Medway NHS Foundation Trust

Inspection report

Medway Maritime Hospital
Windmill Road
Gillingham
ME7 5NY
Tel: 01634830000
www.medway.nhs.uk

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

We carried out an unannounced inspection of the trust's medical care service and an unannounced focused inspection of its children and young people's service.

At our last comprehensive inspection of the trust, the trust was rated requires improvement overall. Our most recent previous core service inspection was an inspection of the trust's urgent and emergency care service in December 2020. We rated this specific service inadequate overall. It was the findings from this inspection along with other intelligence, including from trust and stakeholder engagement that led to this inspection at this time, as we had concerns about the quality of services.

During the core service inspections we spoke with 54 staff members including nurses, doctors, managers, allied healthcare professionals, housekeeping and support staff. We held junior doctor focus groups attended by 17 junior doctors and reviewed 31 sets of patient records.

We also inspected the well-led key question for the trust overall. We decided to carry out a well-led assessment at this time, as we had concerns as to the capability and capacity of the trust's leadership team. The trust had been subject to significant intervention from NHS England and NHS Improvement across several areas of trust service delivery, including support for the trust's executive being provided by their Intensive Support Team.

As part of our assessment of well-led NHS England and NHS Improvement carried-out a well-led assessment of the trust's financial governance, which is included in our well-led summary.

Generally the ratings for both the core service inspections and the well led assessment improved.

- We rated the key questions of safe and well led for its children and young people service as good. We rated its medical care service as requires improvement overall.
- We rated well-led as requires improvement.

Our findings

For the medical care core service inspection we found:

- Medicines brought in by patients were not always recorded at admission and there had been several incidents were medicines had gone missing across a number of wards.
- The service did not always have enough staff to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix to meet the needs of the patients including using locum and bank staff to help keep patients safe. The service was actively recruiting nursing and medical staff from overseas.
- There were clear lines of accountability from the department to the board through the directorate governance structure, but these were not always effective. There was a lack of oversight of issues identified as a risk to patient and staff safety which had not been identified or addressed by the leadership team until we raised them during our inspection. For example, on the temporary coronary care unit, there was a lack of infection prevention and control compliance and the environment was inappropriate creating many risks.
- Patients were not always put on the correct patient pathway which delayed the start of their treatment and increased the risk of deterioration.
- Paper records were still in use and not always fully completed or filled contemporaneously in line with trust policy.
- The service had a back log of serious incidents that were overdue for investigation.
- The service did not always meet their target for responding to complaints.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. We observed positive interactions between staff and patients. Staff introduced themselves to patients before providing care and included patients in discussions about their care. This was an improvement from the last inspection.
- Staff kept detailed records of patients' care and treatment, although there were separate systems for this. The service primarily used an electronic patient record system but we noted some patient care was recorded on a paper system.
- The service treated patient concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Staff assessed and monitored patients and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service had a vision for what it wanted to achieve and each care group had developed individual strategies to achieve this. Staff were aware of the vision and strategy and the part they played in achieving this.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Staff followed guidance in relation to social distancing and the use of personal protective equipment on the wards we visited. However, we escalated our concerns to trust leaders about the coronary care unit as it was unclear if social distancing guidelines were being met due to the environment.
- Staff felt respected, supported and valued by their colleagues. They told us of strong working relationships that had been formed during the COVID-19 pandemic. However, we received mixed views on the support they received from local and executive leaders.

Our findings

For the children and young people core service inspection we found:

- The service had enough staff to care for children and young people and keep them safe. Staff had training in key skills, understood how to protect children and young people from abuse, and managed safety well.
- The service controlled infection risk well.
- Staff assessed risks to children and young people, acted on them and kept good care records.
- The service managed medicines well.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work.
- Staff felt respected, supported and valued.
- The service was focused on the needs of children and young people receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with children, young people and the community to plan and manage services and all staff were committed to improving services continually.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with legal requirements.

Trust wide

The trust MUST ensure it establishes systems and processes that operate effectively to enable it to:

- assess, monitor and improve the quality and safety of the services provided in the carrying-on of the regulated activities (including the quality of the experience of service users in receiving those services) - Regulation 17; and
- assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activities – Regulation 17.

Core service

- The trust must ensure that all mandatory training records are updated promptly via the electronic systems to accurately reflect percentages of staff trained in each subject - Regulation 12

Our findings

- The trust must ensure that medicines brought in by patients are recorded at admission and stored securely - Regulation 12
- The trust must ensure paper patient records are completed in full and are contemporaneous to reflect care provided - Regulation 12
- The trust must ensure that where medical care service risks are identified, mitigation is put in place in a timely manner - Regulation 17
- The trust must ensure that there are sufficient numbers of appropriately skilled staff to keep patients safe from avoidable harm - Regulation 18

Actions the trust SHOULD take to prevent it failing to comply with legal requirements in future, or to improve:

Trust wide

In meeting the trust wide requirements set-out under the trust-wide MUSTS, it SHOULD:

- Review its oversight of clinical incidents and embed an effective system to learn from such incidents.
- Review its mortality governance processes.
- Review and act upon its governance of the Mental Health Act.
- Review the terms of reference and membership of the audit committee.
- Share with the Care Quality Commission recommendations resulting from the findings of the NHS England and NHS Improvement Intensive Support Team review work.
- Agree a process of regular ongoing assurance with the Care Quality Commission through information returns - in order to provide assurance on progress against the findings of the well led summary report and progress against the ECIST recommendations and its own Patient First workstream.

Core service

- The trust should improve the rates of mandatory training completion for both medical and nursing staff.
- The trust should ensure patients are referred to the correct patient pathway at the earliest opportunity.
- The trust should improve the timeliness of incident investigations.
- The trust should embed its new complaints process to respond to patient complaints about the service/s effectively, and in compliance with timelines set in the trust's complaint policy.

Is this organisation well-led?

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

Our findings

We carried-out this inspection as we had concerns about a lack of cohesion within the trust's executive team and the culture within this team. The trust had been subject to significant intervention from NHS England and NHS Improvement (NHSE/I), including ongoing support provided for the trust's executive team from NHSE/I's Intensive Support Team. We had not received the necessary assurance from the trust following our December 2020 inspection of the trust's emergency department - when we issued the trust with a section 29A warning notice. Also, concerningly, the trust's defensive response to those inspection findings factored into our decision to inspect well-led at this time.

At the time of our inspection a new Chief Executive had been in post for a little over three weeks. The Chief Executive had carried-out their own diagnosis of the elements of the well led assessment we were there to carry-out. From their own assessment, they demonstrated a comprehensive understanding, and a very good awareness of the issues we identified.

This summary is focused on the senior and executive management of the trust. Our two core service level assessments of medical care and children and young people services reported on what we found within the teams delivering those services.

Our rating of well-led at the trust improved. We rated well-led as Requires Improvement because:

Not all leaders had the necessary experience, knowledge, capacity or capability to lead effectively. Board members did not present a consistent view on the key risks, challenges and priorities for the trust. Some leaders were not able to demonstrate an awareness of key challenges and conveyed an overly optimistic view of current performance.

Aspects of trust leadership had improved since our last well-led inspection; however, significant improvement was still required.

Leadership was in a transient position with several new executive appointments to a relatively large executive team - some of which were first-time executive appointments. There had been limited intervention to enhance teamworking within the executive team and there was a lack of clarity around some areas of executive portfolio responsibility. Capacity and capability needed to be strengthened.

There had also been instability amongst the trust's non-executive directors with several new appointments. The appointments individually would potentially enhance its leadership capability, but as a unitary board of directors it was underdeveloped.

There was significant ongoing development of nursing leadership but conversely a lack of leadership development for medical roles. There was also a recognised need for group leadership development for the trust's care group triumvirates.

External reviews had highlighted a lack of cohesion within the trust's executive team and particular tensions between operations and corporate nursing functions. Working in silos, executive leads had competing agendas which impacted on operational delivery, as key decisions lacked the necessary wider context.

The trust had not effectively aligned its strategy to local plans in the wider health and social care economy nor demonstrated active involvement in sustainability and transformation plans. The trust needed to improve its ability to monitor its performance against its strategic intent.

Our findings

The trust's overarching strategy does not reflect its priorities (which were summarised for us by its chief executive) and is due to be refreshed.

The trust leadership team acknowledged that the trust had been looking inwardly and had been operationally focused in relation to its strategic aims. The trust's finance team knew their areas of focus but the Integrated Care System (ICS) was outside of their vision. The director of strategy told us that they were engaging with ICS partners and listening to other stakeholders to help the development process. An upcoming planned board away-day included a two hours session on the ICS strategy with the ICS lead, to discuss where this linked to the trust's high-level priorities. The trust chair was sensitive to the need to ensure community and social care service priorities were taken into account in developing the strategy.

The trust had developed new strategies including estates, digital, green plan and research and innovation but there was a risk that strategies were not aligned. The trust's chair and chief executive recognised the need to now develop an overarching strategy that will bring the strands together and enable the organisation to fit within the place.

Progress against the trust's strategic pillars, Our People, High Quality Care, Financial Stability, Integrated Care and Innovation were monitored through the Trust Improvement Board. The trust was not able to effectively monitor progress against delivery of these pillars. The 'Our People' pillar was most able to demonstrate progress against metrics, and work was required to provide assurance on progress against all key strategic aims.

Since the new chief executive joined the trust, these meetings were now a monthly internal management group supported by the introduction of weekly assurance groups to drive the pace of change. The trust also recognised the need to develop a more data driven focus with less narrative on deliverables and an increase in key performance indicators.

The trust's patient experience strategy had been very limited prior to the last six months preceding our inspection. However, a clear approach was articulated, and demonstrable improvement shown by those leading on its development.

Staff satisfaction was mixed. Improving the culture or staff satisfaction has not been shown to be a high priority. Staff did not always feel actively engaged or empowered. Equality, diversity and inclusion was promoted but there was insufficient attention to appropriately engaging those with particular protected equality characteristics. There was a limited approach to sharing information with and obtaining the views of staff, people who use services, external partners and other stakeholders.

Internally within the trust and externally amongst stakeholders, the long-standing issues with the trust's culture were known. Despite this, to date, the trust's leadership team had struggled to resolve these issues and had shown a lack of appetite in some areas, to engage with staff with a focus on resolving these issues. There had however, been significant improvement within nursing to engage meaningfully with nursing staff.

Nursing leaders had held listening events with nurses, maintained regular monthly meetings for heads of nursing and ward leaders, strengthened nursing leadership and improved the visibility of nurse leaders. Staff turnover within the trust had been high, but there had been a reduction in the vacancy rate within nursing.

Our findings

There have been significant cultural, relationship and leadership issues within urgent and emergency care which have had a demonstrable negative impact on patient outcomes. The trust had commissioned mediation for staff and had relied on external intervention from the NHSE/I's Emergency Care Improvement Support Team (ECIST) to help to engage staff and deliver improvements in performance on length of stay and ambulance handovers.

Our conversations on the Freedom to Speak-Up agenda, focus groups with Junior Doctors and discussions with others with roles intrinsically linked with cultural change reflected a lack of engagement with staff. As did the trust's 2020 staff survey results with the majority of relevant indicators falling below the national average, with many falling significantly below.

These cultural issues, along with a lack of meaningful clinical engagement had created a disconnect between management and clinical staff. A clinical summit was held in February 2021 to bring these groups together to look to bridge the gap and work together to make improvements and to begin to reform the medical model. However, a recent follow-up to this summit, around the time of our inspection, showed that this work had proved unsuccessful and the pace of delivery (and reform) had not been improved through this process.

Just prior to this summit, ECIST had reported to the trust that it was their assessment that poor behaviours had been normalised in the organisation and they observed an apathy to challenge these behaviours. They also reported that there was a culture of operational, nursing, and clinical teams working in silos across the organisation at all levels.

There had been a recent commitment by the board to prioritise and drive forward its delivery phase of the Medway Culture and Leadership Programme. This work will be supported by a significant number of staff as part of an internal change team, made-up of volunteers from across disciplines and grades.

A talent management strategy is being developed and was presented as part of the trust's our people improvement programme, in May 2021.

The trust had plans to increase engagement but needs to demonstrate evidence in support of this work. The trust will commence monthly pulse surveys in June, are holding schwarz rounds and the new chief executive is holding what are known as town hall workshops with the aim of engaging with all staff.

The trust had networks for staff with protected characteristics but apart from its BAME network, these networks are in the early stages of development. The appointment of a Head of Equality had helped to improve standards and awareness from a low base, but there was insufficient attention in this area and dissatisfaction was reportedly higher among people with protected characteristics.

