East Kent Hospitals University NHS Foundation Trust

Inspection report

Kent And Canterbury Hospital
Ethelbert Road
Canterbury
CT1 3NG
Tel: 01227766877
www.ekhuft.nhs.uk

Date of inspection visit: 17 May to 5 July 2023
Date of publication: 20/12/2023

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
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

East Kent Hospitals is one of the largest trusts in the country and covers a large geographical area of Kent. The trust became an NHS foundation trust in 2009. It has 5 hospitals and several community clinics serving around 720,500 people in east Kent.

The trust has approximately 1,030 inpatient beds across 49 wards. This includes 30 critical care beds, 58 children's beds and 49-day case beds. The trust receives over 200,000 emergency attendances, 158,000 inpatient spells and one million outpatient attendances.

The trust operates from 5 sites. It has 3 acute sites: William Harvey Hospital (WHH) in Ashford, Queen Elizabeth the Queen Mother (QEQM) Hospital in Margate and Kent and Canterbury Hospital in Canterbury. Across these sites they provide a range of services including urgent and emergency services, medical care (including older people's care), surgery, critical care, gynaecology, services for children and young people, end of life care, and diagnostics. Both William Harvey Hospital and Queen Elizabeth the Queen Mother (QEQM) Hospital provide all core services while Kent and Canterbury Hospital does not have maternity beds and has a minor injuries unit with an emergency care centre rather than a full emergency department.

There are 2 community hospitals, the Buckland Hospital in Dover and the Royal Victoria Hospital in Folkestone. The trust also provides some specialist services for a wider population, including renal services in Medway and Maidstone and a cardiac service for the population of Kent at the William Harvey Hospital in Ashford.

The trust does not have a strong financial track record; formal financial undertakings have been in place since 2015, the trust entered into the Financial Special Measures (FSM) regime in 2017 and has been in the NHS England Recovery Support Programme (RSP) since 2021. The Trust has developed and updated financial recovery plans during this period, with the last formal refresh in 2022/23.

Our findings

We carried out an unannounced inspection of the urgent and emergency, medical care (including older people's services) and children and young people services provided by this trust as part of our continual checks on the safety and quality of healthcare services. We also inspected the well-led key question for the trust overall.

We did not inspect maternity because the services had not had time to make the improvements necessary to meet legal requirements as set out in the action plan the trust provided after the last inspection. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

Our rating of services stayed the same. We rated them as requires improvement because:

- Leaders understood the priorities and issues the trust had but did not always take appropriate action to resolve them. Some executives were visible and approachable in the service, but most staff reported a disconnect between the board and the floor.
- The executive team had reviewed the vision, values and strategy. This was in its infancy and needed time to be developed fully. There were plans to ensure a structured planning process in collaboration with people who use the service, staff and external partners.
- There were systems and processes for managing risk; however, they were not always effective. Leaders and teams used systems to manage performance, but at times this was not effective. While known risks were identified and high-level risks escalated with identified actions to reduce their impact, there was variability and a lack of pace in the trust response to mitigate and manage these in some core services.
- Not all staff felt respected, supported and valued. Not all staff felt the service had an open culture where they could raise concerns without fear.
- Governance arrangements lacked clarity and were not always effective at all levels. The governance reporting needed streamlining and strengthening to be more effective.
- There was a process to deal with reported incidents. During our core service inspections, we found staff knew what incidents to report and how to report them. However, near misses, including those with potential for harm were not always reported.
- The trust did not always deal with complaints within expected timeframes.

However:

- There was a focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.
- The trust understood the negative impact of activities on the environment and strived to make a positive contribution in reducing it and supported staff to do the same.
- There had been improvements in how users of the service were involved in the business of the organisation.
- The trust board received and reviewed integrated performance reports for key local and national targets, monthly. This included those related to: patient waiting times, emergency care standards, quality, patient experience and cancer targets. Outcomes were RAG rated and trends were clearly stated. Trust board minutes demonstrated the report and data within was discussed along with the financial information.

