Similarly, there were other governance and quality measures either just implemented or in prospect.
- While there had been considerable work done to improve the service, we found in some respects the governance structure was not well established. It remained unclear that governance could be fully demonstrated at this stage.
- We found it was too soon to tell if the measures in progress translated to established systems effectively monitoring and managing clinical quality and performance. Senior managers readily and transparently acknowledged this and stated EoLC was on an improvement 'journey'.
- While we saw clear lines of communications and examples of operational problem solving between EoLC and palliative care teams, we were less certain about how the trust and commissioning body measured and managed the strategic direction of the service.

However,

- The trust had addressed governance issues through new policy and the implementation of an end of life steering group with representation from a range of staff groups. We saw plans supporting a number of initiatives either in place or recently introduced.
- The trust had introduced a new vision, values and objectives. EoLC staff and others we spoke to knew and understood the vision and values and spoke positively about the changes and the "improvement journey".
- The local leadership was strong and forward thinking. Staff told us the EoLC team were approachable and visible.
- EoLC staff expressed confidence in the new governance and management systems that had already commenced or were planned.

Vision and strategy for this service

- Overall, we found significant improvements since we last inspected end of life care (EoLC) in 2015. The trust had introduced new vision, values and objectives, which were widely publicised in newsletters, the intranet and at strategic locations throughout the hospital, including audio-visual displays in the main reception.
- Key aspects of the EoLC strategy included the introduction of an advance care plan and further development of the rapid discharge 'Home to Die' pathway. The trust intended to increase awareness and use of advance care planning tools within the GP community for patients thought to be in the last year of life. The advance care plan helped to ensure a smooth transition of care for EoLC patients, if needed, between community services and hospital or hospice. We saw trust report papers and strategy documents that indicated the advance care plan was programmed for approval by stakeholders in January 2017.

End of life care

- Managers and staff confirmed that EoLC were already working to embed 'Priorities for Care of the dying person' and develop EoLC competency and training programmes. Other identified objectives included improvements to the patient affairs service.
- We observed a number of initiatives already in place or just introduced as part of the trust's recovery strategy. We saw a copy of the EoLC action plan, which was consistent with the data presented to us and our observations and discussions with staff. This demonstrated that the trust was actively addressing issues identified previously and working towards the intentions contained in the new strategy.
- We also saw elements of the vision and values being integrated into new EoLC policies as well as activities such as staff appraisal and training. The vision was the 'best of care, best of people' and the values statement was '(being) bold, every person counts, sharing and open, together'. End of Life Care (EoLC) staff and others we spoke to knew and understood the vision and values and spoke positively about the changes.
- We saw an example of the EoLC vision and strategy document due to be agreed by the trust and the Medway and Swale EoLC programme board in March 2017. This body had been recently established by the Medway CCG to coordinate EoLC across the region and was chaired by a CCG Commissioner.

Governance, risk management and quality measurement

- At our last inspection, we found that the EoLC service had significant governance issues. There was no governance framework to support delivery of good quality care and it was unclear at the time what EoLC responsibility the chief nurse held. There was no comprehensive assurance system or service performance measures and staff on the wards were unsure about their roles in delivering EoLC.
- While there had been considerable work done to improve this since, we found in some respects the governance structure was not well established. Senior managers readily and transparently acknowledged this and stated the service was on an improvement 'journey'. The Director of Nursing had been appointed as the executive lead for EoLC and was supported in this role by a head of nursing and a named non-executive director. The trust has implemented an end of life steering group, which was multidisciplinary and included manager level representation from mortuary services, patient affairs and the interfaith spiritual care team.
- The EoL steering group had commenced bi-monthly meetings and was made responsible for the delivery of the Trust's EoLC improvement programme. This group also worked with the recently established Medway and Swale care programme board, representing the CCGs and with a focus on regional and nations EoLC governance and strategy.
- We saw terms of reference published by the trust in preparation for the replacement of the EoL steering group by a larger and more formal 'End of Life Care Group' (EoLG). This was due to start in December 2016 under the umbrella of the trust's patient experience group. The EoLG would continue to report quarterly to the quality improvement group but now via the patient experience forum. The quality improvement group was an executive level board chaired in rotation by the Director of Nursing, Medical Director and Chief Quality Officer.
- We noted the terms of reference stipulated that EoLC would be discussed at trust level annually by the provision of an annual report. This demonstrated an enhanced focus on ensuring EoLC remained visible at trust level and improve accountability.
- The Chair of the EoLG was the Head of Nursing Standards and Practice on behalf of the Director of Nursing, who remained the executive lead for EoLC. The EoLC Consultant was the Deputy Chair and membership of the group included a non-executive director, CNS, Mortuary Manager, Patient Affairs Manager and Lead Chaplain with senior representatives from dietetics, wards and ED, medicine and surgery departments, learning and development, a general practitioner and Medway CCG. This demonstrated a commitment by the trust to a multidisciplinary approach that also involved key stakeholder representatives.
- We saw examples of improved risk management, including entries in the trust's EoLC risk register, which did not exist when we last visited. EoLC and mortuary staff we spoke to were familiar with the risk register and gave examples of its use.

End of life care

- The mortuary complex was licenced and regulated by the Human Tissue Authority (HTA). We saw copies of controlled documents such as policies and procedures as well as records and quality checks relating to the on-going HTA monitoring and inspection program.
- Although based at MFT, another provider employed the palliative care team. According to the new EoLC policy, the role of the care team was to support the education of health care professionals in the trust caring for palliative and EoLC patients and provide advice or support to clinical staff in the management of patients who are dying (including out of hours advice utilising the Wisdom Hospice). This service included the provision of ward based hospice nurses and a consultant or associate specialist in palliative medicine available 24 hours a day seven days a week to support and advise senior medical colleagues about complex or difficult clinical situations.
- Some ward staff we spoke to were less clear about the separation of roles between the two teams. EoLC managers stated that both teams were well aware of the potential for confusion and pointed to initiatives such as the daily ward visits, use of the link nurses and ongoing training to help identify the sources of any confusion and address them. EoLC staff also emphasised the value of the morning 'case conference' between both teams, which was felt to be an effective problem-solving tool.
- We saw that the palliative care team was informally represented on the EoL steering group, although we remained uncertain about the arrangements between the trust and commissioning body for measurement of performance, oversight and strategic direction.

Leadership of service

- EoLC continued to draw upon expertise and support from the relationship with Guys and St Thomas' NHS Foundation Trust.
- Staff we spoke to across the trust were passionate and committed to delivering quality care to the dying patient, the deceased and their relatives at what is generally considered a challenging and distressing time for all involved.
- We saw numerous examples of effective management in the mortuary service, portering and patient affairs office. We also saw that the chaplaincy were visible, responsive and involved in policy development and education. The lead chaplain led an effective interfaith spiritual care team and likewise felt well integrated into EoLC.
- The EoLC nursing team performed better than trust targets for vacancy rates (8%), turnover (8%) and sickness (4%).

Culture within the service

- The EoLC teams felt more engaged and valued. Staff told us that they had benefitted from clearer lines of accountability and responsibility along with effective processes and policies that either had been recently introduced or were under active development.
- EoLC was being emphasised across the trust as everyone's responsibility. We examples of this through a variety of methods such as the education programme, thematic displays and multidisciplinary governance arrangements. This helped the EoLC team to work collaboratively with nursing and medical staff and we saw instances illustrating the respect between specialties and disciplines.

Public and staff engagement

- Public engagement in terms of planning EoLC services and strategy was limited, although we noted that plans for the new EoLCG included stakeholder members drawn from outside the trust.
- Within the hospital, we saw numerous examples of the way staff involved in the care of EoLC patients worked to actively engage an involve service users and their families.
- The trust conducted an EoLC survey, which was requested by the patient affairs office when the bereaved attended the hospital to collect the medical certificate of death and other relevant papers. This request was made to the relatives of all adult in hospital deaths and managers stated that the results were benchmarked against the national voices survey of bereaved relatives.
- The chaplaincy also facilitated 'Schwartz Rounds' within the hospital. These were multi-disciplinary forums where staff discussed, in confidence, emotional dilemmas that arose in caring for terminally ill patients.

- The format followed a standard model and is based on recent cases or themes such as 'when things go wrong' or 'a patient I'll never forget'. Experiences were shared from the perspective of the panel and the emphasis was on the emotional impact rather than clinical issues. We saw evidence that monthly Schwartz rounds were held in a seminar room during lunchtimes and had attracted a cross-section of staff ranging from consultants to support and administrative workers. We saw future dates published in the trust newsletter ('News@Medway') and staff said sessions had been well attended.
- We were told that the chief executive conducted weekly open meetings, which were "packed with staff"; although some commented that clinical staff could not always be released to attend due to work pressure. However, we found that this was not reflected in remarks made to us be EoLC staff. We attributed this to the smaller and specialised nature of the work undertaken by the departments involved in EoLC.

Innovation, improvement and sustainability

- The trust was a member of the recently established Medway & Swale EoLC Programme, which aimed at driving change in the regional health system to deliver improved EoLC quality and outcomes, patient experience and value for money.
- Improvements objectives of the board included the development of best practice pathways across primary, community and secondary care ensuring strong links with social care. We concluded these were positive steps but too soon to tell if the forum would deliver sustainable change.
- The trust was in discussion with a company that provided telephone-based advisory systems, which will enable patients to have monitoring at home when discharged. It was hoped this would complement and enhance the EoLC rapid discharge programme. In addition, part of the process included the retrieval of ambulatory syringe pumps for return to the trust when no longer needed.