External engagement and the trusts patient experience strategy are commented on above. The trust had recently revamped its approach to complaint handling to enhance the patient voice within the trust.

The arrangements for governance and performance management do not always operate effectively.

The trust had been subject to significant external intervention as it had not been able to demonstrate the quality and safety standards required without this additional support.

Our findings

An action plan had been developed by the trust leadership team in response to an external governance review and there had been other reviews of its governance conducted. Despite all of this previous activity to assess and improve its governance, the new chief executive had needed to commission a further governance review. An NHSE/I improvement director was supporting this work.

The trust's clinical governance structure was separated in to two divisions of planned and unplanned care. The model had proven to be unwieldy as while the planned divisional and care group structure was more established, the size of its unplanned division made it challenging to effectively manage, and oversee, the complexity and a greater variety of services.

There was a clear structure and clear routes through divisions and care groups and clarity on how reporting should go up to the quality assurance committee. Information was reviewed at divisional meetings, but reporting was not embedded. The clinical governance structure and reporting were in the early stages of development. Clinical governance meetings had recently been set-up to review complaints, incidents and mortality. Clinical and nursing leads had previously highlighted that these areas were not being given enough time for discussion in business performance meetings.

There had been further recent appointments to strengthen its approach to governance including the appointment of new care group clinical directors and getting it right first time divisional clinical roles.

Mortality governance was immature with no clear approach for reporting issues. Structured judgement reviews had not happened as required and there was a backlog to be completed. Mortality meetings were meant to be held monthly but there had been months when these had not taken place.

There had not been a proactive approach to the governance of the Mental Heath Act and reporting to committees and the board has been on an ad-hoc basis. The trust's lead in this area said that the trust had not focused on this issue effectively. There was an outstanding gap analysis to be carried-out in response to the Care Quality Commission's *Assessment of Mental Health Services in Acute Trusts* report, published in October 2020.

Improvements to the trust's board assurance framework had started to make it a useable tool for the board to use to provide assurance of delivery of the strategy, and to strengthen its relationship with the corporate risk register. As referred to above in relation to strategy, the board are not yet able to have the right level of discussion about delivery of the strategy, but this was work in progress.

The role of the committees in holding executives to account needed to be strengthened.

The trust's Council of Governors expressed that they felt they were engaged, provided with the necessary opportunities to challenge and scrutinise quality and performance, and that they were empowered to perform their role as intended.

There was a greater understanding of how to effectively manage risk since our last inspection and systems and processes had improved. However, risks, issues and poor performance were not always dealt with appropriately or quickly enough.

The trust had completed a full risk review, that had delivered improvements in the rationalisation and use of risk registers, and the development of a risk assurance group to improve risk management. The board had been involved in these developments which had been well received, and it had also led to the use of the corporate risk register as a dynamic tool to inform business planning.

Our findings

The trust recognised though that it needed to do more to embed risk management and to make sure that it filtered through to all levels. As well as creating the necessary skills and capacity to be able to effectively manage risk.

It was concerning that the trust had only recently made improvements to begin to make sure it had sufficient oversight for clinical incidents. The trust hope that its recent appointment of an associate medical director of patient safety will help to support its efforts to make sure that clinical incidents are afforded the necessary attention.

There were significant cultural issues with the use of incident reporting with numerous examples highlighted to us of where behaviour had resulted in staff being discouraged to report.

The approach to governance around mental health was concerningly reactive. The trust had seen a significant increase in incidents related to mental health including missing patients and young people waiting for specialist placements elsewhere, and remaining under the trust's care for long periods prior to placement. There was an admitted absence of assurance on whether trust relationships with external partners, local authorities and the police were effective.

A position was set-out to us that would be expected to be embedded already, in that the trust recognised that they needed a strategy for mental health. They needed to develop a clear approach to training to support staff delivering care for mental health patients. In the absence of a strategy, a proactive review of polices and standard operating procedures needed to be carried-out, with assurance that staff use these to follow procedure.

Unprofessional behaviour and poor performance had been highlighted within the trust and the trust had not yet demonstrated that it is effectively managing staff performance and known behavioural issues.

The trust is sighted on its estate backlog maintenance requirements and it has targeted its capital investment programme to manage the highest risks within the clinical environment and elsewhere. It has also looked to invest on additional improvements to the estate targeted on staff wellbeing. These include

The information used in reporting, performance management and delivering quality care is not always accurate, valid, reliable, timely or relevant. Leaders and staff do not always receive information to enable them to challenge and improve performance.

There was a risk that management information was not reliable; leading to the potential for misleading reporting in turn potentially impacting on the efficacy of decision making. After our inspection we received the final opinion of the head of internal audit which gave data quality significant assurance with minor improvement opportunities. The trust had incorporated the relevant recommendations into its improvement plans.

The trust's leadership team recognised the challenges and were solution focused on driving the necessary improvements. The trust had made changes to the presentation of their integrated quality performance report. However, the format was relatively new for the trust and was not embedded and the information was not accessible to all those that needed to be sighted on it.

Timeliness of data was an issue for the trust with information provided for key meetings often a month behind. The trust had invested in a new system which will provide more up-to-date data and also enable it to benchmark against other organisations**.**

The trust was able to provide assurance on information governance breaches reported to the Information Commissioner and the role of the Caldicott Guardian.

Our findings

The organisation has not always reacted sufficiently to risks identified through internal processes and has often relied on external parties to identify key risks before they start to be addressed. Improvements are not always identified, or action is not always taken. There is minimal evidence of learning and reflective practice. However, there is an appetite to improve and the early stages of developing a framework to deliver necessary improvements. The trust was actively participating in clinical research studies.

The need to repeatedly assess its own governance (as it had not delivered the necessary changes highlighted by previous reviews) was a key indicator of whether the organisation had been able to effectively learn and improve within the last 12 months. However, the trust's latest review, led by its new chief executive had clear terms of reference and a short timescale, to look to rapidly strengthen quality governance.

A learning culture was not embedded within the trust, and the lack of effective governance around serious incidents, mortality and mental health (as well as an inability to effectively learn from complaints and patient experience) showed there had been little appetite for organisation learning.

However, from our core service inspections, we did identify an appetite among teams to learn and improve. In the neonatal unit improvement huddles took place twice weekly and an innovation board displayed ideas, the actions taken and how the ideas were escalated.

Notwithstanding concerns around mortality governance, within medical care we found that the service had identified learning in relation to deaths and were encouraging improvements.

There had been significant improvements made to the trust's frailty pathway which included an operational short stay ward with 12 frailty consultants and two consultants rostered every weekend. The ward was performing well. Leaders of the therapies and older persons care group held an ambition to be the centre of excellence for frailty in the community.

There was now an appetite for the use of improvement methodology within the trust, but this work was in its infancy. Organisational systems to support improvement and innovation work were underdeveloped, as was staff training in improvement methodologies.

The trust's leadership team had very recently reviewed current improvement plans and outputs, as well as emerging new issues to develop a single improvement plan. This would provide greater clarity on outputs and performance indicators and enable more effective tracking and assurance.

The trust had also commenced partnership working with external NHS colleagues to design an improvement methodology for the trust. The new chief executive had experience of implementing a similar methodology to successfully transform services.

The trust had established the Medway Innovation Institute and had held several improvement events which had helped to drive improvements in patient outcomes. However, the trust did not have the necessary infrastructure to be able to assess all projects for quality and impact. The trust needed to strengthen the leadership for the work of the institute and develop its supporting framework.

The trust had a research and innovation strategy and had recently developed a joint research and innovation strategy between itself and Canterbury Christ Church University. Its research and innovation team liaise with the clinical team within the specialties to deliver clinical trials. There were various ways in which its leads for research and innovation promoted its research activity within the trust, including at new staff inductions.

Our findings

The trust had patient research ambassadors who provided an independent view of its research activities from a patient's perspective and looked to improve community engagement in research and innovation. A range of research studies had been made available across specialties.

The trust had a track record of significant financial challenge, linked to the clinical and service challenges faced by the trust. It was subject to undertakings imposed by the regulator of NHS foundation trusts. The trust was working to review and refresh the terms of the undertakings to reflect the progress that it had made in addressing issues of concern although it recognised further work was required to fully address them. The chief financial officer joined in late 2020 and has a track record of working in financially challenged NHS organisations. The trust chair and the incoming chair of the finance committee both have a background in the financial services sector and risk management.

The trust was in a period of transition with the move to an ICS but was beginning to improve relationships between the trust and the system. The trust recognised the uncertainty about the NHS finance regime going forward as a potential risk. Specifically, that there would be a drive to improve productivity and efficiency through transformation, innovation and pressure on capital resources available.

The board and the finance committee had worked to improve the trust's underlying financial position over the past three years. It had delivered significant reductions in the cost of services including savings of £9m (against a £12m target) in 2020-21. The trust was seeking to amend the terms of its undertakings with the NHS in the light of improvements delivered. However, it needed to progress further the delivery of its financial recovery plan to achieve longer term financial sustainability.

The board assurance framework included two significant risks relating to the trust's financial standing. However, these did not reflect the latest financial position of the trust. In particular, the trust needed to reflect the impact of the COVID-19 pandemic on its underlying financial position.

Operational teams acknowledged their budgets and had been engaged with their development. The executive team had undertaken an exercise to challenge and prioritise cost pressures to be funded, and a 'showcase event' was planned to re-energise the transformation and cost improvement agenda. However, at the time of the inspection, the trust had not yet fully developed and agreed its cost improvement programme with operational teams.

At the time of the inspection, the annual report and accounts 2020-21 had not been finalised and remained subject to audit. The draft Head of Internal Audit opinion that was shared with the inspection team gave the trust partial assurance on the operation of its systems of internal control. It was noted that a number of internal audit reports for the 2020-21 financial year had not yet been agreed. Further evidence was being provided to encourage the internal audit to increase confidence in findings for both audits.

The trust subsequently updated us on this position, and upon completion of the work the trust had five reviews rated as significant assurance with minor improvement opportunities and four reviews rated as partial assurance with improvements required. This led to a final Head of Internal Audit opinion of significant assurance with minor improvements.

No use of resources review was carried-out for this inspection.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021	Good ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021	Requires Improvement ↑ Jul 2021	Requires Improvement ➔➔ Jul 2021

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medway Maritime Hospital	Requires Improvement ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021	Good ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021
Overall trust	Requires Improvement ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021	Good ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021	Requires Improvement ↑ Jul 2021	Requires Improvement ➔➔ Jul 2021

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

Rating for Medway Maritime Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021	Good ↑ Jul 2021	Requires Improvement ↑ Jul 2021	Requires Improvement ↑ Jul 2021	Requires Improvement ↑ Jul 2021
Services for children and young people	Good ↑ Jul 2021	Requires improvement Apr 2020	Good Apr 2020	Requires improvement Apr 2020	Good ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021
Critical care	Good Apr 2020	Good Apr 2020	Outstanding Apr 2020	Good Apr 2020	Outstanding Apr 2020	Outstanding Apr 2020
End of life care	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020
Maternity and gynaecology	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Requires improvement Apr 2020	Good Apr 2020	Good Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020
Urgent and emergency services	Requires improvement Apr 2020	Good Apr 2020	Good Apr 2020	Requires improvement Apr 2020	Good Apr 2020	Requires improvement Apr 2020
Diagnostic imaging	Requires improvement Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Outpatients	Good Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Good Jul 2018
Overall	Requires Improvement ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021	Good ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021	Requires Improvement ➔➔ Jul 2021

Medway Maritime Hospital

Windmill Road
Gillingham
ME7 5NY
Tel: 01634833824
www.medway.nhs.uk

Description of this hospital

Medway NHS Foundation Trust is a single-site hospital based in Gillingham. Medway Maritime Hospital serves a population of more than 424,000 across Medway and Swale. The trust employs around 4,400 staff and provides a wide range of specialist and general hospital services to almost half a million patients a year. This includes more than 125,000 emergency department attendances, 88,000 admissions, 278,000 outpatient appointments and more than 5,000 babies born last year.

As an NHS foundation trust, the organisation has a Council of Governors and more than 10,000 public members. The hospital is made up of two clinical divisions; unplanned and integrated care and planned care that are supported by corporate functions. Each division has a dedicated leadership team comprising of a divisional director of operations, divisional medical director and a divisional director of nursing. The board of directors, led by chair Jo Palmer, has eleven executive directors including George Findlay, Chief Executive, and eight non-executive directors.

Medical care (including older people's care)

Requires Improvement ↑

Is the service safe?

Requires Improvement →←

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

Mandatory Training

The service provided mandatory training in key skills to all staff and there were systems to monitor its completion. However, not all staff had completed all the mandatory training expected.