Our findings

- The trust had made improvements in how it included and communicated with users of the service and staff. It supported the divisions to develop engagement strategies and encouraged staff to get involved in projects affecting the future of the trust.

How we carried out the inspection

During the inspection we visited wards and departments across both William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital where Urgent and Emergency Care, Medical Care (including older people's services) and Children and Young People (CYP) services were provided. This included wards, emergency departments, Children's Assessment unit, Neonatal Intensive Care Unit (NICU), Special Care Baby Unit (SCBU), operating theatres and recovery areas used by CYP.

We spoke with a range of staff including doctors, nurses, support staff, executive and non-executive directors, patients and relatives.

We observed ward handovers, daily staffing meetings, safety huddles and the day to day running of each of the services inspected. We reviewed patient records, drug charts and care plans.

We reviewed information received before the inspection from patients and staff. These included meeting minutes; policies; guidance; staff rotas; training figures; feedback from staff and patients, complaints and investigations.

We spoke with members of the trust board and executive team along with senior leaders, and those with key roles such as risk and quality leads. We reviewed meeting minutes, strategy documents, governance documents, performance reports and other documents provided by the trust. We reviewed the information we hold about the organisation.

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.

Outstanding practice

We found the following outstanding practice:

- The design and layout of the paediatric resuscitation room promoted excellent care. The room had been specifically designed to cater for critically ill paediatric patients. The room included advanced monitoring facilities and infection control measures. Staff maintained the integrity of this facility for their most ill paediatric patients.
- Cambridge K Ward had outstanding leadership which had led to a significant improvement in recruiting and retaining staff and reducing staff sickness. Staff on this ward could bring their real selves to work and had worked hard to become a cohesive team which worked seamlessly to provide the highest standard of care for their patients and those close to them.
- The acute oncology and palliative care teams had developed a model of working which ensured close communication and an enhanced service for their patients. Their expertise was apparent and supported all areas in the hospital to provide high quality, timely and expert care 7 days a week.

Our findings

- Sandwich Bay launched a pilot program that was specifically designed for end of life patients. Patients from any ward in the hospital could be moved there to receive care from nurses with additional training in palliative care. The 5 cubicles were dedicated to these patients allowing open access to visitors, and patients received daily input from the palliative care team.
- St Augustine's Ward had a double room for couples who could be cared for together.
- St Augustine's Ward had a traditional sitting room with traditional furniture and kitchenette for patients to use.

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:

Trust wide

- The trust must operate an effective complaints procedure which includes providing timely responses and updates to complainants. (Regulation 16 (2)).
- The trust must ensure all staff report incidents via the trust reporting systems. (Regulation 17)
- The trust must ensure the risks associated with reported safety concerns are mitigated promptly. (Regulation 17)
- The trust must ensure medical staff complete exception reports to identify trends and themes and use these to improve services for patients and staff. (Regulation 17).

Location/core service

William Harvey Hospital - Urgent and Emergency Care service

- The trust must ensure that all staff maintain effective oversight of patients for the duration of their care within the ED. For example, ensuring patients are regularly assessed and reassessed clinically. Regulation 12 (1)(2)(a)(b): Safe care and treatment.
- The trust must ensure medical and nursing staff are up to date with mandatory training in key skills. This includes safeguarding adults and children training to the appropriate level. Regulation 18 (1)(2)(c) Staffing.
- The trust must ensure that patients are treated with dignity and respect at all times, including during medical and clinical assessments when in overcrowded areas. Regulation 10 (1): Dignity and respect.
- The trust must ensure that the premises are appropriately maintained and fit for purpose. For example, ensuring reception and assessment areas are fit for purpose and risk assessed, escalation areas are appropriately risk assessed and completing required maintenance on the mental health assessment room doors. Regulation 15 (1) Premises and equipment.
- The trust must ensure that fire safety risks associated with an overcrowded department are assessed and mitigated. For example, with regard to trolleys blocking corridors and fire exits. Regulation 12 (1)(2)(d) Safe care and treatment.