Outpatients and diagnostic imaging

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

Information about the service

Medway Maritime Hospital provides outpatient appointments for a variety of specialities where assessment, treatment, monitoring and follow up are required. The hospital has medical and surgical speciality clinics, as well as paediatric and obstetric clinics. There were 329,450 first and follow-up appointments between April 2015 and March 2016. The majority of these appointments were for the dermatology speciality with over 4000 appointments between September 2015 and August 2016.

The outpatient clinics are located in different areas, including outpatient areas one to seven located in the main building, with the phlebotomy department in an adjacent building on site.

The diagnostic imaging department carries out a range of procedures including x-rays, magnetic resonance imaging (MRI), computerised tomography (CT) and interventional radiology. The department had recently been awarded Imaging Service Accreditation Scheme (ISAS) accreditation. Between April 2015 and March 2016, 246,963 diagnostic imaging tests were carried out and reported by the department. The department was situated within the main outpatient area of the hospital, with an additional x-ray facility situated in area seven of the outpatient clinic area.

During the inspection we visited outpatient areas one to seven, phlebotomy, the patient booking centre and all diagnostic imaging departments. We spoke with 33 members of staff including managers, consultant radiologists, nursing staff and administrative staff. We spoke with eight patients and their relatives. We reviewed five sets of patient records. Prior to the inspection, 12 focus groups were held and staff from across the trust attended and shared their experiences of working at the hospital.

As part of our inspection, we looked at hospital policies and procedures, staff training records and audits. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the hospital.

Outpatients and diagnostic imaging

Summary of findings

At our last inspection, we rated outpatients and diagnostic imaging services as inadequate. On this inspection we have changed the rating to requires improvement because we have seen improvements in key areas such as assessing and responding to patient risk and learning from incidents, but improvements are still required in key areas such as access and risk management.

Overall we rated outpatient and diagnostic imaging departments at the Medway Maritime Hospital to require improvement. This was because:

- The vacancy, turnover and sickness rates for the departments were worse than the hospital's target. Nurse staffing levels for outpatients and diagnostic imaging were regularly below the planned levels.
- The patient led assessment of the care environment (PLACE) scores for condition, appearance and maintenance were worse than the national average.
- Environmental audits fell below the hospital target of 90%.
- The trust referral to treatment times (RTT) fell consistently below the 92% standard.
- The trust was performing worse than the operational standards set for cancer patients on two week, 62 day and 31 day treatment targets.
- Patients had been consistently waiting longer than the national average for diagnostic tests.
- Whilst the overall mandatory training target of 80% had been met by both departments, there were areas of poor compliance in safeguarding vulnerable adults and children, adult life support and infection control level two training.
- The hospital did not audit whether patient records were available for their consultations.
- Staff appraisal rates were worse than the hospital target for both outpatient and diagnostic imaging staff.
- There were no risks identified for the outpatient department.
- There was no strategy in place for the service, and although these were under development, staff we spoke with were unaware of these.

However:

- Clinical oversight of patients waiting over 52 weeks had been instigated and embedded into the service.
- The departments had systems and processes in place to keep patients free from harm. All staff we spoke with understood the incident reporting process and there was evidence of learning from incidents.
- We observed good radiation compliance as per national policy and guidelines during our visit. A radiation protection supervisor was on site for each test and a radiation protection advisor was contactable if required. This was in line with ionising regulations, 1999 and radiation (medical exposure) regulations (IR(ME)R), 2000.
- The diagnostic imaging department had recently been re-accredited by Imaging Services Accreditation Scheme (ISAS).
- Staff interacted with patients in a caring and considerate manner, and respected their dignity. Patients told us they felt the staff cared for them and this was reflected in the department friends and family test results.
- Staff felt their line mangers were visible and approachable and staff spoke of improvement in the overall culture at the hospital.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

At our last inspection, we rated safe as inadequate. On this inspection we have changed the rating to good because we have seen significant improvements in key areas such as assessing and responding to patient risk and learning from incidents.

Previously, it was identified that there was a lack of clinical oversight for patients waiting longer than the targets set for cancer and 18 week pathways. We saw evidence that clinical oversight had since been introduced and was embedded in the process of monitoring patient pathways. As well as weekly patient tracking list meetings there were electronic flags on computer systems to alert staff to patients going over their target dates. At our last inspection, processes were not in place to ensure that World Health Organisation (WHO) checklists were completed prior to interventional radiology procedures. We saw on this inspection that audits were now in place to monitor the completion of these and that compliance was good.

We rated safe as good because:

- Staff in the outpatient department had a good understanding of the incident reporting process.
- A previously identified issue regarding completion of World Health Organisation (WHO) checklists in interventional radiology had been resolved and improved, demonstrating learning.
- There was evidence that clinical harm reviews were being carried out on patients waiting 52 weeks or more.
- The outpatient nursing and administration teams had met the mandatory training compliance target set by the hospital.
- We observed good medicines management throughout the outpatient and diagnostic imaging departments.
- Patients were cared for in a visibly clean environment. The patient led assessment of the care environment (PLACE) score for cleanliness was better than the national average.
- Most of the Ionising Radiation (Medical Exposure) Regulations IR (ME) R 2000 incidents were reported to the Care Quality commission promptly.

However:

- The overall mandatory training target had been met by both departments overall, but safeguarding vulnerable adults and children level two fell beneath the hospital target of 80%.
- Patients brought to the imaging department from the emergency department did not always have medical or nursing staff accompanying them and there was no process in place for managing the risks around this.
- Nurse staffing levels for outpatients and diagnostic imaging were regularly below the planned levels and the vacancy, turnover and sickness rates in the outpatient and diagnostic imaging department were worse than the hospital's target.
- Whilst staff told us that patient records were usually available for clinic, the hospital did not monitor or audit this.
- The patient led assessment of the care environment (PLACE) scores for condition, appearance and maintenance were worse than the national average.
- Environmental audits fell below the hospital target of 90% compliance.

Incidents

- Between October 2015 and September 2016, the outpatient and diagnostic imaging department reported no incidents that were classified as never events. This showed an improvement from the previous year where one never event had been reported. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in outpatients and diagnostics which met the reporting criteria set by NHS England between September 2015 and August 2016.Each incident was reported under a separate incident type: diagnostic incident (including

delay), medication incident, radiation incident (including exposure when scanning), slips/trips/falls and treatment delay. We saw that investigations and root cause analysis (RCA) were completed for these incidents. This was an increase from the previous year where only two SIs were reported and could indicate an improved reporting culture.

- Staff in the outpatient and diagnostic imaging department used an electronic incident reporting system to record and manage incidents. Staff that we spoke to knew how to access this system and gave examples of incidents they would report.
- The outpatient and diagnostic imaging department reported 127 incidents to the National Reporting and Learning System (NRLS), which is a system for reporting and benchmarking patient safety incidents nationally.
- The majority of incidents resulted in no harm (106, 83.5%). On average 11 incidents per month were reported, however higher numbers of incidents were reported in January 2016 (20) and February 2016 (23). The highest reporting specialties were radiology (64) and general medicine (13). The most frequently reported incident type was 'other' with 23 incidents (18.1%). Twelve of these were related to documentation issues.
- There was a higher number of no harm incidents between September 2014 and August 2015 (175) compared to September 2015 and August 2016 (139) but in terms of a proportion of all incidents, there were more no harm incidents reported between September 2015 and August 2016 (84%) compared to September 2014 to August 2015 (79%).
- There were similar numbers of moderate harm incidents in the two periods and between September 2015 and August 2016 there were no incidents resulting in severe harm or death.
- Three out of the four incidents reported as causing moderate harm were in radiology. Certain radiology incidents are reportable under the Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2000 to the Care Quality Commission (CQC) under regulation 4 (5). Between August 2015 and September 2016, six radiology incidents were reported to the CQC. Two of the incidents reported at the end of 2015 were not reported in a prompt manner, however, the four incidents reported in 2016 were reported promptly, which demonstrated an improvement in the reporting culture.
- Staff had awareness of duty of candour but could not describe any recent examples of where this had been discharged within the outpatient or diagnostic imaging departments. Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.

Cleanliness, infection control and hygiene

- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance.
- PLACE audits were undertaken at a trust wide level only. The result for cleanliness was 98.76% which was marginally better than the national average of 98.06%, and an improvement on the hospital's 2015 response of 97.85%.
- We found that the environment was clean and well maintained in most areas. Patients that we spoke with thought the hospital was clean and we saw cleaning rotas and complete checklists in consulting rooms indicating they were regularly checked and cleaned.
- Environmental audits were completed in all areas of outpatients and diagnostic imaging. The audits covered areas such as care of equipment, documentation, environment, hand hygiene and personal protective equipment, sharp and waste management and the linen room. The compliance rate was 87%, which was worse than the target of 90%.
- All staff we saw in outpatient and diagnostic imaging departments were bare below the elbows, which was in line with the hospitals infection control policy.