Mandatory training modules included, but were not limited to, adult basic life support, fire safety, infection prevention and control and conflict resolution. Staff we interviewed said they received enough training to ensure they had the skills to do their jobs. Staff reported having adequate time to complete training courses.

Senior nurses accessed training compliance via the trust's digital systems. Each department had its own spreadsheet. Managers demonstrated the ease of which individual and team reports could be produced and described how the learning management system generated email alerts sent to the individual concerned and their line manager whenever a topic became 'due'.

In the 12 months prior to our inspection, the trust offered mandatory training exclusively through online learning in response to the COVID-19 pandemic. Simulated training was postponed; however, these sessions had recently been re-instated in smaller groups to allow for social distancing. This was reflected in the lack of compliance with moving and handling level 2 training. The trust target of 85% had only been met by allied health professionals.

Among all staff groups, allied health professionals performed better, meeting the trust target of 85% in eight out of the 10 modules.

Nursing staff met the trust target in six of the 10 mandatory training modules. This was the same as reported at the last inspection in December 2019. Unregistered and administrative staff groups also met the trust target in six of the 10 modules they were eligible for.

Medical staff performed slightly worse than the other staff groups, achieving the 85% target in five of the nine mandatory training modules. However, this was a significant improvement on the last inspection where the target had been met in only one module.

Safeguarding

Staff understood how to protect patients from abuse. Most staff had completed training on how to recognise and report abuse and those we spoke with knew how to apply it.

Safeguarding policies and procedures were accessible to all staff via the trust intranet. We observed that information on how to contact the safeguarding team was displayed on wards.

Staff we spoke with stated they were aware of these policies and would follow them if they identified an at-risk patient.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with could give examples of potential safeguarding issues and how they would escalate these.

However, we noted that the trust had several safeguarding policies. There was a general safeguarding policy, which listed the responsibilities and referred staff to the other policies. A safeguarding and protecting children policy dated December 2020 contained the contact telephone numbers of local authorities. The policy had various sections on types of abuse including neglect, physical abuse, and modern slavery. However, it did not mention female genital mutilation (FGM), nor did it contain a referral form. We also reviewed the safeguarding adults' policy. This policy defined types of abuse although FGM was not mentioned. There were no contact telephone numbers or the name of the named nurse for safeguarding in either policy.

We were shown an online safeguarding flow chart which contained details of what constituted abuse and the local authority contact details. However, the name of the lead for safeguarding was not identified.

Records confirmed that all staffing groups met the 85% target for safeguarding adult level 2 training. Similarly, all staffing groups met the 85% target for safeguarding children level 2 except for medical staff who were shy of this target at 83%.

Safeguarding alerts were written on referral letters or inputted onto the trust's electronic patient record to alert other staff looking after the patient.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, we had concerns about the environment of the temporary coronary care unit.

At the last inspection in December 2019 we found that the service did not have effective systems to control infection risk in line with best practice. We saw that staff did not always clean their hands or use personal protective equipment (such as gloves and aprons) in line with trust policy.

During the COVID-19 pandemic, the trust leaders decided to pause hand hygiene and other related infection prevention and control audits to focus on COVID-19. At this inspection we saw staff following good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures. There were enough hand wash sinks and hand gels. Paper towels and soap dispensers were adequately stocked. We saw staff correctly followed hand hygiene practice, were bare below the elbow and used relevant personal protective equipment in appropriate areas including wearing face masks at all times. All wards had antibacterial gel dispensers at the entrances and by patient's bedside areas. There was signage, regarding hand washing for staff and visitors displayed.

Posters were displayed throughout all medical wards reminding staff, patients and visitors to maintain social distancing.

Medical care (including older people's care)

The last inspection of medical care highlighted a lack of compliance with the safe use and storage of products subject to Control of Substances Hazardous to Health and under the Control of Substances Hazardous to Health Regulations 2002. During this inspection we saw all substances subject to these regulations were stored securely with PIN-code access to the cleaning cupboards.

Side rooms were used where possible as isolation rooms for patients with an infection to reduce the risk of cross infection. There was clear signage outside the rooms so staff were aware of the increased precautions they must take when entering and leaving the room. Personal protective equipment was stored in a trolley outside each side room for ease of access.

We observed disposal of sharps, such as needles, followed good practice guidance. Sharps containers were dated and signed upon assembling and the temporary closure was used when not in use.

Cleaning schedules and records of completion were kept. Wards used the national colour coding scheme for hospital cleaning materials and equipment, so items were not used in multiple areas reducing the risk of cross infection.

However, when we visited the coronary care unit, we found that there was a build-up of dust and food debris in hard to reach places, such as underneath equipment. Staff told us this was due to the lack of space, and it was difficult to move furniture and equipment to clean these areas effectively. We raised our concern with trust leaders who immediately responded by carrying out an urgent infection prevention and control risk assessment of the unit and deep cleaning of environment within 24 hours.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, we had concerns about the environment and storage of equipment on the temporary coronary care unit.

During our inspection we visited radiology, the emergency care unit, Emerald, Jade, McCulloch, and Trafalgar ward. The areas appeared visibly clean and dust free. We saw that equipment was kept clean and staff were seen cleaning equipment after use. Wards and departments, we visited used ‘I am clean’ stickers to inform colleagues that equipment or furniture was cleaned and ready for use.

Staff told us, and we observed, that there were plenty of supplies of personal protective equipment in all medical care areas, including different types and sizes of facemasks, gloves, aprons. We saw all staff using PPE when providing patient care and in accordance with COVID-19 guidelines.

Staff had access to emergency equipment in the wards and other clinical areas, including portable oxygen, suction and automated defibrillators stored on purpose-built trolleys. These were stocked and checked daily or weekly in accordance with trust guidance sheets attached to each trolley.

Beds, furniture and electrical equipment were labelled with asset numbers and labels showing service dates. Staff told us that the medical equipment was well maintained centrally, and none reported any problems in obtaining sufficient items for use. Staff told us non-standard equipment such as bariatric beds or wheelchairs could be ordered at short notice when required.

We saw fire safety equipment available throughout the hospital with labels showing fire equipment safety checks had been completed by an external specialist contractor.

At the last inspection we found that the design, maintenance and use of facilities, premises and equipment did not always keep people safe. This was still the case in the temporary coronary care unit. The unit had been moved from its dedicated location with four beds and a pacing room into a bay on Nelson ward. Spacing within the bay was a challenge and was non-compliant with the Department of Health and Social Care, Health Building Note (HBN) 04-02: Critical care units. Minimum dimensions are important to allow staff to access the patient from all sides of the bed and move equipment safety.

Unlike other wards and areas, we visited, there were no signs displayed at the entrance indicating the maximum capacity of the coronary care unit to allow for adequate social distancing. Staff told us the maximum capacity was 10 people including the patient; however, this was often exceeded. Staff said the number of people in the room exceeded 15 people, especially during clinical emergencies.

We were told there were on average 18 members of staff on duty per shift from both Nelson ward and the coronary care unit. All 18 members of staff shared a small break room with a maximum capacity of three people at a time, and this was displayed clearly. There was one toilet available for all 18 members of staff per shift which did not meet Regulation 20, Sanitary conveniences of the Workplace (Health, Safety and Welfare) Regulations 1992. The regulation states there should be two toilets and two wash basins for between six and 25 people.

As well as being an inpatient facility, the bay was used to store some coronary care equipment including monitoring screens, central lines, drip stands, emergency pacing equipment, a medicines trolley, and chairs for staff, patients and visitors. This resulted in the area being cluttered and difficult to move around.

The space and equipment created hazards. There were many obstacles when manoeuvring around the bay. For example, we saw a yellow bin partially restricting access to the fire exit as there was nowhere to store it. Staff told us in the event of a cardiac arrest they had to move equipment and furniture out through the fire escape to create room for the team managing the patient. There was no space to carry out invasive procedures such as central lines, so staff had to move beds and equipment around the bay to be able to perform the procedure.

Emergency call bells were located above patient beds but were too high for some members of staff. On some occasions staff said they had to climb on the bed to reach the alarm bell. One patient told us on two occasions they helped raise the alarm because the staff could not reach the bell. This meant the arrival of emergency support was delayed, increasing the risk of patients deteriorating further.

The service had reduced the level of therapy for coronary care patients. Staff told us the environment had affected the way they worked, and they were not able to give patients the appropriate level of care or therapy with limited resources. For example, the unit had access to piped oxygen however, staff were unable to offer patients continuous positive airway pressure (CPAP) in this particular area because it was an aerosol generating procedure. Patients requiring CPAP were to be transferred to the high dependency unit, intensive care unit or the medical dependency unit. Staff told us it was difficult to get a bed for patients in these areas and therefore at times patients did not receive this treatment which had the potential to affect their recovery and increase their hospital stay.

The unit did not have a pacing suite therefore patients requiring temporary pacing were transferred to theatre 5. Staff told us they were delays in carrying out invasive pacing procedures because the necessary equipment had to be sourced

in the hospital. Staff kept a trolley with pacing equipment in the bay to reduce any delays. However, this contributed to the clutter in the bay. Staff told us that the coronary care unit was located a considerable distance from the other areas including theatres, high dependency unit and intensive care unit that it was stressful organising and transferring critically ill patients.

We reported our concerns about the temporary coronary care unit to trust leaders on the day. The service took immediate action in response to our concerns and produced an action plan. Actions taken included a health and safety risk assessment, the removal of a bed from the bay to reduce the risk and create more space for both patients and staff. Staggered visiting times were implemented for the coronary care unit to address visitor numbers preventing adequate social distancing. The service removed any clutter and obstructions in the bay and provided shelving to assist with storage. The service said arrangements were made to relocate alarm buttons to meet the requirement of Health Technical Memoranda and an alternative alarm point was identified to mitigate risk.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and acted when patients were at risk of deterioration.

Staff completed risk assessments for each patient on admission / arrival, using recognised tools, and reviewed them regularly. We saw nursing staff carried out comprehensive risk assessments on patients' admissions which were kept in the patients' records. This included assessing the patient against the risk of falls, nutrition status, skin integrity and pain. We reviewed eight sets of electronic patient records and saw nursing staff had reviewed and repeated risk assessments within suitable and recommended timescales.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the National Early Warning Score (NEWS) monitoring tool to identify deteriorating patients. NEWS is based on a simple scoring system in which a score is allocated to physiological measurements, for example blood pressure and pulse. Staff used an electronic system to record NEWS observations. This information system displayed patients' details, when assessments and observations had been completed and when they were next due.

We reviewed NEWS records for eight patients and saw they had been escalated and repeated in line with trust policy. Ward sisters monitored completion of NEWS and other risk assessments electronically. Matrons monitored compliance with NEWS calculation and escalation of the deteriorating patient as part of monthly audits. Results from February 2021 to April 2021 showed 99% of NEWS scores were escalated appropriately.

Staff shared key information to keep patients safe when handing over their care to others. We observed several daily huddles during our inspection. We saw staff discussing the risks of deteriorating patients. Staff told us daily huddles were held twice a day with minutes kept in folders at the nurse's station for staff to read. We noted that staff discussed any issues identified during handovers to ensure everyone was up to date on each patient care and those at risk of deterioration.

Nursing staff told us they had good support from the doctors and the outreach support team whenever a patient's deterioration was observed. We saw members of the outreach team working with ward staff during our visit.

Staff on the frailty unit conducted a frailty assessment to identify patients at increased risk of adverse outcomes including falls, mortality and worsening mobility.

Medical care (including older people's care)

Nurse staffing

The service did not always have enough staff to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix to meet the needs of the service including using locum and bank staff to help keep patients safe.

Ward managers were aware at the earliest opportunity of any staffing issues for the shift and could escalate any staffing concerns. Staff discussed staffing levels as part of the safety huddle at each shift handover. Wards also had access to a "bleep holder" (usually a band 7 nurse) who was supported by a matron. They were responsible for contacting all ward areas in the mornings to understand their staffing needs in order to move staff with the right skills to mitigate risks to patient care.

Medical care wards clearly displayed the number of staff on duty at the entry to each ward to enable staff, patients, and visitors to see staffing levels on the ward.

We saw the number of nurses and healthcare assistants did not always match the planned numbers. From April 2020 to March 2021, 8% of shifts were filled by bank staff and 4% by agency staff to cover sickness absence or vacancy for qualified nurses out of a total of 915,350.18 total working hours available. In the same period, the service was not able to fill 8% of the available hours with either bank or agency staff.

We saw on Harvey ward the actual clinical support workers on duty matched the planned staff for both the day and night shifts. Nursing staff on duty on the night shift matched the planned numbers but were understaffed during the day with five planned nurses versus the actual staffing number of three.