Our findings

William Harvey Hospital – Medical care (including older people's services)

- The trust must ensure all staff received mandatory training (Regulation 18(2)(a)).
- The trust must ensure all staff receive training in safeguarding adults and children (Regulation 18(2)(a)).
- The trust must ensure fire escape routes are kept clear and fire doors are always kept closed. (Regulation 12(2)(b)).
- The trust must make sure equipment, such as resuscitation trolleys, are safe to use and checked daily to ensure they are in working order. (Regulation 12(2)(e)).
- The trust must ensure staff comply with infection control and prevention procedures when looking after patients with or suspected of having an infectious illness (Regulation 12(2)(h)).
- The trust must ensure chemical products hazardous to health (COSHH) are stored safely and securely. (Regulation 17(2)(b)).
- The trust must ensure there is a clinical pharmacy service across all medical wards, including escalation areas where medically fit patients reside. (Regulation 12(2)(g)).
- The trust must ensure radiology staff use the World Health Organisation checklist before each radiology intervention (Regulation 12 Safe Care and Treatment).
- The trust must ensure all computer terminals are locked when not in use (Regulation 17 Good governance).
- The trust must ensure fire extinguishers are maintained correctly (Regulation 12 Safe Care and Treatment).
- The trust must ensure all boarded patients have had a full risk assessment prior to boarding (Regulation 17 Good governance).

William Harvey Hospital – Children and young people core service

- The trust must ensure all relevant staff are trained to the highest level of life support. This includes ensuring the Childrens Assessment Unit has a staff member on duty trained in Advanced Paediatric Life Support in line with the Royal College of Nursing safe staffing guidelines, which states, a Paediatric Assessment Unit should have Advanced Paediatric Life Support trained staff. Regulation 18 (1)(2)(a): Staffing.
- The trust must ensure staff training compliance rates for Resuscitation training level 2 and level 3 are in line with trust targets. Regulation 18 (1)(2)(a) Staffing.
- The trust must ensure medical staff are up to date with mandatory training in key skills. This includes safeguarding adults and children training to the appropriate level. Regulation 18 (1)(2)(c) Staffing.
- The trust must ensure all temporary staff are provided with an induction and are competent to work within a paediatric setting. Regulation 18(2)(a) Staffing.

Queen Elizabeth The Queen Mother Hospital – Urgent and Emergency Care

- The trust must ensure all staff maintain effective oversight of patients for the duration of their care within the ED. For example, ensuring patients are regularly assessed and reassessed clinically. Regulation 12 (1)(2)(a)(b): Safe care and treatment.
- The trust must ensure medical and nursing staff are up to date with mandatory training in key skills. This includes safeguarding adults and children training to the appropriate level. Regulation 18 (1)(2)(c) Staffing.

Our findings

- The trust must ensure patients are always treated with dignity and respect, including during medical and clinical assessments when in overcrowded areas. Regulation 10 (1): Dignity and respect.

Queen Elizabeth The Queen Mother Hospital – Medical care (including older people's services)

- The trust must ensure staff at all levels complete the necessary training to enable them to carry out the duties they are employed to perform. (Regulation 18(2)(a)).
- The trust must ensure fire escape routes are kept clear and fire doors are kept closed. (Regulation 12(2)(b)).
- The trust must ensure staff follow infection control principles, including the use of Personal Protective Equipment. (Regulation 12(2)(h)).
- The trust must make sure equipment, such as resuscitation trolleys, are safe to use and accurately checked daily to ensure they are in working order. (Regulation 12(2)(e)).
- The trust must ensure chemicals that are hazardous to health (COSHH) are stored safely and securely. (Regulation 17(2)(b)).
- The trust must ensure they keep patient records secure. (Regulation 17(2)(c)).
- The trust must ensure there is a clinical pharmacy service across all medical wards, including escalation areas where medically fit patients reside. (Regulation 12(2)(g)).
- The trust must ensure the appropriate storage of medicines across all medical wards, including escalation areas where medically fit patients reside. (Regulation 12(2)(g)).