Outpatients and diagnostic imaging

- Hand hygiene audits were completed within the individual areas in outpatients and diagnostic imaging. The hospitals target compliance for hand hygiene audits was 100%.
- The CT, breast screening, interventional radiology and ultrasound units had scored 100% in their monthly hand hygiene audits from April 2016 to October 2016. The MRI department had scored 100% on three of the last six months audited. However, between June and September 2016, general imaging scored 67%, which was below the below the target of 100%. This indicated they were not compliant with the code of practice for infection, prevention and control in this area.
- Outpatients had scored 100% in their hand hygiene audits from April to November 2016. We saw that the phlebotomy department had been audited three times since April 2016 and scored 100% at each audit. Results from hand hygiene audits and any issues arising from these were discussed at team meetings, which we saw the minutes from.
- In most outpatient areas we saw that disposable curtains were in use and these had all been changed within the last twelve months, which was in line with the trust infection control policy. However, the consultation rooms in area five used patterned fabric curtains. Because of the pattern on the curtains, it was not clear if the curtain had been soiled in any way, and there was no labelling or signage on the curtains indicating when they had last been cleaned or changed.
- We saw sharps bins were available in the treatment areas and consulting rooms. This demonstrated compliance with the health and safety regulation 2013 (The Sharps Regulations), 5 (1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps containers had been fully completed ensuring traceability of each container.
- Nasoendoscopes (cameras used to look inside the nose) were cleaned in a dedicated scope washer. Scopes were tracked – this could be done manually and had an electronic backup system to ensure traceability.
- We saw that waste was separated in different coloured bags to signify the different categories of waste in the rooms we saw. This was in accordance with Health Technical Memorandum (HTM): Safe Management of Healthcare Waste, control of substances hazardous to health (COSHH), and health and safety at work regulations.
- We saw posters displaying the process to follow in the events of a sharps injury.
- We saw personal, protective equipment (PPE) was available to staff if required.
- There were hand washing sinks available, in all patient examination areas, in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. Sanitising hand gel was readily available throughout the departments and corridors leading to the departments.

Environment and equipment

- The PLACE assessment score for condition, appearance and maintenance was 89%, which was worse than the national average score of 93%. However, this score demonstrated an improvement from the 2015 assessment which was 81%.
- We saw the equipment maintenance log for outpatient and diagnostic imaging. All equipment listed was either in date or scheduled for maintenance, with the exception of one set of patient weighing scales in the outpatient department and a defibrillator in the MRI department which the hospital confirmed had been updated after the inspection. We saw stickers on equipment indicating that they had been serviced in the last 12 months.
- We saw the most recent physics annual report for the diagnostic imaging department which took place in May 2016. This is a report that checks equipment such as the scanners and their service records to ensure they are up to date and we also saw all of the maintenance records.
- There were resus trolleys situated in area 5 and area 1. When we last inspected the resus trolley in area 5 was situated within a treatment room was considered a risk as it could not be accessed easily. We saw that this had now been moved into the main waiting area and was now easily accessible. We saw that the consumables within the trolley were in date and the defibrillator was charged. We saw that the trolley was checked weekly and saw checklists to demonstrate this for the previous

six months. In one of the trolleys we saw that an oxygen mask had no use by date – we checked this with staff who advised that the resus officer had advised this was still safe to use.

- A variety of disposable items of clinical equipment was available in treatment rooms and all items we checked were in date.
- The waiting rooms were spacious and had a sufficient amount and range of chairs available for waiting patients that we saw during our inspection. The hospital main reception had an area for outpatients to 'check-in' and they would then be directed to the relevant area for their appointment.

Medicines

- The trust had an in date policy for the safe and secure handling of medicines. The policy ensured that medicines were prescribed, stored and administered safely according to best practice.
- Some prescription medicines were controlled under misuse of drugs legislation and we saw that these controlled drugs were stored securely in lockable cupboards. Only a registered nurse such as the sister or staff nurse held the keys for this cupboard in line with the hospital policy.
- We saw medicines used for injection of contrast (dye agent) during imaging procedures was securely stored and in date.
- We checked medicines refrigerators within the outpatient department. We saw that the minimum and maximum temperatures were checked and recorded daily to ensure the temperature remained within the required range. This ensured that the medicine had been consistently stored at the correct temperature.
- We saw patient group directions (PGDs) for buscopan, multihance & Proliance and these were reviewed annually by the pharmacy team. PGDs are documents that allow the supply of certain medicines to groups of patients without requiring individual prescriptions.
- We saw the results of an FP10 (prescription) audit undertaken on areas one to seven in the outpatient department in October 2016. No major issues were identified, however it was noted that the logging form which documented which forms had been assigned to clinic and doctors, did not document patient names. This meant that it could not be identified which patient had been given a specific FP10. The audit team re-visited in November and the new logging form had been updated to comply with trust and national guidance.
- We observed that FP10s were kept in locked cupboards that only trained nurses had access to. Each FP10 that was taken was signed out and the number was logged, which we saw.
- The Medicines Health and Regulatory Agency (MHRA) monitored medicines within the nuclear medicines department and we saw the most recent inspection report from November 2016. This detailed no major or critical failures in the department, but did outline some other failures which the trust were in the process of responding to. Inspections are required every two years and provide independent assurance of systems and processes for the storage and management of these medicines.

Records

- The medical records library was situated off site and notes were requested for clinics through an electronic system. Staff showed us how they did this and told us that this system worked well. However, the trust was not able to provide us with figures demonstrating how many patients were seen in the outpatients department without the full medical record being available. This meant the hospital could not provide assurance that nursing and medical staff always had access to appropriate medical notes.
- Administrative staff we spoke with told us that patient notes were usually available for the clinic. The hospital told us that they hoped to start collecting this data from September 2016.
- Between August 2015 and August 2016, approximately 100 incidents reported by the outpatient department were related to documentation issues. Of those, more than half were incidents, where the wrong patient's notes were found misfiled in another patients notes. The second highest reported incident of this type was documentation not being completed when patients attended the plaster theatre.

Outpatients and diagnostic imaging

- During the inspection we saw that patient records were stored securely, and we saw records being transported to the outpatient clinic area in covered trolleys, protecting patient information. However, two incidents were reported between August 2015 and August 2016 where patient records were left unsecured and in one example on a reception desk overnight.
- We looked at five sets of patient record and saw that they were complete and legible with no loose filing. Each set had a patient identification sheet in situ, investigations that had been carried out and history sheets. We also saw NHS charge sheets present for overseas visitors which was in line with the Overseas Visitor Hospital Charging Regulations 2015.

Safeguarding

- Staff told us they accessed safeguarding training online and in the classroom and knew how to raise a safeguarding alert. The outpatient and imaging departments had raised one adult safeguarding and two children safeguarding alerts between September 2015 and August 2016.
- The target compliance for safeguarding training was 80%. Not all staff groups had completed the appropriate level of safeguarding training.
- The administration teams in both outpatients and diagnostic imaging were at 55% and 70% compliance respectively for safeguarding adults level one training, which was worse than the hospital target. However, these teams had both met or exceeded the hospital target for safeguarding children level one training, at 81% and 85% respectively.
- The overall compliance rate for outpatient nurses completing their safeguarding adults training (levels one and two) had met the hospital target of 80%. The overall compliance rate for safeguarding children's training (levels one and two) was better than the hospital target at 93%.
- However, the outpatient nurses compliance with safeguarding adults level two training was worse than the hospital target at 72%.
- The overall compliance rate for the diagnostic imaging department completing their safeguarding adults training (levels one and two) was better than the hospital target at 87%. The overall compliance rate for safeguarding children's training (levels one and two) was also better than the hospital target at 83%.
- However within these figures, the diagnostic imaging nursing staff had poor compliance with adult safeguarding training, with compliance rates of 76% and 0% respectively for safeguarding adults levels one and two. No members of the directorate and outpatient management team had completed safeguarding level two training.

Mandatory training

- Staff were required to undertake mandatory training courses which were designed to cover the areas where the provider was subject to regulation from other bodies and was under a duty to ensure that all staff complied. The courses included health and safety, information management, equality and diversity, vulnerable adults and children at risk.
- We saw the hospital's statutory and mandatory training procedure which applied to both substantive, locum and bank staff. Agency staff were required to be compliant as outlined in their individual contract and service level agreement with the agency.
- The hospital's mandatory training target was 80%. The outpatient nursing and administration teams had exceeded this target overall with 87% compliance. Two of the lowest compliance courses were adult and paediatric life support training, with 78% and 61% respectively.
- The diagnostic imaging department overall compliance with mandatory training was 84% which was better than the hospital target. However, there were three areas with poor compliance within the overall percentage. These were adult life support, fire training and infection control level two with overall compliance rates of 68%, 77% and 60% respectively, which was worse than the hospital target.
- Staff told us that training could be easily accessed online, and that some classes were supplemented by classroom or face to face learning.