We saw the discharge lounge was staffed with two senior nurses, two clinical support workers and one ward clerk. Staff in the discharge lounge told us that the usual compliment of staff was two senior nurses and four clinical support workers.

In the emergency care unit, staff told us rosters were completed up to two months in advance and staff told us that they had not had any issues booking their annual leave. We were told that at the time of the inspection, the department relied on a bank nurses to cover as there were only two substantive whole-time equivalent nurses to cover the seven days.

The service had high vacancy rates. From May 2020 to April 2021, the service reported a vacancy rate of 17% for nursing staff in medical care. This was higher than the trust's target vacancy rate of 12%. The service was actively recruiting nurses. Three wards had successfully recruited from overseas and were waiting for the nurses to start working. For example, we were told Harvey ward would be fully established with nursing staff in May 2021 while Jade ward expected to be fully established in June 2021.

The service had low sickness rates which exceeded trust targets. From April 2020 to March 2021, the service reported a sickness rate of 6% for nursing staff in medical care. This was higher than the trust target of 4%.

Medical staffing

The service did not always have enough medical staff to keep patients safe from avoidable harm and to provide the right care and treatment

Medical care (including older people's care)

Medical staff reported the service did not have good skill mix of medical staff on each shift. We spoke with several junior doctors, who told us they were unhappy with the shift rotas. They told us there were many foundation year-one and year-two doctors and not many middle grade doctors. Junior doctors felt there needed to be more experience on the wards and better supervision for them. They reported being exceptionally busy.

However, medical staffing arrangements for registrars was better than the England average while junior and middle grade doctors were in line with the England average. Compared to the last inspection there was an increase in middle grade doctors from 3% to 6% while there was a decrease in registrars from 35% to 33%.

Staffing skill mix for the 146 whole time equivalent staff working in medicine at Medway NHS Foundation Trust.

In November 2020, the proportion of consultant staff reported to be working for the service was lower than the England average at 42% compared to 45% for England.

The proportion of junior (foundation year 1-2) staff and middle grade doctors (at least three years at senior house officer or higher grade within their chosen specialty) was the same as the England average at 20% and 6% respectively.

The proportion of specialist registrars working for the service was higher than the England average with 33% compared to 29%.

(Source: NHS Digital - Workforce Statistics - Medical (01/11/2020 - 30/11/2020)

The service was staffed by eight consultants Monday to Friday. Staff told us there should be 14 consultants to meet the needs of the service. There were two medical consultants on call, on site from 5pm to 9pm and remotely until 8am. At the weekend consultants were available from 8am to 8pm, and then remotely until 8am.

The medical staff on-duty did not always match the planned number. From April 2020 to March 2021 4% of shifts were filled by bank staff and 1% by locum staff to cover sickness, absence or vacancy for medical staff out of a total of 428,447.2 total working hours available.

In the same period the service was not able to fill 2% of the available hours with either bank or locum staff. Staff told us there were many long-term locum doctors. The locum doctors were said to often call in sick, which meant junior doctors on the frailty ward had “to pick up the slack elsewhere” including doing two ward rounds a day. Junior doctors said this was common practice and they felt it was unfair and unsafe having to review patients they did not know. The issue had been escalated to the rota co-ordinator and consultants, but we were told there were opposing views on the practice therefore the issue had remained unresolved.

The service had low vacancy rates for medical staff. Trust records for the same time period showed the service had a vacancy rate of 8% for medical staff. This was lower than the trust’s target vacancy rate of 12%. However, staff told us recruitment and retaining of medical staff was still an issue. In the specialist medicine care group, there was a consultant vacancy for diabetes, respiratory, gastrology and rheumatology. The therapies and older people care group had no consultancy vacancies at the time of our inspection.

Sickness rates for medical staff were low. From April 2020 to March 2021, the service reported a sickness rate of 2% for medical staff in medical care. This was lower than the trust target of 4%.

Records

Medical care (including older people's care)

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Staff kept detailed records of patients' care and treatment although there were separate systems for this. The service primarily used an electronic patient record system, but we noted some patient care was recorded on the paper system. Patient records included records of treatment, care plans, risk assessments, medicines administration, and patient history.

Patient notes were comprehensive, and all staff could access them easily. In all the electronic patients records we reviewed we found a good standard of record keeping. Records were clear and up to date. We saw staff had completed records in full, were concise, legible and signed. The records included multidisciplinary input where required for example, entries made by physiotherapists, occupational therapists and medical staff. We saw care plans focused on individual needs of patients and their families and included clear instructions and review dates.

Patient notes were stored securely in lockable trolleys, while electronic records required individual log in information to access.

However, we found some paper records were still in use and not always fully completed contemporaneously in line with trust policy. We reviewed 11 paper records and noted that NEWS scores were not always clearly documented. Patient allergies not clearly highlighted on front of paper records. We saw NEWS accurately completed on admission, but no evidence of daily NEWS after admission. Out of 11 patient records reviewed only four had a multidisciplinary team care plan.

The service's most recent audit of patient records dates was from May 2020 to October 2020 therefore we could not make judgement on their performance in the months prior to our inspection. The audit was based on health records standards such as file condition/ structure, nursing documentation, doctor documentation and additional compliance. Results provided showed that the service was performing well below their target of 100 with the highest score for file condition at 86 and the lowest for nursing documentation at 69.

Medicines

The service used systems and processes to safely prescribe and administer medicines. However, controlled drugs were not always recorded or stored safely.

The trust had current medicines management policies, together with protocols for high-risk procedures involving medicines such as the intravenous administration of antibiotics. These were readily available for staff to access. Prescribers also had access to relevant resources on medicines management such as electronic and hard copies of the current British National Formulary.

Staff followed systems and processes when safely storing medicines. During our visit we saw medicines were stored securely in locked, wall mounted cabinets and kept in key-coded rooms away from visitors. Medication cabinets were only accessible to key staff with key codes and the controlled drugs cabinets required a set of keys which were held by the nurse in charge of the shift.

The temperatures in the treatment rooms and medicine refrigerators were recorded and monitored centrally. Staff told us that any discrepancies were acted upon immediately.

Medical care (including older people's care)

Medicines requiring cool storage were correctly stored correctly in fridges. Staff consistently completed daily temperature checklists on the wards we visited. Staff we spoke with were aware and could explain the process to follow if there were gaps in these records or if the fridge temperature were outside the required range.

Controlled drugs (medicines which are required to be stored and recorded separately) were stored and recorded appropriately. Access was limited to qualified staff employed by the trust. Two nurses were observed following the correct procedures for the recording and administration of controlled drugs for a patient. Spot checks on balances showed that contents of the cupboard matched the register.

Emergency medicines were available for use and records indicated that these were regularly checked and were in containers with tamper-proof seals.

Staff followed systems and processes when safely prescribing medicines. We reviewed eight prescription charts and found these were legally valid and contained information about people's allergies.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Charts were clinically screened by a member of the pharmacy team who we saw during our inspection carrying out their ward rounds. Staff told us pharmacy staff were present on the ward daily.

The service had systems to make sure staff knew about safety alerts and incidents, so patients received their medicines safely. The matron and senior nurses communicated all medicine related alerts and recalls to the nurse in charge of the ward who cascaded to all ward staff. Staff recorded any medicine incidents on the electronic reporting system. Staff gave examples of how they made improvements following recent incidents to prevent them from re-occurring.

However, the service did not have an effective process for the safe management and storage of patients' own medicines. From January 2021 to April 2021 medical wards had reported six incidents of missing controlled drugs. The service shared their initial incident reports and it showed staff did not always record medication brought in by patients in the controlled drugs book or store the medication in the controlled drugs cupboard. Care group leaders told us a thematic review had been commissioned to find the root cause and make recommendations for learning.

Incidents

The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support. However, there was a large backlog of incidents yet to be reviewed and closed.

Staff generally reported serious incidents clearly and in line with trust policy. All the staff we spoke with knew what incidents to report and how to report them. Staff reported incidents through an online reporting system and staff we spoke with could give examples of the types of incidents they had reported.

However, not all staff reported incidents and near misses in line with trust policy. For example, staff on the coronary care unit told us, they did not report incidents or near misses often because previous reports did not result in any changes being made.

Never Events

Medical care (including older people's care)

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 May 2020 to April 2021, the service reported one never event for medicine. This incident occurred on Milton Ward in December 2020 and involved a nasogastric (NG) tube which had been inserted into the lung rather than the stomach. Data provided demonstrated that duty of candour had been undertaken following the never event incident.

(Source: Strategic Executive Information System (STEIS))

Serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the service reported 15 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from May 2020 to April 2021. A breakdown of incidents by incident type are below.

Incident type

Percentage of total and Number of incidents

Slips/trips/falls meeting SI criteria represented 33.3% (5) of incidents.

Treatment delay meeting SI criteria represented 20% (3) of incidents.

HCAI/Infection control incident meeting SI criteria represented 13.3% (2) of incidents.

Diagnostic incident including delay meeting SI criteria (including failure to act on test results) represented 13.3% (2) of incidents.

Abuse/alleged abuse of adult patient by staff represented 6.7% (1) of incidents.

Medication incident meeting SI criteria represented 6.7% (1) of incidents.

Sub-optimal care of the deteriorating patient meeting SI criteria represented 6.7% (1) of incidents.

(Source: Strategic Executive Information System (STEIS))

The trust had a duty of candour policy of which staff were aware. Three nursing staff we spoke with stated that they knew the duty of candour regulation meant that they had to be honest and open when things went wrong with patient care or treatment. We saw duty of candour issues were discussed as part of the division governance board meetings and patient stories were included for learning and reflection for staff to improve patient experience.

Medical care (including older people's care)

Managers reviewed accidents and incident reports, but these were not carried out in a timely way. The trust reported that they had a large backlog of serious incidents to investigate. At the time of our inspection records showed medical care had 330 incidents that were overdue by 45 days and a further 203 incidents overdue by 60days. This meant the service could not in a timely manner, learn from the incidents or take action to prevent the incidents from happening again.

Learning from incidents was shared in several ways. Staff met to discuss the feedback and look at improvements to patient care. Incidents were a regular agenda item during daily staff huddles and team meetings to ensure learning was shared with all staff. We saw minutes of team meetings that also detailed actions taken for learning.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We observed care on medical wards during our visit and found it was delivered in line with evidence-based guidance such as that published by National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies, and was supported by local guidelines and standard operating procedures.

Patient assessments were based on national tools, such as the National Early Warning Scores (NEWS). Care pathways were used for conditions such as sepsis, diabetes, cardiology, and stroke and were based on national guidance.

Staff could access national and local guidelines through the trust's intranet. There were enough computer terminals and devices provided on the wards we visited. Staff could also download an application on their mobile phones which allowed them access to these resources, and we saw staff using this. We noted there were links on the trust intranet to help access national guidelines if needed.

However, on the emergency care unit we saw that some care pathways were not easily accessible. We asked staff in the unit to show us the chest pain pathway following a concern that had been identified during our inspection. Staff were not aware of the pathway and had to ask several colleagues before the standard operating procedure was found.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Medical care (including older people's care)

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients could choose from a variety of food options that were cooked on-site. During our visit we saw patients in the emergency care unit and the discharge lounge were offered tea and coffee from a tea trolley and there were snacks available whilst they waited to be seen.

The trust had protected mealtimes and we saw red trays were used to indicate patients who needed help at mealtimes. We observed staff supporting these patients with feeding.

Staff used Malnutrition Universal Screening Tool (MUST) when they assessed patients at risk of malnutrition. Nutrition and hydration risks were assessed and monitored on patients' records. Fluid balance and nutritional intake charts were held and completed at the patient's bedside. In the eight electronic records we reviewed, we found MUST scores were consistently recorded. Patient records also showed contributions in the notes from dieticians.

Specialist support from staff such as dietitians was available for patients who needed it. Dietitians monitored patients who received nutrition through a nasogastric or percutaneous endoscopic gastrotomy feeding tube. Percutaneous endoscopic gastrotomy is the process by which a patient receives nutrients through a tube inserted via the abdominal wall directly to the stomach.

Staff explained that they referred patients to dietitians if they were concerned about the patient's nutrition and hydration and said they were very responsive. They provided practical; evidence based dietary advice to patients. They worked with the catering department to provide optimum nutrition for patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Pain relief was managed on an individual basis and was regularly monitored. Patients told us that they were consistently asked about their pain and supported to manage it. Patients we spoke with generally felt they were provided with pain relief when they raised it as a concern with staff. We observed good communication from staff to patients when administering analgesia. Staff stated they would regularly check with patients if they were in pain, and if they needed any medication to relieve this.