Queen Elizabeth The Queen Mother Hospital – Children and young people services

- The trust must ensure staff training compliance rates for mandatory training are in line with the trust target. Regulation 18.
- The trust must ensure safeguarding training rates for medical staff are improved to the trust target. Regulation 18.
- The trust must ensure the environment in the Special Care Baby Unit (SCBU) is kept at a suitable temperature. Regulation 15.
- The trust must ensure suitable alternative arrangements for the delivery of SCBU services are documented in the child health risk register if the environment becomes unsuitable. Regulation 15.
- The trust must ensure cooling equipment for the SCBU is properly maintained, and risk assessed for Infection Prevention and Control and records are maintained to support this. Regulation 15.
- The trust must ensure there are clear arrangements for patients in the SCBU if the environment becomes unsuitable due to uncontrolled temperatures. Regulation 17.
- The trust must ensure staff are referencing the same medicine formularies across the CYP departments. Regulation 17.

Action the trust SHOULD take to improve:

Trust wide

- The trust should consider reviewing current staff engagement processes to ensure they are effective.

Our findings

- The leadership team should consider how future leaders operationalise the vision and support continuation of work introduced by people in current interim roles.
- The trust should ensure the Freedom to Speak Up processes are sufficiently resourced to support staff to raise concerns.
- The trust should ensure staff with long-term health conditions are protected in line with The Equality Act 2010and have meaningful personal adaptation plans to ensure they are treated fairly, with dignity and respect they deserve.
- The trust should ensure all staff are protected in line with Equality Act 2010, to ensure they are treated fairly, with dignity and respect they deserve.
- The trust should ensure it seeks and acts quickly on feedback from staff for the purposes of continually evaluating and improving services.

Location/core service

William Harvey Hospital - Urgent and Emergency Care

- The trust should ensure all staff have regard to trust policy when reporting incidents and near misses. 17(2)(b) Good governance
- The trust should ensure staff are given regular appraisals. 18(1)(2)(a): Staffing.

William Harvey Hospital – Medical care (including older people's services)

- The trust should ensure patient equipment is maintained well and can be cleaned in between patient use.
- The trust should ensure ward areas are always tidy and clutter-free.
- The trust should ensure patient call bells are answered promptly.
- The trust should ensure audits are accurate so they can be used to drive improvements in the service.

William Harvey Hospital – Children and young people

- The trust should ensure staff working under their enhanced observation framework are given suitable rest periods in line with their policy. Regulation 18(2)(a): Staffing.
- The trust should ensure staff are given regular appraisals. 18(1)(2)(a): Staffing.
- The trust should ensure staff receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained. 18(2)(a): Staffing
- The trust should consider introducing education facilities for children staying on wards. Regulation 9(1): Person-centred care.
- The trust should ensure a suitable paediatric trained physiotherapist is available for children. 9(1): Person-centred care.
- The trust should consider how Information is analysed and reviewed and its significance is understood. For example, how results should be escalated, and appropriate action taken.17(2)(b): Good governance.

Our findings

Queen Elizabeth The Queen Mother Hospital – Urgent and Emergency

- The trust should ensure all staff have regard to trust policy when reporting incidents and near misses. 17(2)(b): Good governance
- The trust should ensure staff are given regular appraisals. 18(1)(2)(a): Staffing.