Assessing and responding to patient risk

Outpatients and diagnostic imaging

- Staff in diagnostic imaging told us that patients who had been brought for CTs from the emergency department (ED) were sometimes left in the CT clinical preparation room (inpatient waiting area for CT) without a designated member of staff looking after them. We did not see unattended patients during our inspection, however staff told us that this regularly happened and gave an example where a patient had a fit and another patient alerted radiology staff who attended the patient. We checked the reported incidents and could not see one matching this description. The trust told us that the issue had been discussed, following our inspection, at the Emergency Department Trauma Board meeting. We saw the minutes from this meeting and that the issue had been raised, this was scheduled for further discussion at a further ED audit meeting.
- There was not a formal policy in place for the supervision of patients at the time of our inspection.
- In the MRI department, staff showed us how the tables detach from the scanner in the event of a cardiac arrest to allow easy and quick access to provide emergency care to the patient.
- We observed three safety huddles during our inspection and they varied in the content and length of time they took. One was in the CT department, and two within outpatients. The CT department huddle discussed upcoming procedures for the day, and advised staff regarding any identified issues, for example flushing of cannulas prior to use. This followed staff identifying issues with cannulas of patients from the wards the previous day. The staff member leading the huddle checked whether staff had any issues. They discussed an infectious patient was due for a procedure and that area would need to be deep cleaned afterwards. They updated staff on the progress of the new CT scanner.
- A radiation protection supervisor was on site for each diagnostic test and there was a contract with a local NHS trust for provision of a radiation protection adviser. This was in line with the Ionising Regulations 1999 (IR99) and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.
- At our last inspection, we found that patients referred on 18 week and two week wait pathways were not always monitored when they had been waiting longer than their target dates. During our inspection senior staff told us that there were now mitigations in place to ensure that these patients were reviewed by a clinician. We saw minutes from weekly Patient Tracking List (PTL) meetings, both for 18 week patient and cancer patients, which monitored compliance on the pathways and escalated any potential breaches and included patients approaching a 52 week wait. We saw three examples of patients that had waited 52 weeks or longer having a clinical review by the relevant speciality consultant. This indicated the clinician carrying out the review, the speciality, the contributing factors to the delay, a root cause analysis and recommendations for the patients' management.
- At our previous inspection, it was identified from a never event investigation that the World Health Organisation (WHO) checklist audits were not been fully completed prior to interventional radiology procedures. We saw copies of these audits had been undertaken since our last inspection which demonstrated that the learning from the never event had been embedded, and the audits demonstrated improved and consistent compliance with the checklist. The team had been auditing this monthly, but after regularly achieving 100% compliance, was now reducing the audit frequency to bi-monthly.

Nursing staffing

- The vacancy rate for nursing and midwifery staff in outpatients and diagnostic imaging was 14.8%,
- Between October 2015 and September 2016, the trust reported a turnover rate of 9.7% for nursing and midwifery staff in outpatients and diagnostic imaging. The trust target for turnover rate is 8%.
- The trust target for sickness rate is 4%. Between October 2015 and September 2016 the trust reported a sickness rate of 6.7% for nursing and midwifery staff in outpatients and diagnostic imaging which was worse than the trust target.
- Between April 2015 and March 2016, the trust reported a nursing bank and agency usage rate of 16.8% for outpatients and diagnostic imaging.
- We looked at the shift allocations for the outpatient department between April and July 2016. We saw the actual number of staffing fell beneath the planned amount of staffing in each of these months. For

registered nurses, this gap was between 3 and 19%, and for unqualified staff this ranged between 19 and 28%. This meant that staffing levels were regularly below the planned level.

Medical staffing

- The trust target for vacancy rate was 8%. As at July 2016 the trust reported a vacancy rate of 1.8% for medical and dental staff in Outpatients and Diagnostic Imaging
- The trust target for turnover rate was 8%. Between October 2015 and September 2016 there were no medical and dental staff reported in the turnover data for Outpatients and Diagnostic Imaging
- The trust target for sickness rate is 4%. Between October 2015 and September 2016 the trust reported a sickness rate of 1.5% for medical and dental staff in Outpatients and Diagnostic Imaging which was better than the trust target.

Major incident awareness and training

- Some staff were required to complete Emergency Preparedness Resilience and Response (EPPR) training. As at 21 November 2016, 52 members of staff had completed this training, 32 were nursing staff, and 20 were other staff, including administrative staff.
- Staff were able to give examples of major incidents that had occurred within the last twelve months where members of the outpatient and diagnostic imaging team had been involved in the response teams. They felt these incidents had gone smoothly and had received scenario training beforehand.
- We saw in date copies of the business continuity plans for outpatients and diagnostic imaging. Within diagnostic imaging, each modality (breast screening, CT, MRI, X-ray, interventional radiology & nursing support, ultrasound) had continuity plans. There were also continuity plans for the picture archiving system (PACS) and Radiology Information system (RIS) systems.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We saw improvements in competency of staff with additional training opportunities being offered, and in multidisciplinary team working in the service.

We inspected but did not rate effective, as we do not currently collect sufficient evidence to rate this.

We found:

- The diagnostic imaging department had recently been re-accredited by Imaging Services Accreditation Scheme (ISAS).
- We saw policies and procedures that referenced evidence based care and best practice.
- There were several 'one stop clinics' that involved multi-disciplinary team working.
- Staff we spoke with demonstrated a good understanding of the mental capacity act and deprivation of liberties safeguards.

However:

- The appraisal rates for both departments were worse than the hospital target.

Evidence-based care and treatment

- Diagnostic imaging services participated in the Imaging Services Accreditation Scheme (ISAS) and the department was last assessed and re-accredited in November 2016.ISAS is a patient-focused assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. A requirement of the programme was to audit services regularly. We saw that a variety of audits were on-going in the imaging departments which could evidence that best practice was being achieved.
- The nuclear imaging department took part in the Medicines and Healthcare product Regulatory Agency (MHRA) audit in November 2016. We saw that there were some compliance failures identified during this

inspection, but none of these were listed as 'major' (indicating significant risk to patients) or 'critical' (indicating non-compliance or deviation from good manufacturing process). The hospital was developing an action plan for the 'other' failures identified in the report.

- We saw the diagnostic imaging department's standard operating procedure (SOP) for 'Intimate examinations and use of chaperones in the imaging department'. This was in date and in line with national guidance produced by the General Medical Council and the Royal College of Radiologists (RCR).
- The diagnostic imaging department had a safe and effective use of radiation policy which was in date and referenced two key regulatory documents: The Ionising Radiations Regulation 1999 (IR99) The Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- We saw a SOP for the diagnostic imaging department learning and discrepancy process. This was in line with the RCR publication 'Standards for Learning from Discrepancy meetings' October 2014.

Pain relief

- If pain relief was required in the outpatient department, staff could give patients a prescription, which they could take to the pharmacy department within the hospital.
- In diagnostic imaging, staff would contact the ward if an inpatient was in significant discomfort. This was in order to return them to the ward as soon as possible and inform ward staff pain relieving medication was required.
- We saw a variety of pillows and pads were available to make patients as comfortable as possible whilst undergoing an examination in the diagnostic imaging department.
- The outpatient department ran consultant led pain clinics, and facet joint (joints of the spine) injections could be given in these clinic to help relieve joint pain.

Patient outcomes

- We looked at five sets of patient notes; all contained a dynamic patient outcome form which was completed. All were completed correctly and contained relevant patient outcome information.
- We saw waiting time audits displayed for October 2016, 92% of patients were seen within 30 minutes wait.
- The micropigmentation clinic involved two appointments. The first one to discuss the procedure and the patient's expected outcomes, which are documented on a consent form, followed by the procedure at a second appointment. However, the expected outcomes were not followed up after treatment, which meant staff were reliant on outpatient comment cards and personal thank you cards to assess patient outcomes. Staff told us they were considering formalising the follow up process.

Competent staff

- The trust target for completion of staff appraisals was 95%. Between April 2015 and March 2016, the trust reported a staff appraisal completion rate for outpatients and diagnostic imaging of 67.9% and between April 2016 and September 2016 the appraisal rate was 69.2% which was worse than the trust target. However, staff we spoke with told us that they had an appraisal within the last twelve months and found the appraisal process was useful.
- We saw evidence of staff competencies in MRI for cannulation. Cannulation is the insertion of a small plastic tube into a patient's vein, used to administer medicines, or in some circumstances in MRI scans, contrast (a dye agent) to help give a clearer picture during the procedure.
- We saw administration of radioactive substances advisory committee (ARSAC) certificates for doctors in the diagnostic imaging department. The ARSAC is a public body who advises the government on the certification of doctors and dentists who are competent to administer radioactive medicinal products to patients.
- Staff told us that a new training and development team at the trust had put on extra courses for staff, in addition to the mandatory training courses. These included courses such as 'being in the patients shoes' and 'managing difficult conversations'.

Multidisciplinary working

Outpatients and diagnostic imaging

- We observed good multi-disciplinary team (MDT) working throughout the inspection. Staff we spoke with gave examples of MDT working such as clinical nurse specialists working alongside Macmillan cancer nurses in speciality cancer clinics.
- The outpatient department ran three 'one stop' clinics, where patients could attend and have diagnostic tests and consultations in one appointment slot. These were the breast, urology and fracture clinics and involved medical, nursing and radiology staff working together.
- Staff in the interventional radiology department told us they worked alongside the obstetric team to assist with the delivery of babies from mothers at high risk of bleeding during delivery. During caesarean section procedures, if required, they were able to perform a procedure to help stop the bleeding.