All electronic records we reviewed showed pain had been assessed regularly. One set of notes for a patient living with dementia included the appropriate use of the cognitive impairment pain assessment scale. The scale is a tool used to help assess pain in patients who are unable to clearly communicate their pain needs.

Patient outcomes

At the last inspection we reported outcomes for people who use services did not always meet expectations, compared with similar services. This was still the case at this inspection.

Medical care (including older people's care)

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Information about the outcomes of patient's physical and mental care and treatment, were routinely collected and monitored. This was done through local and national audits. Local audits included but were not limited to; appropriate completion of NEWS2, fluid balance chart and visual infusion phlebitis (VIP) scores. VIP is a scoring system used to identify early signs of phlebitis, along with prompt removal of peripheral intravenous cannulas.

Quality and safety information boards for each ward were clearly displayed on notice boards, which allowed patients and visitors to see how well the wards were performing. This included information on staffing levels, the nurse in charge, falls, and infection control. For example, Harvey ward had not had an infection acquired on the ward in 304 days on the day of our inspection. The team had been awarded a gold star award for this achievement. Managers told us this initiative was driving improvement and staff echoed this stating recording and displaying the ward's performance data encouraged them to work together to keep achieve better care outcomes for all patients.

Trust level

From December 2019 to November 2020, patients at the trust had a similar expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Risk of readmission for elective specialties:

- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions
- Patients in medical oncology had a lower than expected risk of readmission for elective admissions.

Risk of readmission for non-elective specialties:

- Patients in general medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a similar expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a lower than expected risk of readmission for non-elective admissions

(Source: Hospital Episode Statistics - HES - Readmissions (01/12/2019 - 30/11/2020))

National Audit of Dementia

Medway Maritime Hospital

The data below summarises Medway Maritime Hospital's performance in the 2019 National Audit of Dementia in comparison to other hospitals nationally. The audit did not have a national standard to compare against.

The hospital reported low numbers compared to other hospitals nationally, with a performance score of 0.0% for the metric: Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good *(A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital).*

Medical care (including older people's care)

The hospital reported a similar audit rating to other hospitals nationally, with a performance score of 72.8% for the metric: Percentage of staff responding “always” or “most of the time” to the question “Is your ward/ service able to respond to the needs of people with dementia as they arise?” *(This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)* .

The hospital reported a similar audit rating to other hospitals nationally, with a performance score of 41.3% for the metric: Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium *(Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary*).

The hospital reported a worse audit rating compared to other hospitals nationally, with a score of 77.1% for the metric: Multi-disciplinary team involvement in discussion of discharge *(Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission).*

(Source: National Audit of Dementia)

A review of the medical care indicators in the CQC Insight Acute publication identified the areas where the trust’s performance had improved/deteriorated or where it differed from the national comparison.

Of the 27 Medical care indicators, 0 (0%) were categorised as **much better**, 0 (0%) as **better**, 2 (7%) as **worse** and 1 (4%) as **much worse**.

Indicator

From January 2020 to December 2020, in-hospital mortality: Acute myocardial Infarction (HES) declined over time and was worse than the national comparison.

From January 2020 to December 2020, in-hospital mortality: Chronic obstructive pulmonary disease and bronchiectasis (HES) declined over time and was worse than the national comparison.

From October 2019 to December 2019, SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (RCP) had no significant change and was much worse than the national comparison.

22 indicators were compared to data from 12 months previous, of which 1 (5%) has shown an **improvement** and 2 (9%) have shown a **decline**.

Indicator

In February 2021, the referral to treatment on completed admitted pathways in medicine, within 18 weeks (NHSE) had improved and was about the same as the national comparison.

From January 2020 to December 2020, in-hospital mortality: Acute myocardial infarction (HES) had declined over time and was worse than the national comparison.

Medical care (including older people's care)

From January 2020 to December 2020, in-hospital mortality: Chronic obstructive pulmonary disease and bronchiectasis (HES) had declined over time and was worse than the national comparison.

(Source: CQC Insight)

The endoscopy unit was accredited by Joint Advisory Group (JAG) on for gastrointestinal endoscopy in June 2020. This is a quality improvement and service accreditation programme and meant the team had demonstrated consistent care, quality and safety in line with national standards.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service offered staff development opportunities to improve staff competence. Staff said they used their appraisals and supervision sessions to identify personal and competency-based learning needs.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they received an annual appraisal. The trust target was 85% which had been met by both nursing and medical staff. Trust records showed that 86% of medical and nursing staff across medical care in the service had received their annual appraisal. Administrative staff and allied health professions had not met the target at the time of our inspection, achieving 74% and 80% respectively.

Most staff we spoke with had an appraisal in the last twelve months and felt that it had been valuable to their roles. However, other staff had not had an opportunity to formally discuss their continuing professional development and performance in an appraisal and felt this could be more structured with formal plans and support for career progression.

Managers gave all new staff including locum and agency staff a full induction tailored to their role before they started work. New staff completed an induction program when they first started employment. This included completing mandatory training, information on the trust values, and competency assessments where necessary. Staff we spoke with felt they were well supported when starting employment in trust.

Managers made sure staff received any specialist training for their role. Staff we spoke with in specialist areas told us about additional training they had done to ensure they were competent. For example, the ward manager on the coronary care unit had created a workbook to upskill staff in this area and had also set up an accredited cardiology course with a local university. Similarly, on the high dependency unit staff that had been redeployed had completed additional training such as tracheostomy training in response to care for patients admitted with COVID-19 symptoms.

We reviewed four staff files and saw staff completed a competency package relevant to their role. We also saw certificates providing evidence of continuing professional development. We also checked four staff competencies for equipment for equipment and all had received training for equipment appropriate to their roles.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Medical care (including older people's care)

Staff described good, collaborative working practices. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary team (MDT) working was established on the medical wards with daily ward meetings held on all the wards and medical care areas we visited. These were called board rounds and attended by the full range of professionals from allied health professionals, discharge co-ordinators, nursing staff, GP trainees and end of life/ elderly care leads as appropriate. We observed four board rounds in different medical areas and noted there was good communication throughout.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff reviewed discharge planning with occupational therapy input, resuscitation status, mobility status and confirmed actions for those people who had complex factors affecting their discharge. This was particularly evident on Emerald ward. Every patient was discussed. We saw staff identified actions that had not been carried out and identified patients for discharge. We saw all staff were encouraged to speak up and provide input to the meeting.

In the discharge lounge we saw staff liaising other organisations within the Medway and surrounding areas of Kent to ensure patients were provided with continuous support once they were discharged from the hospital.

Staff throughout medical care wards told us of strong working relationships that had been formed during the COVID-19 pandemic which resulted in better patient outcomes. Staff were proud of the relationship and shared their desire to keep this going into the future.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Medical wards at Medway Maritime had access to diagnostic imaging seven days a week although not all modalities were available 24-hours Staff we spoke with stated they felt there were no issues in accessing these services.

Mental health support was available 24 hours a day seven days a week for patients with mental health problems. There was a psychiatric liaison service available.

The discharge lounge was open between 7.30am and 8.30pm, seven days a week.

The hospital pharmacy department was open Monday to Friday 9am-5pm, Saturdays and Sundays 11am-2:30pm.

Physiotherapy services, occupational therapists and assistant therapists were available Monday to Friday. Services were also available over the weekend either provided by bank staff or substantive staff over a shorter day. Each speciality had its own arrangements for allied health professionals cover to suit its needs. Staff in the medical assessment unit told us patients were normally seen within 24 hours of referral.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Medical care (including older people's care)

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had a referral process for patients to seek specialist help for smoking cessation. Medway Maritime Hospital had a smoking cessation service, staff told us that patients would be encouraged and supported to access the service. The trust was a smoking free site.

The service had relevant information promoting healthy lifestyles and support on wards. We saw information on health promotion clearly displayed around medical wards and the hospital. There were advertisements for initiatives on the flu and COVID-19 vaccine, recognising the signs of sepsis, and smoking cessation displayed.

Patients had access to physiotherapists and occupational therapists that provided practical support and encouragement for patients with both acute and long-term conditions. Patients spoke highly of the therapy staff and told us of the help and support they received from them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

At the last inspection we saw that consent was not always obtained or recorded in line with relevant guidance and legislation. Staff did not ask patients for consent before undertaking care. During our inspection we saw this had improved. Patient notes we examined contained evidence of discussions around consent and we saw staff gaining verbal consent from patients to assist with their personal care needs.

Both nursing and medical staff were below the trust target for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. During this inspection we saw this had improved.

Staff received and generally kept up to date with training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training records showed nursing, allied health professionals and administrative staff met the trust target for Mental Capacity Act and Deprivation of Liberty Safeguards training. Training levels for unregistered nurses were just below the 85% trust target, achieving 83% while medical staff's compliance rate was 76%.

We found consistent standards of Deprivation of Liberty Safeguards documentation on wards and staff demonstrated a good understanding of their responsibilities. Staff had documented whether a discussion had taken place with relatives in relation to a Deprivation of Liberty Safeguards

application. For those patients who lacked capacity and had no relatives, staff told used independent mental health advocates (IMCAs) to represent patients and support staff during best interest processes.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We reviewed three 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) records during the inspection and saw that all correctly completed, and patients were aware of the records.

Medical care (including older people's care)

Is the service caring?

Good ↑

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

At the last inspection we reported that staff did not always deliver compassionate care to patients in medical areas. Staff did not always consider the privacy of patients and did not always introduce themselves. During this inspection we noted an improvement in the way staff delivered care.

We observed positive interactions between staff and patients. Staff introduced themselves to patients before providing care and included patients in discussions about their care. For example, on Jade ward we observed a pharmacist speaking with a patient about their current medication and asked for verbal permission to look at their GP records in order to provide the patient with tailored advice. This was an improvement from the last inspection.

We saw staff interacted with patients in a respectful and considerate way. We observed staff spending time with a patient discussing their discharge plan. Staff communicated in a positive manner with patients whilst undertaking routine observations, assisting patients to eat and drink and assisting them with various aspects of their care. Patients told us staff were knowledgeable and provided good care.

The service participated in the national Friends and Family Test. We saw the average 'would recommend' rate for March 2021 was 74%, which was worse than the trust target of 79%.

Staff followed policy to keep patient care and treatment confidential. Patients confirmed that they drew curtains round the bed space when providing care and treatment to protect patients' privacy and dignity. In the emergency care unit doctors had their own consulting rooms. This ensured patients had a review in private without being overlooked or heard. However, in the temporary coronary care unit, we found that although staff made attempts to ensure patient dignity and privacy was maintained, it was difficult due to the positioning of the beds and lack of space. Patients could hear all confidential conversations concerning each other and patients told us they had witnessed or heard other patients having cardiopulmonary resuscitation despite staff efforts to minimise this.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

We observed examples of emotional support provided for patients on the medical wards. This included actions to ensure patients comfort and ensure patients felt cared about and supported. We saw staff encouraged patients and their families to establish links with support services and condition specific special interest groups.

Medical care (including older people's care)

Staff told us senior staff reviewed each patient's record daily to check if family had been in touch, or if an update was needed. We saw patient records which reflected this, which patients confirmed.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with said they had received good information about their condition and treatment. Patients stated that their care planning included several clinicians input, but also was patient centred. We spoke with three patients in the radiology department who told us they were happy with the care and information they had received so far. Patients had received a telephone call from a staff member who had explained the procedure they were undergoing. Patients told us they were given the information in writing and had the opportunity to discuss the procedure

During the peak of the COVID-19 pandemic, relatives were not allowed to visit except under exceptional circumstances such as patients receiving end of life care. Staff encouraged and supported patients to use other means of communication such as video calls however, staff told us this was not always possible. Lack of visits could leave patients feeling isolated from their loved ones and those living with dementia requiring stimulation. At the time of our inspection, visiting had been reinstated. Detailed guidance for visiting non-COVID-19 areas could be found on the trust website.

A patient on the temporary coronary care unit told us staff had taken the time to go through after care information including signposting the patient to an organisation responsible for maintaining a database of drivers and vehicles in Great Britain in order for the patient to declare their health status in line with national guidance.

Is the service responsive?

Requires Improvement ↑

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

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Staff planned and organised services, so they met the changing needs of the local population. The service worked collaboratively with local social services to facilitate timely and appropriate discharges for those patients requiring complex social care packages in the community. Staff told us patients who lived alone were identified and offered a packed lunch at discharge.

Staff provided the patient with information and contact details of the local voluntary service who offered discharged patients who lived alone, shopping support, medication collection and company if required. If patients declined this support within the discharge lounge, they were given the contact information via a leaflet if they changed their mind. However, this leaflet was not available in other languages during our visit.

The service relieved pressure on other departments by treating frailty patient who did not require admission or lengthy hospital stays. The frailty assessment team aimed to improve care and reduce the length of stay and readmission rates for elderly patients with complex medical needs. Staff completed frailty assessments for patients referred to the department and we saw evidence of the frailty team having regular contact with patients to support their care and discharge needs.

The service relieved pressure on other departments when they could treat patients in a day. Patients referred to the emergency care unit had access to diagnostics testing. The waiting room was next to phlebotomy and an electrocardiogram (ECG) clinic. The unit had a separate eight bedded clinical ward area where patients requiring immediate care for example fluid balance or intravenous antibiotics were moved to and cared for by staff. Doctors in the emergency booked MRI and CT scans for patients in the unit. After having the scan, patients returned to the unit for the doctor review and their diagnostic results. Staff told us that most results were returned within an hour and patients told us it was an efficient service as they did not need to return to their GP for a referral request.

Each ward had established visiting times for relatives and friends. However, staff worked flexibly within these times to facilitate the needs of each patient.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service employed specialist nurses to support ward staff. This included dementia and learning disabilities nurses who provided support, training and had developed resource files for staff to reference.

In the discharge lounge staff used a "decision to support" tool to ensure patients that required extra, physical, financial, emotional and psychiatric support were assessed.

Patients with mental health needs could be referred to the psychiatric liaison services for assessment and support which was provided by a neighbouring mental health trust. Staff we spoke with were aware of the process of accessing the liaison psychiatry service.

There were several specialist staff available to medical wards to support patients with complex needs. This included a dementia and delirium team who supported the dementia and delirium pathway, and a learning disabilities team (shared across sites) that supported patients diagnosed with a learning disability and/or autism spectrum disorder. Wards also had "champions" who acted as additional resources to promote best practice.

Wards were designed to meet the needs of patients living with dementia. The unit had a separate area to assess and care for frailty patients which has been recently redesigned to ensure it was dementia friendly.

Medical care (including older people's care)

Staff supported patients living with dementia. Wards used the “butterfly scheme” to identify patients living with dementia. A butterfly shaded in blue meant the patients had a confirmed diagnosis, an outline meant the patient could be suffering with delirium and might need reassessing. The butterfly was displayed above a patient’s bed, on the name board and the patient’s ID bracelet. This meant staff could easily see if a patient might need additional assistance in a discreet way.

The service used the ‘What matters to me’ board for patients living with dementia so staff knew how a patient normally achieved their daily activities and how best to help the patient in the hospital environment.

Patients with a learning disability or those living with dementia had a ‘This is me passport’. This was designed to help hospital staff understand each patient’s needs, likes, dislikes and interests.

Medical care departments had several volunteers recruited in the role of “dementia buddies”. Volunteers undertook specialist dementia training to carry out the role. Patients living with dementia admitted to medical wards were given activity blankets, twiddle muffs and other knitted items to bring them comfort and serve as a distraction in an unfamiliar environment.

A butterfly garden had been opened in the summer of 2020 however, patients and relatives had not had the opportunity to use the space due to COVID-19 restrictions.

Patients had access to interpretation and translation services for patients and families whose first language was not English. Staff we spoke with were aware of these services and told us they had used them previously. Throughout the hospital we saw leaflets and useful information on display to help patients and their relatives understand their conditions and the treatment options available. The printed information was only available in English, but staff told us they could have the leaflets translated into other languages as necessary.

The trust was fitted with a hearing loop to aid people with hearing impairments.

Patients with additional needs, for example those with a learning disability, were highlighted on the trust’s electronic system. This alerted staff early of patients who may need additional support. Patients’ support needs were then discussed during the safety huddles and board rounds and reasonable adjustments made.

The hospital could care for patients with mobility difficulties. The general environment had been designed to help those with limited mobility. This included assisted bathrooms and lavatories, mobility aids and manual handling equipment. Staff told us that specialist equipment such as bariatric equipment or specialist pressure relieving mattresses were available on request.

A chaplaincy and spiritual service was available to support meeting patient’s religious needs. Chaplains offered pastoral and spiritual care for those who had been bereaved, going through end of life, facing distressing news or those that required a listening ear.

Psychological support for medical wards was delivered by a neighbouring mental health trust who had an onsite team supporting Medway Maritime patients. The team was available to provide advice to staff as well as assessments for patients on wards 24 hours a day and were as involved in discharge planning when required.

Access and flow

Medical care (including older people's care)

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

The service had a patient flow policy which described what good flow through the hospital looked like, how information was communicated and had defined responsibilities for staff and departments.

At the last inspection we found that the risks to people were not always assessed and their safety monitored and maintained to support patient safety. Although this had improved, we saw patients were incorrectly referred to the emergency care service (SDEC) and onward referrals from the department to a speciality were not always appropriate or timely. Staff in the emergency care unit told us the most referrals were from the emergency department and they felt it was clinically unsafe to have vulnerable patients needing specialist care in the department.

For example, we saw the day before our inspection one patient was referred to the emergency care unit within an hour of arriving by ambulance and through the emergency department having presented with chest pain, shortness of breath and dizziness. Staff did not check the patient's blood levels which were significantly above normal levels. The patient was transferred to Lister ward an acute medical ward. The patient was on Lister ward for one day before being transferred to the coronary care unit on Nelson ward. Staff did not follow the chest pain pathway and the standard operating procedure for acute medicines.

There was a logbook for recording inappropriate referrals which were then reported as incidents. However, we noted that this incorrect referral was not documented in the logbook. Nursing staff said medical staff were responsible for completing the log. Medical staff told us they did not always have the time to complete the log which was evident from this incident.

Inappropriate referrals can be an indicator that standardised care pathways have not been followed, or staff not having the knowledge and skills to make the right clinical decisions. We reviewed the logbook of inappropriate referrals and noted that within the month of our inspection there were nine inappropriate referrals recorded. One example was a neurological patient presenting with left sided nerve pain, who was referred to the emergency care unit as a cardiology patient.

Although staff were concerned about the safety of some referrals, we noted that the department saw approximately 1,500 patients a month. This meant approximately 99% of patients were referred to the correct patient pathway. From December 2020 to May 2021, the emergency care unit reported 41 incidents of patients who were affected by an incorrect and inappropriate referral. Most of incidents resulted in no harm caused, with one incident considered moderate and resulting in short term harm caused.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. They worked to minimise the number of medical patients on non-medical wards. Medical outliers were reviewed daily through the site meetings, where staff worked to move the patients to most appropriate wards. During the peak of the COVID-19 pandemic, the service minimized the amount of moves for patients due to the infection control risk associated with multiple contacts.

The service had set up beds up across the directorate (130+ beds) to absorb and allocate patients where best suited rather than be randomly placed. Medical care had flow coordinators who were available from 9am to 5pm visiting outpatient areas to identify patients needing a bed. After 5pm the site team had oversight of which patients had been admitted and where they were in the hospital with the aim to place them in the most appropriate ward.

Medical care (including older people's care)

Staff reported improvements in the volume of bed moves at night. Trust records showed that from April 2020 to March 2021, there were 5,291 moves after 10pm across medical care. Increased bed moves often result in increased patient confusion, length of hospital stay and adverse clinical outcomes such as patient falls. Records showed Lister ward had the highest number of moves at night, with 758, this was less than the 924 moves reported at the last inspection.

From April 2020 to March 2021 records submitted by the service showed an average bed occupancy across medical care was 82%. Bed occupancy was highest in January and February 2021 when the trust was affected by a variant of concern of the COVID-19 virus.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharges were discussed daily in board rounds which were consultant led and the needs of patients were discussed as part of this process. We attended these meetings and reviewed patient records and observed discharge planning to be multi-disciplinary and well managed.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Patients were assessed for discharge on the wards where they have been cared for. Once they arrived at the discharge lounge, the nurses completed a discharge checklist and arranged transport. Checks included a copy of the electronic discharge notification, to take home medication, referral letters, do not resuscitate (DNR) notifications (as appropriate), patients' valuables, and contact details of carers or relatives. The team also made sure patients had keys or could access their homes.

The service had developed an early discharge pathway for patients with long covid, so they could be cared for in the community, therefore freeing up beds in the hospital.

The service had a surgical medical acute response team (SMART), whose role was to streamline all patients to avoid admissions and reduce length of inpatient stay. The team provided follow up care within the community. They reviewed patients at home, administer oxygen therapy, nebulizers, provided physiotherapy, assessed surgical drains and casts and collars.

The discharge team told us patients had access to a therapy lead, a dementia lead who worked Tuesdays and Thursdays and liaised with the psychiatric team. This was to ensure that mental capacity was assessed prior to discharge and care could be co-ordinated accordingly to ensure that decisions made in the best interest of the patients.

The discharge team had access to several organisational digital care systems and had a daily call with the clinical commissioning group (CCG) who had oversight of the organisations who had available beds within the community. We were told that the pandemic has helped reduce the red tape meaning the trust was able to adapt and implement the NHS choices care pathway.

When appropriate, staff contacted community care links and social care to ensure care packages were initiated and ready for the most vulnerable patients being returned to the community setting.

Some community hospices and care homes only accepted patients back into the community before 4pm and so these discharges were prioritised.

Medical care (including older people's care)

Delays for patient discharge were more common during the weekend when there were fewer medical staff on duty. Staff told us that one of the barriers to flow was due to medical staff not having enough time to complete the electronic discharge notifications. Before a decision was made to discharge patients, doctors had to review care, pathology and other diagnostic results and review medication.

Managers and staff worked to make sure patients did not stay longer than they needed to. There was a system to reduce the volume of delayed discharges. The discharge team conducted three ward rounds a day to review and assess patients' fitness for discharge. This model was designed to free up space in the hospital, as patients waiting for social care reviews and care placements created challenges on NHS establishments.

If there were severe delays the team reviewed medical records to ensure patients had their reviews and were fit for discharge. On the day of our inspection there were 63 medically fit patients across medical care, and 34 were being discharged that day.

Staff told us failed discharges were rare due to the systems in place to prevent discharges from failing ensuring patients were discharged safely. Failed discharges were reported as an incident. Trust records showed that there were less than 1% of discharges which failed reported across medical care in the last 12 months.

Medway Maritime Hospital

From January 2020 to December 2020 the average length of stay for medical elective patients at Medway Maritime Hospital was 6.5 days, which is similar to the England average of 6.5 days. For medical non-elective patients, the average length of stay was 5.1 days, which is lower than England average of 5.8 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in Clinical haematology was lower than the England average.
- Average length of stay for elective patients in Endocrinology was lower than the England average.
- Average length of stay for elective patients in Cardiology was higher than the England average.
- Average length of stay for non-elective specialties:
- Average length of stay for non-elective patients in General medicine was lower than the England average.
- Average length of stay for non-elective patients in Geriatric medicine was higher than the England average.
- Average length of stay for non-elective patients in Respiratory medicine was higher than the England average.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From March 2020 to December 2020 the trust's referral to treatment time (RTT) for admitted pathways for medicine was worse than the England average. However, the trust's performance improved from December 2020 onwards and in February 2021 the trust's RTT time was better than the England average.

(Source: NHS England)

Medical care (including older people's care)

Referral to treatment (percentage within 18 weeks) – by specialty

Referral to treatment for cardiology was above the England average for admitted RTT (percentage within 18 weeks) with 73.4% compared to 68.6%.

Three specialties were below the England average for admitted RTT (percentage within 18 weeks).

Referral to treatment for general medicine was below the England average for admitted RTT (percentage within 18 weeks) with 80% compared to 89%.

Referral to treatment for gastroenterology was below the England average for admitted RTT (percentage within 18 weeks) with 50% compared to 84.4%.

Referral to treatment for thoracic medicine was below the England average for admitted RTT (percentage within 18 weeks) with 33.3% compared to 88.2%.

(Source: NHS England)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The trust clearly displayed information about how to raise a concern throughout the hospital. We saw this in wards and departments we visited where there were leaflets prominently displayed advising people how to make a complaint. Information on how to raise a concern or complaint was also available on the trust's website.

Staff understood the policy on complaints and knew how to handle them. Staff told us they when verbal complaints were made, they tried to resolve these immediately and therefore the service received few formal complaints. However, when issues were not resolved, patients and visitors were encouraged to make a formal complaint using the complaints process.

Staff understood the policy on complaints and knew how to handle them. Medical care had received 515 complaints between May 2020 and April 2021. The top three complaint themes were clinical care and treatment which received 54% of complaints (275), followed by attitude of staff with 15% (76) and communication/ information to patients with 10% (49).