Seven-day services

- The diagnostic imaging department provided a seven day, on call service. This was in line with; NHS services, seven days a week, priority clinical standard 5, 2016. This requires hospital inpatients to have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, CT and MRI and radiology consultants to be available, seven days a week.
- Radiology consultants worked seven days a week, on a rota basis, to provide consultant-directed diagnostic tests and completed reports.
- There was on- call radiology consultant cover for CT and MRI for the emergency department and inpatients between the hours of 20:00 and 08:00 provided by an external company with the support of a hospital radiographer.
- There was radiographer cover 7 days a week. Radiographers worked and reported on imaging 8am to 8pm 7 days a week. Outside of these hours, three radiographers and an assistant was available to perform x-rays required by the emergency department.

Access to information

- Staff used electronic systems for booking patient appointments and we observed that individual patient records flagged what type of pathway they were on and their breach date. This allowed staff to book patients for their appointments ahead of this date, capacity allowing.
- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system (PACS). This is medical imaging technology which provides economical storage and convenient access to diagnostic images from multiple machine types. Other areas of the hospital were able to access the PACS system when required.
- Staff from both departments could access a shared drive on the computer where pathology results, policies and hospital wide information was stored. Staff demonstrated this to us.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw an in date policy on consent, which incorporated the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DOLS) policy.
- All DOLS training was delivered under the mandatory adult safeguarding modules. As at 18 November 2016, 87% of staff had completed MCA training. Staff told us MCA training was completed online, and that this was easily accessible. Staff we spoke with demonstrated a good understanding of the MCA and explanation of DOLS.
- We reviewed five sets of patient notes, one of which had an outpatient procedure, which required a consent form. We saw the form was complete and signed by the patient.
- We saw examples of the consent forms used for the breast micropigmentation service. Patients undergoing this procedure had two appointments, which gave patients time to consider the procedure. This was in line with the Royal College of Surgeons Professional Standards for Cosmetic Surgery, 2016.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services caring?

Good

At our last inspection, we rated caring as good for outpatients and diagnostic imaging. We have maintained this rating and saw improvements in areas such as emotional support and provision of clinical nurse specialists.

We rated caring as good because:

- We saw positive interactions between staff and patients.
- The friends and family test (FFT) demonstrated the majority of patients would recommend the service.
- Patients commented positively about the care provided from staff they interacted with.

However:

- The PLACE score for privacy and dignity had deteriorated from the previous year's score.

Compassionate care

- The Patient Led Assessment of the Care Environment (PLACE) score for privacy and dignity was 70% which was worse than the national average of 84%. This had also deteriorated from the 2015 score of 79%.
- The outpatient department participated in their own friends and family test. We saw the results for October 2016. Two hundred and thirty patients took part in the survey, which was 11.5% of the total number of patients seen in outpatients that month. The majority (59%) said they were extremely likely to recommend, 36% said they were likely to recommend and 3% of patients surveyed responded with unlikely or extremely unlikely to recommend the service.
- The diagnostic imaging department ran their own patient satisfaction survey and one of the questions asked was: "were you treated with dignity and respect by our imaging staff?". The survey was held twice a year, and we saw that the most recent survey held in May 2016, indicated that 99% of patients answered yes, and the previous survey from November 2015, 100% answered yes.
- All patients we spoke with felt they were treated with care, dignity and respect.
- We saw chaperone notices in and around the outpatient department. Outpatient staff told us that a nurse was assigned to every clinic and they would routinely act as the chaperone if requested, and we saw the staffing for the clinic was discussed at the daily safety huddles.
- There were 'knock and wait' notices on consulting room doors ensuring privacy and dignity was maintained for patients. We observed staff knocking on doors before entering.
- All of the patients we spoke with were satisfied with the clinical care they received at the hospital.

Understanding and involvement of patients and those close to them

- We saw leaflets containing information about the dementia butterfly scheme available for patients and carers.
- The diagnostic imaging department ran their own patient satisfaction survey twice a year in May and November. When asked the question whether they would recommend the service to family and friends, 99% of patients answered yes in both November 2015 and May 2016. The November 2016 results had not yet been published.
- We saw a variety of health-education literature and leaflets produced by national bodies. Some of this information was general in nature while some was specific to certain conditions. This literature was available in all waiting areas of the outpatient departments.
- Patients and relatives that we spoke with felt they had a good understanding of the care that was given to them and that they were involved in their care.

Emotional support

- We saw that clinics had access to clinical nurse specialists (CNS). CNS's formed part of a multi-disciplinary team to provide support to patients with a cancer diagnosis, as well as their families and carers. We spoke to patients who had appointments with CNS's, and they expressed that their role was valued.

Outpatients and diagnostic imaging

- Chaplains could provide spiritual and pastoral support to people of all faiths, those who were unsure of their beliefs and those who had no faith.
- Staff told us that there were three dementia buddies available in the department. The role of the dementia buddy was to provide a "friendly face, a listening ear and companionship" for patients who were living with dementia. The buddies were volunteers who had received training to enable them to perform this role.
- In the breast unit they had a breaking bad news room, which enabled staff and patients to have potentially upsetting news delivered in a private and quiet environment. Not all departments had access to specific breaking bad news rooms, but staff were able to give examples where they had allocated a clinic room to enable patients to have time and space when receiving bad news.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

At our last inspection, we rated the service as inadequate for responsive. On this inspection, we have changed the rating to requires improvement because we have seen positive changes in key areas such as access and flow. During out last inspection, the trust was consistently not meeting the cancer targets and 18 week referral to treatment (RTT) targets set by NHS England. This remained an issue on this inspection, with the trust not formally reporting 18 week RTT data between October and August 2016. However, local data showed that although the targets were not being met during this period, there was evidence of improvement over the last six months and the hospital told us they planned to be on target by April 2017. Formal reporting of the 18 week data re-started in November 2016.

We rated responsive as requires improvement because:

- The hospital had not reported referral to treatment times (RTT) figures, since September 2015 and locally reported RTT data for 18 week patients was worse than the England average.
- Patients consistently waited longer than the England average for their diagnostic test.
- Patients on a suspected cancer pathway waited consistently longer than the NHS England targets set.
- Reporting times for histology and pathology were consistently below the contractual target set by the hospital.
- The time taken to respond to complaints was worse than the trust target.

However:

- Clinics and pharmacy services were run in the evening and on weekends to meet the needs of people who could not attend in normal working hours.
- The butterfly scheme was used in most areas of outpatients and diagnostic imaging.
- Waiting areas had water fountains available and areas for nursing mothers to breastfeed in privacy.
- There were patient information leaflets available in waiting areas.
- Staff regularly updated waiting times and reasons for delays on waiting room noticeboards.

Service planning and delivery to meet the needs of local people

- Evening and weekend clinics gave patients more options to attend appointments at a time that was convenient for them. Between September 2015 and August 2016, the outpatient department held 408 evening clinics and 155 Saturday clinics.
- The diagnostic imaging department provided a walk in service for general x-ray between 8am and 5pm. This allowed patients to attend at a time that suited them. The hospital told us that occasionally patients arrived outside of these times and at the weekends. These patients could still be seen at the discretion of the staff on duty and informed that emergency patients take priority during these times and that there would be a wait before they were seen. Patients who required imaging in the emergency department (ED) had access 24 hours a day, seven days a week.
- The pharmacy was open to staff and patients Monday to Friday from 9am to 5.30pm. At the weekend, the pharmacy was open from 10am until 3pm on Saturdays and 10am until 1.30pm on Sundays.

Outpatients and diagnostic imaging

- A pharmacist was on call via the switchboard from 5pm until 8.45am the following day every weekday. At weekends, the pharmacist was on call from Friday 5pm until 8.45am on Monday. On call pharmacists were based from home, but were expected to attend the hospital within one hour of being paged, whenever necessary.
- The pharmacy department had a 30-minute target in which to dispense outpatient prescriptions. We saw data from June 2015 to June 2016 which indicated the hospital had failed to meet this target. During February and March, the percentage of prescriptions dispensed in 30 minutes, dropped as low as 45%. The data also indicated that the number of outpatient prescriptions processed during this time had shown a steady increase, with 1099 prescriptions processed in June 2016 compared with 895 in June 2015.
- Between April 2015 and March 2016 the 'did not attend' rate for the hospital was worse than the England average for all months with the exception of July 2015 and March 2016. We saw that there was an in date procedure for dealing with patients who did not attend to ensure that patients were not 'lost' in the system.
- We spoke to the general manager who told us they were aware of capacity issues, in particular with the MRI department. At the time of the inspection, the trust had a mobile MRI scanner on site to assist with capacity issues.
- Patients and relatives told us that a big issue for them was the lack of available parking. Patients told us they would arrive at the hospital in good time for their appointments but would end up being late due to a lack of available space to park their vehicle

Access and flow

- In September 2015 the trust's referral to treatment time (RTT) for both non-admitted and incomplete pathways for outpatient services was worse than the England overall performance. Between October 2015 and August 2016 the trust did not submit RTT data.
- Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month. Non-admitted pathways are waiting times (time waited) for patients whose treatment started during the month and did not involve admission to hospital.
- Although the trust did not formally report RTT data between October and August 2016, they recorded the data locally and the monthly data demonstrated that patients were consistently waiting longer than the national average. However, since December 2015, the percentage of patients seen within 18 weeks had steadily risen from 67% to 79%, with minor increases each month from July (79.1%) to October 2016 (79.7%).
- We saw that weekly patient tracking list (PTL) meetings were being held to monitor the position of each speciality in regards to the 18 week target. Areas of concern could be highlighted at these meeting and the trust overall position could be monitored.
- The trust started to report RTT to NHS England again in October 2016, with the percentage of patients seen within 18 weeks at 77.9%, which was worse than the NHS operational standard of 92%. However, the directorate lead told us that they were ontrajectory to meet this standard by March 2017.
- We spoke to staff in the 18 week and two week wait booking offices, who told us that although there were still capacity issues, there was more support from the general managers in getting additional clinics or in overbooking clinics.
- Patients should wait no longer than six weeks for their diagnostic test. Between September 2015 and August 2016 the percentage of patients waiting more than six weeks to see a clinician was higher than the England average. Since April 2016, the percentage of patients waiting over six weeks varied between 10.5% and 4.8%. The most recent data for October 2016 indicated that 6.6% of patients waited longer than six weeks for their test, which although is worse than the operational standard, was an improvement compared to the previous two months.
- When these figures were broken down to type of test and percentage of patients waiting over six weeks, the tests that were consistently over a six week wait were MRI, colonoscopy, flexi sigmoidoscopy and gastroscopies, with percentages being as high as 63% patients waiting over six weeks (gastroscopy – April 2016). However, we saw that significant improvement had been made on percentages waiting over six weeks with a gradual reduction in waiting time since April 2016

for colonoscopy, sigmoidoscopies and gastroscopies. The October data demonstrated that 2.5%, 2.3% and 0.9% respectively were waiting over six weeks for these appointments.