The service did not always meet their target for responding to complaints. The target response time for all complaints was 30 working days and 60 days for complex complaints. At our inspection the specialist medicines care group had 27 outstanding complaints, 23 of which had breached their target date. Staff told us there had been an increase in patient complaints and minutes from the care group board meeting showed that some complaints were breaching their target as they needed to be signed off by the executive team.

Staff received feedback from managers after the investigation into their complaint. Staff we spoke with said concerns or learning from complaints was discussed at board rounds and huddles.

Medical care (including older people's care)

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They were visible in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Medical services were split into the therapies, older persons and specialist medicines care groups. The therapies and older persons care group had a well-established leadership led by a general manager, a clinical director, a head of nursing and a head of therapies. The specialist medicine care group was led by a clinical director and a head of nursing.

Staff reported there was clear visibility of local leaders and members of the trust board throughout the service. Staff could explain the leadership structure within the trust and the executive team were accessible to staff.

We received mixed views on the support staff received from local and executive leaders. Some staff told us leaders "make the right noise but nothing changes". Other staff told us the chief nurse had invested in nursing leadership training to support the care group leaders. This meant that matrons focussed on quality and visited wards and clinical areas regularly to offer support and conduct audits. Ward sisters also worked clinical shifts to support staff on the ward.

We received mixed feedback about executive leadership. Some staff told us members of the executive team were visible and when issues were escalated, they were quick to respond. However, other staff told us that although members of the executive were visible on the wards, when issues were escalated, there was an initial response, but some issues were not followed up or given the attention they required.

There were opportunities to develop and progress. Managers told us they were often "star spotting" to identify junior staff with the potential to become leaders and upskilling them ready for senior positions. Managers in the therapies and older persons care group recognised the need for staff to hone their interview skills. They had introduced a robust feedback process for staff who were not successful at interview and supported then to gain the skills needed for progression

Medical care leaders told us they were based in the same office therefore there were many opportunities to work collaboratively.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders understood and knew how to apply them and monitor progress.

The trust's vision was to aspire to be the best by using the trust's values in everything they did. We saw values statements based on the word "BEST", which meant "Bold, Every person counts, Sharing and Open and Together". All staff were able to tell us about the trust's vision. We saw posters on display and other publications about the vision and

values as we visited the wards. These were readily available for staff, patients and the public to view. The trust also published information about its mission, values and vision on its public website. The strategy consisted of strong foundations, strategic themes, values, all creating a pyramid topped by the vision and values. Most wards and departments we visited displayed the trust strategy.

Care groups had their individual strategies. The therapies and older persons care group told us their current focus was on designing frailty pathways for the future which included identifying frailty within 30 minutes of patients arriving in the emergency department, and 60 minutes for patients with geriatric syndrome or end of life. The specialist medicines care group's current focus was on completing the cardiac "village" and expanding services such as endoscopy and the catheterization laboratory.

Culture

Staff did not always feel supported and listened to. There were mixed views about the openness of the culture and not all staff felt they could raise concerns without fear.

The trust had a freedom to speak up (FTSU) team working across the hospital and a whistleblowing policy. Staff could access the FTSU team if needed and contact and other information was available on the intranet site. Freedom to speak up posters were displayed in some of the wards we visited. Staff were aware and understood the role of the FTSU team; however, some staff did not feel confident to raise concerns through any of the internal channels. Others said they had raised concerns but had not seen any changes. The therapies and older people care group told us they were aware of some significant ongoing FTSU concerns and were addressing these. The specialist medicines care group were not aware of any concerns. However, staff told us they felt unheard and neglected after raising concerns particularly in the coronary care unit.

Junior doctors said they did not always feel supported due to gaps in the middle grade of doctors. Within the medical rotation junior doctors expressed concerns with training and support. Junior doctors also told us some consultants were said to be more approachable than others.

Service leaders, including matrons, said they were proud staff had shown great resilience and pulled together to work as a team through the COVID-19 pandemic. For example, staff on the temporary coronary care unit said although the staff on Nelson ward did not always have the necessary skills, they still supported the coronary care unit where possible, particularly when they were short staffed. We received plenty of similar feedback and examples from staff.

Governance

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, we found local governance processes were not always fully effective. Some key issues we identified during the inspection had not been acted on.

Although there were clear lines of accountability from the department to the board, through the directorate governance structure, it was not always effective. This was evident in the handling of the coronary care unit; controlled drugs incidents and overdue incidents investigations.

The medicine care groups had a set structure of meetings that supported the governance of the service. The meetings used a standard agenda to ensure there were consistent discussion of key agenda items. Performance, including clinical incidents, complaints and compliments, appraisals and mandatory training rates, referral to treatment times, patient length of stay, occupied bed days, sickness rates and financial situation were reviewed.

Mortality and morbidity meetings were established. The service reviewed mortality and morbidity through the structured judgement review process. The mortality group facilitated learning from deaths that had happened in the department, particularly when a death may have been avoidable. The service had identified an annual increase in the deaths of patients with learning disabilities where the learning disability team had not been involved during the patients care or were involved at an advanced stage. The service were encouraging staff to involve the learning disability team from admission if necessary. Patient records we reviewed showed evidence of this and staff confirmed that they routinely asked the team for support to ensure they were meeting the needs of each patient.

Care groups held weekly governance meetings led by the nursing leadership; these fed into the monthly care group board meetings held separately. There was a further monthly divisional meeting attended by both care groups as well as other unplanned care and integrated care groups.

Staff meetings had not taken place in the care groups during the COVID-19 pandemic due to the social distancing requirements. Daily safety huddles were held to keep staff updated. The service had started reinstating meetings starting with the clinical support workers meeting. We were also told that Keats ward had held their last meeting virtually using videoconference which was well attended. Senior staff were hoping to use this going forward to ensure as many people as possible could attend.

Management of risk, issues and performance

Risks, issues and poor performance were not always dealt with quickly enough. The risk management approach was sometimes inconsistent or not linked effectively into planning processes.

At the last inspection leaders could not demonstrate adequate systems and process to provide assurance that they had full oversight of the service in terms of risk, quality, safety and performance. They were not always aware of the risks, issues and challenges in the service. We identified several issues that were a risk to patient safety, which had not been identified or addressed by the leadership team until we raised them during our inspection.

Both care groups had a risk register. It was unclear how often the registers were reviewed. For example, in the specialist medicines care group we noted a risk under the ownership of someone who had left the service. Some risks had not been reviewed since March 2020.

Leaders had failed to recognise the many issues present and had not taken any action to mitigate risks. There was no record of ongoing reviews of the coronary care unit risk assessment. The care group told us a risk assessment of the current coronary care unit had been completed three weeks before our inspection. However, ward staff showed us four risks assessments, the most recent having been completed in June 2020. We asked the care group if the local risk register included the coronary care unit. We were told this was not the case although they had “thought about it three weeks ago”. Staff told us members of the executive team had visited the unit.

The division did not have effective processes to ensure the board were made aware of issues. We reviewed public board minutes from the last 12 months and there was no mention of the issues in coronary care unit. The only mention stated that the area was being reconfigured and this was reported in the board meeting minutes in June 2020.

We were unclear about the level of care provided in the coronary care unit. During our inspection staff had told us they provided level 2 critical care. Level 2 patients require more detailed observations or intervention including support for a single failing organ system or post-operative care or those 'stepping down' from level 3 care. Minutes from public board papers in July 2020, reported that coronary care unit was a specialist cardiac critical care unit. Patients within the unit met the criteria for level 2 critical care staffing suggesting that staff provided specialist care to patients categorised as requiring level 2 care. In the response letter from the service dated 18 May 2021, the service told us that the coronary care unit provides standard coronary care for patients with acute cardiac conditions. Patients requiring higher levels of care (for example intubation or renal hemofiltration) were to be cared for within the intensive care/high dependency unit (ICU/HDU) (Trafalgar) environment.

In response to our concerns the service had assessed the options to keep or move the location of the unit. The decision was made to continue with the current location due to mitigated risk and work towards a more permanent solution by September 2021.

Information Management

The service collected reliable data and analysed it.

Staff received training on information governance. Records showed that 91% of nursing staff, 100% of allied health professionals, 90% of administrative staff and 92% of medical staff had completed this training against a trust target of 85%.

There were arrangements for the confidentiality of patient identifiable data and records. We found patient notes stored in locked trolleys on all wards and found unattended computers were kept locked. Staff had individual access codes to trust computers and devices that contained patient information.

Staff for the most part could access policies, procedures and other key information through the trust intranet. This was accessible to all staff, and contained information on mandatory training, professional development, and staff support. The trust also used the intranet to provide reminders of patient safety initiatives and how to access specialist support in the hospital.

All wards carried out a daily matron's assurance audit looking at various elements of the service including patient care, documentation, medication management, infection control, environment and equipment. We saw a completed audit for Emerald ward. The completed audits were sent to the matron and the head of nursing for the service each week to assess performance and highlight areas of improvement.

Engagement

Leaders and staff actively and openly engaged with patients, to plan and manage services. They collaborated with partner organisations.

At the last inspection staff told us they were not always informed or consulted on plans for the areas they worked in. We found this was still the same in some areas during this inspection. We found there was a lack of effective communication by care group and executive leaders about decisions that affected staff. For example, staff on one ward told us there had many decisions made by senior leaders without their involvement.

Similarly, in March 2020 a decision had been made to temporarily move the coronary care unit to a bay on Nelson ward. Nursing staff understood the reasons behind the move however, they told us they were moved one Saturday without any planning or leadership support on the day.

Staff told us the completion date for the new coronary care unit had been pushed back many times over the last 14 months with little to no communication to explain the delay.

Minutes from the March and April 2021 specialist medicines care group meetings stated the new coronary care unit would be ready mid-April 2021. During our interview we asked the care group for a completion timeframe of the proposed cardiology village where the new coronary care unit would be located. The care group told us other areas within the hospital had been given more priority over the coronary care unit through the pandemic. We were told the new completion date was June 2021. Leaders said, they had given staff a completion date of September 2021 in case there were further delays. After our care group interview, we spoke with coronary care unit staff who told us they had received a text before we arrived on the unit, advising them of the new competition date of September 2021. Staff were not confident that this would be completed as stated having experienced many delays with little communication over the last 14 months.

There was a positive process to address annual leave. The service had introduced a long week annual leave option to enable overseas staff to visit their home countries with an agreed isolation period on their return accommodating the various COVID-19 travel guidance. On one ward, three members of staff had successfully applied for this. The option allowed for staff to take three weeks of annual leave and on their return self-isolate. We were told this was also available to home staff.

There were many wellbeing initiatives across the trust. Staff told us they had access to wellbeing and mindfulness support through the intranet. Staff has also attended a wellbeing day organised by the trust which staff said was helpful.

The service had identified that staff were suffering from COVID-19 related issues such as sleep disturbances, depression, anxiety and post-traumatic stress disorder. Managers told us the second wave of the pandemic had been very difficult and staff had cared for each other's friends and relatives which had an impact on staff wellbeing. The trust was working in partnership with other organisations to offer staff psychological therapy services including a six-week psychologist course delivered individually or to a group via video conferencing. Staff also had access to a sleep physiologist.

Staff had designed their own "wobble room" on the respiratory ward, where they could step away from the stressful environment of the ward and have a moment of respite.

Staff participated in the 2020 staff survey. This included how staff felt about the organisation and their personal development. Seventy two percent of staff said they were enthusiastic about their job which was similar to the national average of 73%. Sixty four percent of staff felt they were valued by managers. This was below the national average of 74%. The response rate was 35%, which was lower than the national average of 45%. Six of the survey themes had remained the same while four themes including staff engagement and diversity and inclusion had seen a statistically significant decline since the last staff survey.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Medical care (including older people's care)

The service had developed a COVID-19 diabetes and respiratory clinic for patients requiring oxygen in the community. The service worked collaboratively with the community respiratory team and the community and diabetic team to identify patients and arranging the prescription and administration of oxygen in the community.

Medical care had a service called biologics homecare offering patients living with long term conditions like rheumatoid arthritis biologic medication via infusion. These patients now had their treatments at home therefore did not need to attend the hospital to receive treatment.

We saw significant improvements in the caring domain across medical care. At our previous inspection in December 2019, we reported that staff did not always interact with patients in a respectful way or consider the privacy of patients. During this inspection, we observed staff taking time to speak with patients, explaining their treatment, making sure they were comfortable or keeping them company. Staff we spoke with, spoke proudly of the care they were providing.

The service had a growing acute frailty pathway which included an operational Emerald short stay ward with 12 frailty consultants and two consultants rostered every weekend. The ward was performing well with an average length of stay of three days. Leaders of the therapies and older persons care group told us they wanted to be the centre of excellence for frailty in the community.

The service had introduced a rapid access clinic for the elderly (RACE) two weeks before our inspection. The clinic was open Monday to Friday. There was a drop off zone near the clinic for elderly patients reducing the distance they had to walk to the clinic. The service offered patients a range of diagnostics tests including echocardiograms, blood tests and blood pressure monitoring.

Services for children and young people

Requires Improvement 

Is the service safe?

Good 

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training requirements.

The mandatory training was comprehensive and met the needs of children, young people and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

The trust training target was 85%. Most training requirements met their agreed targets with three exceptions. Nursing staff failed to meet the target with manual handling training. Medical staff did not meet the 85% target in manual handling training, mental capacity act training and health and safety training. We were informed that health and safety training figures were low because two electronic recording systems were not compatible and that the actual figures were above 85%. Manual handling training had been difficult to organise as this was face-to-face training that allowed limited staff numbers attend each session. Managers showed us prospective training dates for these subjects and numbers of staff booked to attend.

At the previous inspection in 2019 paediatric life support training was below the trust target. The trust had increased the number of available training courses and compliance had improved to above the trust target of 85% at 89% of staff trained by April 2021.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Safeguarding training amongst all staff groups and within all levels of training was above the trust target of 85%. Safeguarding training incorporated female genital mutilation and child sexual exploitation training was delivered to all staff.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff confidently made safeguarding referrals and knew who to inform if they had concerns. The children's safeguarding practitioner was present daily and worked closely with the unit.

There was a system to monitor which children had, had a safeguarding assessment completed and where concerns were identified

Services for children and young people

Staff completed an electronic reporting system to highlight safeguarding concerns involving the trust and this information was reported within the weekly safeguarding governance meetings.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were also clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff we observed during the inspection were 'bare below the elbows' and dressed in accordance with trust policy. We saw ample supplies of personal protective equipment such as aprons, gloves and face masks and we saw these items being used. Gloves, in the full range of sizes, and various types face masks were readily available. Staff had convenient access to the correct personal protective equipment to keep themselves and their patients safe.

There had been no hospital acquired infections reported on the unit since 2019. There were dedicated hot and cold waiting areas in the outpatient department as a measure to prevent the spread of infection. All guidance to prevent the spread of Covid-19 had been implemented and was adhered to.

Audits including hand hygiene and use of personal protective equipment were undertaken to monitor compliance with infection control standards. Information was used by the staff to drive improvement where required. Environmental audits were used to monitor the effectiveness of cleaning.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of children and young people's families. There were separate facilities for younger and older children within the children's unit. Although there were some restrictions on use of certain areas due to the Covid-19 pandemic, there were play facilities indoors and outside for children of different ages.

The service had enough suitable equipment to help them to safely care for children and young people. Staff carried out daily safety checks of specialist equipment. Children, young people and their families could reach call bells and staff responded quickly when called.

During the inspection in 2019 some areas were not secure and had the potential to place children at risk. A review of potential risk had been completed and doors to some areas such as the kitchen were now secure However, there was a broken fire door in the neonatal unit that had been reported to maintenance and was awaiting repair. Senior leaders agreed to remedy this on the day of inspection.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Services for children and young people

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Risk assessments were completed for each child and young person on admission, using a recognised tool, and staff reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues. For instance, the service had clear guidelines for both paediatric and neonatal sepsis. The neonatal unit had guidelines for early and late onset of neonatal infection and the children's unit used the sepsis six initiative to recognise sepsis early and start treatment rapidly.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. There were two safety huddles per day, each following shift handover. Shift changes and handovers included all necessary key information to keep children and young people safe.

At the inspection of 2019, there was no separate recovery area for children in theatre recovery. However, improvements had been made and paediatric-friendly screens were now used as a privacy barrier to separate children from adult patients. Staff working in theatre had also undertaken specialist training to ensure they were able to care for children recovering immediately after surgery.

There had been an increase in admissions for children and young people with mental health admissions in 2020 and 2021. Physical intervention training had commenced to equip staff with the restraint skills needed to deal with children and young people with challenging behaviour. Over a third of staff were trained and all staff had training planned before October 2021. No shift was left uncovered without at least two staff who had completed this training course. If patients were sectioned or needed extra care, registered mental health nurses were employed on an agency basis.

Children and young people with mental health needs were risk assessed during their stay on the ward. Children and young people had lengthy stays on the ward waiting for mental health beds. These admissions were beyond 50 days due to the unavailability of beds in specialist children and adolescent mental health services.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep children and young people safe. The service had low vacancy rates. At the time of the inspection there were four nurse vacancies and an ongoing active recruitment plan

The senior sister accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance.

The rota could be adjusted daily according to the needs of children and young people. The number of nurses and healthcare assistants matched the planned numbers. Children in the high dependency unit were nursed on a 2:1 staffing ratio and staff needed to have completed specialist training to work there.

Managers limited their use of agency staff for registered mental health nurses only and requested staff familiar with the service. Bank staff were used to fill shift vacancies, and these were always staff who worked on the unit in their substantive roles.

Services for children and young people

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep children and young people safe. There was a shortage of substantive middle grade doctors, but managers accessed locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends in line with the Royal College of Paediatrics and Child Health and British Association of Paediatric Medicine guidelines. Consultant paediatric medical cover was provided by the consultant of the week who was on call from 5pm on a Friday until 5pm the following Friday and Saturday and Sunday 9am to 1.30pm.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Records were comprehensive, staff could access them easily and were stored securely in a locked trolley. When children and young people transferred to a new team, there were no delays in staff accessing their records. Children and young people discharged into the community or within other multidisciplinary teams had completed and informative discharge summaries and letters available.

We reviewed 12 sets of patient records, saw no omissions or errors and all documentation completed was legible. Weights and heights were recorded for all children without exception. A paediatric nursing documentation audit was completed monthly by senior staff. The overall scores were calculated at 86% compliance for Dolphin ward and 93% compliance for the Penguin assessment unit for April 2021. Learning from these audits and areas for improvement were highlighted then discussed at team briefings.

Patient records were completed on paper throughout the service though there were ambitions to move to an electronic format. Following some research undertaken on best practice for good care plan paperwork, changes had been made to charts, forms and documentation to assist with easier documentation. This addressed issues noted at the previous CQC inspection.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff reviewed children and young people’s medicines regularly and provided specific advice to children, young people and their families about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. There was a dedicated ward pharmacist who visited daily to check stock, reorder medicines and review medicine charts.

Services for children and young people

Staff followed current national practice to check children and young people had the correct medicines. The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

After the 2019 CQC inspection, improvements had been made in how to share learning from incidents. Information was shared via huddles, safety briefings, messages of the week and governance snapshots. Posters, displays and information boards were updated throughout the unit to keep everyone informed.

Staff had a good knowledge of duty of candour and understood their responsibilities. When asked about incidents or complaints that had occurred, staff were able to advise how they had responded to the issues and when they had apologised to families if something had gone wrong. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients or relevant persons of notifiable safety incidents and provide reasonable support to that person.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was a clear leadership structure although the head of nursing and general manager posts had been vacant for several months. Staff informed us they missed having a nurse leader. Appointments to these roles had now been made and we did not see any evidence of a negative impact on patient care or the daily functioning of the unit. Staff felt that services for children and young people were not at the forefront of the wider trust's agenda without these managers in post.

Leaders generally understood the challenges the department faced and made attempts to address any difficulties. Staff spoke highly of the local leadership and described them as approachable, knowledgeable and supportive. They supported staff to develop their skills and take on more senior roles.

Vision and Strategy

Services for children and young people

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust vision was "to deliver brilliant care through brilliant people" which was displayed in the hospital. Staff knew the principles of this statement although they could not always remember the exact wording. The trust's strategy focused on continuous improvement called "best of care, best of people". The service area strategy fed into the wider trust strategy. This was underpinned by the trust priorities and the care group priorities. Each service produced a plan so there were separate mission statements and strategic objectives for the children's wards and the neonatal unit.

The neonatal unit had a vision and timeline to make improvements. There were plans and intentions to develop technology, deliver better and additional services in the community, improve outcomes for babies and maintain a focus on quality and safety in the unit. Whereas, obtaining separate funding for the high dependency unit was high on the agenda for the children's wards.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where children and young people, their families and staff could raise concerns without fear.

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with during the inspection said they were positive about working for the service and proud to work at the hospital. They appeared passionate about the care they provided and improving patient outcomes. There was an overwhelming culture of putting the child and family at the heart of everything

The service had an open culture where children, young people, their families and staff could raise concerns without fear. Staff felt respected, supported and valued. Experienced staff who had worked at the trust for some time felt encouraged by actions taken since the last inspection and that managers were driving change.

All staff spoken to knew that they could contact a freedom to speak up guardian or champion if they wished to air concerns or seek support on work related issues.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had monthly team meetings where staff discussed local issues including staffing, training, audit findings, complaints, risks and learning from incidents. This information was shared with all staff during daily handover and safety huddles. Information on these matters was seen on notice boards within the staff meeting room and staff offices.

We saw that meeting minutes were available for all staff to read if they were not able to attend the meeting. A colourful one page snapshot was produced monthly that had easy to read updates on governance matters affecting the department.

There was a structured programme of meetings for governance, mortality and morbidity, paediatric education and paediatric critical care.

Staff felt information and learning was shared well and there was a clear strategy to mitigate risks when required through learning and action plans. There were ongoing safety projects and clinical audits happening throughout the unit.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Risks for the service were held on a comprehensive risk register. The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Information technology systems were utilised effectively to monitor and improve quality of care

Risks were rated and reflected current issues staff and the leadership told us they were concerned about. There were clear process and systems for leaders to escalate risk and performance issues through monthly leadership and governance meetings. Risks and performance were discussed within meeting minutes.

Performance information was shared when pertinent. For instance, information about the neonatal unit performance such as neonatal care accountability score (NCAS) was on display. The NCAS scored the compliance of specific aspects of care such as documentation and fluid balance charts, neonatal temperature on admission. In the neonatal ward, we saw a quality improvement board and both medical and nursing staff took the lead on improvement each week.

Following the 2019 CQC inspection, the trust had written and adopted a policy about age of admission. Children over the age of 16 were assessed for suitability for admission to the children's ward. A discussion took place with the young person to help them make an informed choice about where to be cared for.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Records were managed securely, and computer screens were shielded from public view behind nurse stations. There was no patient identifiable information on display throughout the unit. Staff meetings and handovers took place in specified rooms to maintain privacy.

There was easy electronic access to systems that included shared child protection information, safeguarding, pathology, online learning and local and trust-wide policies. All these systems were secured with protected access.

Staff had been keen to embrace technology that enabled remote team meetings to occur. Staff dialled into calls and could join meetings from home.

Services for children and young people

Engagement

Leaders and staff actively and openly engaged with children and young people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for children and young people .

The service worked well with teams, children and young people and families to develop and improve the children's and neonatal units. Staff told us they felt able to speak up about their concerns and had the opportunities to do this.

Staff had worked closely with families who were keen to raise funds for the children's unit to improve areas for patients. Families were keen to give donations or buy gifts for the ward. A 'wish list' was displayed on a notice board of items needed and had proved popular way to show gratitude.

As mental health patient admissions escalated, networks had been created to support patients, families and staff. There was a national call led by disordered eating specialists that senior nurses dialled into. This afforded staff the opportunity to seek help, share information and learn from professional knowledge.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Improvements had been made since the previous inspection in 2019. As well as the improvements in record keeping, the upgraded recovery area and shared learning communications, there was now a dedicated ward dietitian. A nutrition tool was used for all patients to assess their nutrition and hydration needs on admission.

Education and staff development were key to the department. New staff were supernumerary for six weeks, newly qualified nurses received clear competencies and there was a focused preceptorship period. Development days and leadership training had been relaunched after the restrictions imposed by the Covid-19 pandemic had been lifted. Clinical education was well resourced. There were three education facilitators in neonatal care and a dedicated practice development nurse covering the rest of the unit. There was a manager of the week role within the children's wards enabling nursing staff to assume extra managerial challenges to promote their career development.

Nurses each had a designated 'link role'. Every nurse linked to a clinical speciality field such as pain management or enteral feeding to increase awareness of issues on their ward. This motivated staff to improve practice, enhance learning and nurture relationships across the trust.

Improvement huddles took place in the neonatal unit twice weekly and an innovation board displayed ideas, the actions taken and how the ideas were escalated. Across the children's wards, staff focused at every handover on the 'Big 4'. Staff communicated four agenda items for staff learning, reflection or as a knowledge update and these were repeated regularly to reinforce each message. This was a quality improvement innovation that had been adapted elsewhere in the trust.