- The test that consistently had the largest percentage of patients waiting over six weeks for was MRI scans. Between April 2016 and September 2016, the percentage of patients waiting over six weeks ranged from between 4% and 24.5%.
- There were mobile scanners on site to help ease the capacity issues and these were outsourced to a third party group. The hospital told us that When we were on inspection, one of these mobile scanners broke down and we saw that management staff responded quickly to resolve issues and communicate with staff.
- Patients who have suspected cancer should expect to see a specialist consultant within two weeks of referral from their GP, should have received their cancer treatment within 31 days of a decision to treat the cancer being made, and overall should receive their cancer treatment within 62 days from being referred from their GP, in line with national targets.
- The trust performed worse than the 93% operational standard for people being seen within two weeks of an urgent GP referral for three of the last four quarters. We saw that there had been an improvement from the previous year's figures in two out of the three quarters reported this year (quarter 1 and quarter 3 2016/17). There was a variation in how quickly patients were seen depending on the suspected tumour site. Suspected skin cancer was consistently the worst performing tumour site with compliance against the two week wait standard as low as 53% in quarter two, and although there was improvement to 82% in quarter three, this was still worse than the operational standard. Suspected haematological and testicular cancer patients were the best performing tumour sites over the last three quarters, demonstrating 100% compliance with the two week wait standard.
- The trust performed worse than the 85% operational standard for patients receiving their first treatment for cancer within 62 days of an urgent GP referral. In 2016/17, quarters one, two and three saw compliance of 76%, 81% and 76% respectively, all of which were worse than the operational standard. There was a variation in how quickly patients received their treatment depending on the tumour site. Breast patients could expect to receive their treatment within 62 days and the trust performed consistently better than the 85% target in this tumour site in quarters two and three. Lung and lower gastrointestinal tumour sites, performed consistently worse than the compliance rate of 85%.
- The trust had consistently performed worse than the 96% operational standard for patients waiting fewer than 31 days before receiving their first treatment following a diagnosis (decision to treat). However, a gradual improvement could be seen from quarter one in 2016/17 to quarter three, with an increase from 92% in quarter one to 94% of patients seen within fewer than 31 days in quarter three.
- We saw minutes and action logs from the cancer PTLs, where patients who were about to pass or had passed their target date could be highlighted to general managers who would review the availability of clinics.
- The hospitals histology and pathology reporting was outsourced to a local NHS trust.
- The hospital did a snapshot audit of patients who were seen within 30 minutes of their appointment time. Between October 2015 and August 2016, the percentage of patients who were seen within 30 minutes of their appointment time ranged between 77% and 87%. The hospital told us there was no target in place for this, however in October 2016 we saw that 92.1% of patients were seen within 30 minutes.
- In the outpatient waiting areas we saw noticeboards detailing which clinics were running late and reasons for these delays.
- The cancellation policy states that a minimum of six weeks' notice should be given for cancellation of clinics. Between May 2016 and August 2016,161 clinics were cancelled, of these 112 (72%) were cancelled with less than six weeks' notice, this meant overall 1% of all clinics were cancelled with less than 6 weeks' notice.
- There was no protocol or procedure in place to monitor the turnaround times for clinic letters to be sent to GPs. The hospital told us that This indicated that there was no overview or monitoring of this.
- A reporting radiographer provided 'hot reporting' for the A&E department between the hours of 8am and 8pm, 7

days a week, which gave the referrer an immediate result of the investigation and led to the patient receiving appropriate treatment in a timely manner. Outside of these hours, if an x-ray was required by A&E, these would be performed by a radiographer and reported the following day.

Meeting people's individual needs

- The trust offered face to face, telephone and written translation services, as well as sign language, and most staff we spoke with were aware of these services.
- Staff in the MRI department told us they were aware of how to book translation services for patients who did not speak English and showed us posters on the staff noticeboards demonstrating the procedure. Staff were able to give us examples of when they had used the translation services for their patients.
- Chaplains were on call 24 hours, with Protestant and Catholic provision. This was available for all patients and relatives. The switchboard held the details of Local Faith Leaders that could be contacted. The intranet had Guidelines for Spiritual and Pastoral Care which gave helpful information about the requirements, beliefs and practice of people associated with the major faith groups. The chapel was a shared quiet space, open to all, regardless of belief or practice.
- The trust used the 'butterfly' scheme to discreetly make health professionals aware if a patient was living with dementia. A butterfly sticker is attached to the patient records or referral letters, and staff in both outpatients and diagnostic imaging knew about this scheme.
- The PLACE assessment for dementia was included for the first time in 2015, and focused on key issues such as flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia. The hospital scored 63% for 2016, which was worse than the national average score of 75%. This was also worse compared to the hospital's 2015 result of 69%, indicating that services for patients living with dementia patients could have worsened in the last year.
- Staff told us that they have smiley face stickers that can be used on referrals when booking in to indicate if a patient had learning difficulties. Staff endeavoured to fast track these patients through the department and always ensured that two members of staff were available to assist them.
- The PLACE assessment for disability was included for the first time in 2016. The hospital scored 64% which was worse than the national average of 78%.
- In main waiting area, seats were available in varying heights and bariatric seating and equipment was also seen.
- There were water fountains available in patient waiting areas. Staff told us that they could provide 'snack boxes' for patients who were waiting a long time and gave examples where patients transportation had not arrived on time and patients were left waiting longer than expected.
- In one of the main outpatient waiting areas there was a sectioned off area for nursing mothers and babies which allowed privacy for mothers wishing to breastfeed. The area could be made completely private by the use of a disposable curtain which was changed within the last 6 months in line with infection control procedures. There was also a child-gate to allow children accompanying their mother to play in a secure area. There were leaflets within the area regarding breastfeeding support and comment cards available regarding the service.
- In the main x-ray waiting area, there was a separate children's play area that was screened off. Books and toys were available and there was an art mural on the wall. Posters showed a teddy bear having an x-ray and we saw stickers that staff could give to children saying 'I had an x-ray'.
- We saw 'certificates of bravery' for children who attended for a blood test.

Learning from complaints and concerns

- Between August 2015 and July 2016there were 111 complaints about outpatients.
- The common themes for complaints about the outpatient department related to; waiting time for appointments (26%) and lack of care/attention and treatment (19%). Orthopaedics had the highest number of complaints (19).

Outpatients and diagnostic imaging

- The CQC received 30 enquiries relating to outpatients between August 2015 and November 2016. Of these, 18 were negative and 13 were positive.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

At our last inspection, we rated the service as inadequate for well led. On this inspection, we have changed the rating to requires improvement because we have seen improvements in key areas such as quality assurance and the culture of the service. At our last inspection, processes were not in place to review the quality of imaging that was outsourced to a third party company during out of hours scans. We saw that there was now a forum for any identified errors to be flagged and discussed, and a standard operating procedure. We saw that these meetings had been taking place since May 2016, however the process and meeting format was currently under review and had not yet been formalised.

We rated well-led as requires improvement because:

- There was no formal strategy in place for the outpatient and diagnostic imaging department and whilst we were told that a draft was being processed, we did not see any evidence of this being discussed at senior meetings.
- There were key vacancies in the department that other staff were covering on an interim basis.
- There were no risks identified on the outpatient programme risk register and no evidence that any outpatient risks were discussed in team or governance meetings.

However:

- We saw that the culture of the service was good. Staff felt more supported and found their line managers were accessible.
- Staff were proud of the work they did, and understood the trust vision and values.
- Quality indicators for the directorate were produced monthly on a dashboard and reviewed by the senior management team.
- There were processes in place to assure the quality of outsourced diagnostic imaging reporting.
- There were regular staff meetings in place throughout the department. Imaging management meetings had not been occurring for the last six months but we saw that following our inspection, these had re-commenced.

Vision and strategy for this service

- The hospital vision was the 'best of care, best of people'. The values were: 'bold, every person counts, sharing and open, together'. We spoke to staff who knew and understood the vision and values.
- At the time of the inspection there was no formal strategy in place for the outpatient and diagnostic imaging department. Senior management told us that the strategies were currently under development and the draft strategy was due to be presented to the outpatient and imaging programme board in December 2016. However, we reviewed the minutes of the December meeting and saw that this was not presented or discussed.
- Staff we spoke to were aware that there was no formal strategy in place but were not aware if one was being developed. We saw minutes from the December imaging management meeting where the chair informed the meeting that the strategy was under development currently and that any comments or suggestions from the group were welcomed.
- We saw the High Level Milestone Outpatient tracker. This was a document that outlined proposed dates for reviews and updates of the outpatient department, including the production of the dynamic outcome form which we saw and was completed in September and the introduction of electronic check in kiosks at the front of the hospital which was due in December 2016.

Governance, risk management and quality measurement

- The outpatient department held monthly governance meetings, where incidents, risks and complaints were discussed. We saw minutes from two of these meetings in June and July 2016, we were advised that the August and September meetings had been cancelled as they

were not quorate, which meant that the minimum number of staff to be present for the meeting was not met. These fed into the monthly programme board meetings.

- The Imaging Management meeting had recently been re-instated and we saw minutes from the December meeting that explained purpose was to be able to feedback information from the Programme Board meetings.
- The co-ordinated surgical directorate produced a monthly dashboard which measured quality across the directorate. It measured a range of key performance indicators and was discussed at the monthly programme board meetings.
- The director of clinical operations for the directorate and deputy director of nursing for the directorate attended the monthly quality improvement group (QIG) meetings. Serious incidents (SIs), complaints and safeguarding issues were discussed on a set agenda and the directorate had its own agenda item dedicated to discussing issues and themes from the directorate. Minutes from July, August and September were seen.
- Staff in imaging told us that the governance meetings were held monthly. Modality leads attend but they give feedback and were open to being asked questions.
- We saw the outpatient and imaging programme risk register. There were seven risks listed on this, all of which related to diagnostic imaging. This indicated that there were no risks identified for the outpatient department. We saw minutes from three sets of governance meeting minutes, where no new risks were identified for the outpatient department. This may indicate that risks were not being appropriately recognised and recorded within the outpatient department. We did however see that failure to meet the 18 week target was recorded on the directorate wide risk register, however as this risk was not discussed regularly at governance meetings, assurance cannot be given that it was being dealt with or addressed.
- Management told us that they had gone out to tender in October 2015 for new provision of outsourced histology and pathology reporting services following poor performance and a failure to meet the contracted turnaround time. Following the tender process, the same NHS trust was re-contracted following "changes to processes, staffing and tougher contractual penalties" and whilst the turnaround target had not been met at the time of reporting in October 2016 of 90% of specimens to be reported in ten days, steady improvement had been made with the trust anticipated they will reach their target by early 2017.
- Imaging that had been outsourced to external companies for reporting was monitored for quality assurance. We saw quality audit reports from the external companies that completed out of hours reporting and learning and discrepancy meetings were held monthly. These were meetings where radiologists could flag and discuss any reporting errors. However, this meeting and process was under review at the time of the inspection and meeting minutes were not formally documented. However, we saw the attendance record from May 2016 to December 2016 which indicated that radiologists and on two occasions radiographers were in attendance.

Leadership of service

- The outpatient and diagnostic imaging program sat under the coordinated surgical care directorate along with four other programs. The Director of Clinical Operations oversaw the directorate, with a deputy medical director and deputy director of nursing in support. A clinical director oversaw the outpatient and diagnostic imaging program, with the imaging general manager and matron for outpatients.
- There were clear lines of management responsibility within the outpatient and diagnostic imaging department. Staff in all areas told us they were well supported by their direct line managers and described them as accessible and approachable.
- The majority of the staff in the diagnostic imaging department told us that they felt senior management had developed a greater understanding of capacity and demand of the diagnostic imaging department. In comparison some staff told us they felt that there was still a disconnect between them and senior staff and felt that their voices were not always being heard.
- Some staff we spoke with felt that senior managers did not take their role and contribution seriously. An example of this was that some administrative staff did not have access to their own phone lines in their office,

which they felt was essential to be able to fulfil their job role efficiently. Staff explained that when cancelling clinics they would be fighting over the phones and that this had been escalated but had not been resolved.

- There were two vacancies within the outpatient and diagnostic imaging management team. The roles of head of imaging and medical records manager were covered by the general manager for outpatient and imaging and the patient services manager at the time of inspection.
- The general manager for outpatients and diagnostic imaging had a wide remit and was currently also covering the role of head of imaging. The patient service manager had also had to undertake the role of medical records manager as that role was vacant. Both jobs had been approved for recruitment at the time of the inspection however, this additional remit for both roles meant that a significant amount of additional work was being undertaken by these staff members.

Culture within the service

- The majority of staff we spoke to told us that the culture had improved since the last inspection and were positive about the changes made in the last twelve months.
- The trust had a freedom to speak up guardian (FTSUG). FTSUG guardians have a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled.
- Staff told us there were 'constant communications' and updates from across the trust which had improved since our last inspection.
- Relationships between staff and senior management was varied across the modalities in both outpatients and diagnostic imaging. Most staff told us the management team felt more stable than before and that they were starting to feel more secure and starting to notice a difference.
- Staff told us that some doctors were bringing their imaging referrals to the department outside of normal hours. This was to avoid having them checked by trust radiologists and possibly being declined as an inappropriate examination. By bringing these referrals out of hours, they would be passed onto the outsourcing team who would often authorise the procedure. We spoke to the imaging general manager who told us she was aware of this issue and felt that it was a legacy problem and one that was decreasing as the culture improved.
- Staff in outpatients told us they felt that since the new Chief Executive (CEO) had come into post, significant changes had been made. They felt that there was more opportunity for interaction with staff, and they felt more involved. Staff gave examples where they had seen the CEO in the department and how she had taken an interest in the staff within the department. Staff said this made them feel they weren't 'just a number'. We saw weekly global emails to staff from the CEO, thanking everyone at the end of the week.
- We spoke to patient administration clerks who worked in the patient services centre. They told us that previously there had been a backlog of referrals and the department felt generally "in a state" but that this had improved significantly. They gave examples of escalating capacity issues to service managers previously and not getting a response, and told us that now they get more support and can book extra clinics or overbook. Staff spoke highly of immediate line managers but said they sometimes feel 'forgotten' as not on the shop floor and don't feel they always get recognition from senior management.
- Staff told us that nothing keeps them awake at night anymore. They felt they had the support they needed and that the culture had changed.
- Staff who worked in the booking centre told us that things had improved significantly since our last inspection and showed an example of number of outstanding referrals currently compared to this time last year which showed a significant reduction in number. However, they did report that sometimes the grading of referrals could delay the booking of appointments. Once a referral is received, it should be graded by the appropriate speciality consultant within 48 hours, however there are certain specialities where booking staff have to constantly chase. Staff told us they escalated this to service managers who tried to help but were told 'not really much can do'.

Public engagement

Outpatients and diagnostic imaging

- The outpatients department ran a Patient Experience Group meeting. We saw minutes from October and November 2016 meetings. Friends and Family Test results were discussed and any issues arising from these considered.
- There was a patient experience board in the outpatient department waiting area. This had the contact details for the patient experience team and the outpatient friends and family test results were displayed for October 2016.
- Volunteers, who had previously attended the hospital as patients, provided a selection of hot and cold drinks to waiting patients. We saw a number of volunteers offering drinks to patients in waiting areas.

Staff engagement

- Staff in outpatients and diagnostic imaging departments had daily safety huddles where they had an opportunity to come together with their colleagues and share information at the beginning of their shift.
- Staff in radiology told us that they have not had imaging management team meetings for a long time, however the general manager told us these were due to be re-instated and we saw minutes from the first one of these meetings under the new manager from December 2016.
- We saw three sets of minutes from the outpatient staff meeting. We saw that a range of staff members attended, including nurses, clinical support workers, non-clinical support workers and administrative staff and porters.
- We saw minutes from the outpatient management meetings which were attended by the matron, senior sisters and sisters from the department. Acknowledgment of the reduced amount of administration staff in the outpatient department and recruitment updates were given. We saw that incidents were discussed at the outpatient team meetings.
- We saw three sets of minutes from the general imaging team meetings. We saw that incidents, complaints, staffing and infection control were routinely discussed, and there were opportunities for open discussion after the agenda had been completed.
- Staff told us that the chief executive at the trust ran weekly open sessions to speak to her which they thought was a good initiative and made the chief executive more visible to the trust. These sessions were well attended but clinical staff could not always access these as easily as non-clinical staff.
- The hospital ran Wow! awards where patients could nominate members of staff for outstanding patient experience. We saw that several members of the outpatient team had been nominated in the past year.

Innovation, improvement and sustainability

- Staff in the breast unit told us that their breaking bad news room was due renovation, and this had been made possible by the use of charitable funds. They planned to include a coffee machine and radio and staff told us that this would be invaluable for partner's or family members waiting while wife had their biopsy.
- Two of the senior sisters in outpatients ran a micropigmentation clinic for patients who have had either partial or entire breast removal surgery. Micropigmentation is a form of cosmetic tattooing to re-create the nipple following reconstructive surgery. This nurse-led clinic had grown in demand since starting up the service, and the clinic was on average seeing six patients per month.
- In the nurse-led micropigmentation clinic, staff told us that practice was changed after the two practitioners of this clinic attended an areola artistry workshop. A dry needling technique (M.C.A. Multi Trepannic Collagen Actuation Treatment) was discussed as best practice for scar tissue management. This was adopted by the practitioners and new needles sourced, which are gentler to the skin and better results achieved.
- Approximately two endovascular aortic aneurysm repair (EVAR) procedures are performed in the diagnostic imaging department per week. This type of surgery is less invasive than alternative forms of surgery to treat aortic aneurysms as it is performed via 'keyhole' surgery. This results in faster recovery times.
- The diagnostic imaging department had been trained to perform carbon dioxide angiography. This is a procedure where carbon dioxide is used as an alternative to iodine or dye to highlight areas of blockages within the veins whilst being x-rayed.

Outstanding practice and areas for improvement

Outstanding practice

The neonatal unit improved their breast-feeding at discharge compliance rates from one of the lowest rates in the country to the highest.

A critical care consultant, nurse practitioner, GP lay member and physiotherapist led an innovative programme to improve patient rehabilitation during their ICU admission and after discharge. This included a training and awareness session for all area GPs and a business case to recruit a dedicated rehabilitation coordinator. In addition, a critical care consultant had developed app software to be used on digital tablets to help communication and rehabilitation led by nurses. The consultant was due to present this at a critical care nurses rehabilitation group to gather feedback and plan a national launch.

Critical care services had a research portfolio that placed them as the highest recruiter in Kent. Research projects were local, national and international and the service had been recognised as the best performer of the 24 hospitals participating in the national provision of psychological support to people in intensive care (POPPI) study. Research projects for 2016/17 included a study of patients over the age of 80 cared for in intensive care; a review of end of life care practices; a respiratory study and a study on abdominal sepsis.

The 'Stop Oasis Morbidity Project' (STOMP) project had reduced the number of first time mothers suffering third degree perineum tears. The project had been shortlisted for the Royal College of Midwifery Award 2017, Johnson's Award for Excellence.

Team Aurelia was a multidisciplinary team. Women who were identified in the antenatal period as requiring an elective caesarean section would be referred to team Aurelia. Women were seen by an anaesthetist prior to surgery and an enhanced recovery process was followed to minimise women's hospital stays following surgery.

The bereavement suite, Abigail's Place, provided the "gold standard" in the provision of care for parents and families who experience a still birth. The suite created a realistic home environment for parents to spend time with their child.

The frailty and the ambulatory services, which required multidisciplinary working to ensure the needs of this patient group, were met.

The individualised care and pathway given to patients attending with broken hips. The care ensured this group of patients' needs were met on entering the department until admission to a ward.

The development and implementation of the associate practitioner role.

Areas for improvement

Action the hospital MUST take to improve

Ensure flooring within services for children and young people is intact, in accordance with Department of Health's Health Building Note 00-09.

Ensure all staff clean their hands at the point of care in accordance with the WHO 'five moments for hand hygiene'

Review the provision for children in the recovery area of theatres and Sunderland Day Unit to ensure compliance with the Royal College of Surgeons, standards for children's surgery.

Ensure staff record medicine fridge temperatures daily to ensure medicines remain safe to use.

Ensure compliance with recommendations when isolating patients with healthcare associated infections.

Ensure that all staff have appropriate mandatory training, with particular reference to adult safeguarding level two and children safeguarding levels two and three where compliance was below the hospital target of 80%.

Ensure all staff working in recovery main theatres and nursing staff looking after children (including in

Outstanding practice and areas for improvement

recovery)on Sunderland day unit have Safeguarding Level three training in line with the 'intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014'.

Ensure that all staff receive an annual appraisal.

Ensure that an appropriate policy is in place ensuring that patients transferred to the diagnostic imaging department from the emergency department are accompanied by an appropriate medical professional.

Ensure the intensive care unit meets the minimum staffing requirements of the Intensive Care Society, including in the provision of a supernumerary nurse in charge.

Ensure staffing levels in the CCU maintain a nurse to patient ration of 1:2 at all times.

Ensure that consultant cover in the emergency department meets the minimum requirements of 16 hours per day, as established by the Royal College of Emergency Medicine.

Ensure fire safety is a priority. Although the trust has taken steps to make improvements we found some areas where fire safety and staff understanding needed to be improved.

The trust must ensure people using services should not have to share sleeping accommodation with others of the opposite sex. All staff to be trained and clear of the regulation regarding same sex accommodation.

Ensure clinical areas are maintained in a clean and hygienic state, and the monitoring of cleaning standards falls in line with national guidance.

Ensure end of life (EoLC) patients have face-to-face access to EoLC or palliative care services seven days a week.

Take action to ensure emergency equipment (including drugs) are appropriately checked and maintained.

Action the hospital SHOULD take to improve

Ensure the electronic flagging system for safeguarding children in the children's emergency department is fully embedded into practice.

Review safeguarding paperwork to ensure it can be easily identified in patient's records.

Ensure there is a system in place to identify Looked after Children (LAC) in the children's emergency department.

Enhance play specialist provision in line with national guidance.

Ensure children's names and ages or not visible to the public, in compliance with the trusts 'Code of conduct for Employees in Respect of Confidentiality' policy.

Ensure compliance with NICE QS94, and ensure children, young people and their parents or carers are able to make an informed choice when choosing meals, by providing them with details about the nutritional content..

Identify risks for the outpatient risk register.

Begin monitoring the availability of patient records in outpatient clinics.

Ensure that referral to treatment times improve in line with the national targets.

Monitor the turnaround times for production of clinic letters to GPS following clinic appointments.

Ensure there is sufficient resource in allied health professionals teams to meet the rehabilitation needs of patients.

Ensure medical cover in the CCU is provided to an extent that nurses are fully supported to provided safe levels of care.

Medicines and IV fluids should be stored securely and safely. Intravenous (IV) fluids were stored in a draw on a corridor on pearl ward this was not secure as it did not ensure that IV fluids could not be tampered with. We found ampoules of metoclopramide and ranitidine, drugs commonly used for stomach problems, stored in a box together. This created a risk that patients may have been given the incorrect medicine.

Ensure equipment cleaning is thorough, including the undersides of equipment.

Ensure there is a policy or guidelines in place in regards to babies' identification.

Display 'do not disturb' signs on the delivery suite rooms.

Ensure complaints are responded to in accordance with the trust's policy for responding to complaints.

Outstanding practice and areas for improvement

Meet the national standards for Referral to treatment times (RTT) for medical care services and continue to reduce the average length of stay of patients.

The driving gas for nebulised therapy should be specified in individual prescriptions as can be harmful to the patient.

Continue to address issues with flow to improve performance against national standards.

Repair/replace the two patient call bells in the majors overflow area.

Install a hearing loop in the emergency department reception area.

Consider how staff are made aware of internal escalation processes.

Take action to ensure patients recover from surgery in appropriate wards where their care needs can be met.

The trust should take action to ensure there is sufficient access to equipment. In particular, sufficient sling hoists for patients on Arethusa and Pembroke Wards and sufficient access to computers for staff throughout the surgical directorate.

Improve the provision of side rooms for end of life care (EoLC) patients on wards and improve facilities for relatives to stay by the bedside.

Improve the timescales for provision of Death certificates.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 10 (2) (a) Privacy, dignity and/or safety had been compromised where in some instances people using services had to share sleeping accommodation with others of the opposite sex

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Consultant cover within the emergency departments does not meet the minimum requirements of 16 hours per day, as established by the Royal College of Emergency Medicine. Patients transferred to the diagnostic imaging department from the emergency department were not always accompanied by an appropriate medical professional. The intensive care unit did not always meet the minimum staffing requirements of the Intensive Care Society, including in the provision of a supernumerary nurse in charge. Staffing levels in the CCU did not always maintain a nurse to patient ration of 1:2 at all times.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18(2) (a) The provider must ensure appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform. How this regulation was not met: Some staff did not have an up to date appraisal in line with trust policy. Some staff were not up to date with their mandatory training including safeguarding training in line with trust policy.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control 12(2) (h) The provider must assess the risk of, and prevent, detect and control the spread of, infections. How this regulation was not met: We found some staff not cleaning their hands at the point of care in accordance with the WHO 'five moments for hand hygiene' We found the trust did not always follow recommendations when isolating patients with healthcare associated infections. The frequency of cleaning audits did not meet the national specification for cleanliness. The flooring within services for children and young people was not intact, in accordance with Department of Health's Health Building Note 00-09.

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

This section is primarily information for the provider

Requirement notices

12 (2) (d) Ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way

How this regulation was not met:

The provision for children in the recovery area of theatres and Sunderland day unit did not ensure compliance with the Royal College of Surgeons, standards for children's surgery.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (2) (g) the provider must ensure the proper and safe management of medicines. How this regulation was not met: medicine fridge temperatures were not recorded daily to ensure medicines remain safe to use. We found 11 vials of out-of-date Dantrolene on an emergency toxicity trolley in main theatres. We found an unlocked drugs cupboard containing medicines to take out on Phoenix Ward. We also saw evidence of intravenous drug administration on Phoenix Ward that was not in line with Nursing and Midwifery Council (NMC) Standards for Medicines Management. This was because two members of staff had not signed to confirm they had set up and checked the administration of an intravenous (IV) drug on two patients' MAR charts.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...