Queen Elizabeth The Queen Mother Hospital – Medical Care (including older people's services)

- The trust should ensure Allied Health Professionals have access to enough space in the hospital to conduct patient assessments.
- The trust should ensure they have enough Allied Health Professionals available to provide care to patients on medical wards, including those in escalation areas where medically fit patients reside.
- The trust should ensure they make efforts to reduce the number of times patients are moved from one ward to another, and to avoid moving patients outside of regular working hours.
- The trust should ensure all risk assessments on patients are completed on admission to medical wards.
- The trust should ensure they follow their Standard Operating Procedure when placing patients in escalation areas.
- The trust should ensure they have systems and processes in place to ensure all incidents, regardless of whether they result in harm, are reported.

Queen Elizabeth The Queen Mother Hospital – Children and young people

- The trust should ensure ligature risk is reassessed and added to the risk register for the paediatric emergency department.
- The trust should ensure a risk assessment is completed for the play area of the ward.
- The trust should ensure staff working under their enhanced observation framework are given suitable rest periods in line with their policy.
- The trust should ensure medical staff appraisal rates are improved.
- The trust should consider systems and processes which support managers own oversight of training completion rates and renewal dates held centrally by the trust governance team.
- The trust should consider an audit process associated with why patients were transferred between CYP environments.

Is this organisation well-led?

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

Leadership

Leaders understood the priorities and issues the trust had but had not always taken appropriate action to resolve them. Some executives were visible and approachable in the service. Most staff reported a disconnect between the board and the floor.

Our findings

Since the last well-led inspection in 2018 the trust had experienced changes in the senior leadership team, including the appointment of a new and experienced chief executive in April 2022, and chair in April 2021.

The trust was led by a unitary board composed of 10 non-executive directors, including the chair, and 8 executive directors, including the chief executive, and a non-voting executive director. This was held to account by the council of governors composed of publicly and staff elected members, and the appointed governors.

Along with the 10 non-executive directors (NED) there was 1 associate non-executive director, 8 executive directors and 1 non-voting executive director. There were previously 2 further non-voting executives: the director of infection prevention and control who left in July 2023, and the director of quality governance, who left in March 2023. Several post holders held interim positions. They came from a variety of backgrounds, including previous experience as a chair of another medical provider, accountancy and medicine. We spoke with the non-executive directors and were assured they had a clear understanding of their roles and responsibilities.

At the time of the inspection the trust did not have a substantive chief finance officer (CFO), the previous post holder left the trust in March 2023. The substantive deputy director of finance who joined the trust in 2022, was the current interim CFO. The interim CFO was supported by an experienced finance improvement director on a part time basis. The trust went through an unsuccessful recruitment process for a substantive director of finance in April 2023 and decided to maintain the current temporary financial leadership arrangements for a period of 6 months (with reduced input from financial improvement director), before a further round of recruitment would be initiated. The main concerns in relation to these arrangements were the instability in financial leadership and the capacity of the interim CFO, who did not have a deputy backfilling their post, to drive through the wide range of initiatives that underpin the trust's financial improvement plan.

The trust board had responsibility for operational and financial management of the trust. A formal register of director interest was available and indicated the individual's appointment date.

The chair of the trust board and its non-executive directors were independently appointed by NHS Improvement. The chief executive and other executive posts serving on the trust board were appointed by the trust in liaison with NHS Improvement. All members of the trust board were appraised through subject performance framework.

The executive directors managed the day-to-day running of the trust, while the chair and non-executive directors provided advice, particularly regarding setting the strategic direction for the organisation, and scrutiny and challenge based on wide ranging experience gained in other public and private sector bodies. There was a significant amount of support available from system partners and key stakeholders to support the trust in delivering the best care possible for patients in east Kent. Leaders were passionate about the trust and worked to try to deliver good outcomes for patients despite the challenges they faced. Although the current executive team shared a common view of the improvement programme, this was not fully joined up. We were told there were plans to strengthen this common view, once the substantive executive team were in place.

Purpose and responsibilities of senior leaders were stated. For example, we saw the purpose and functions of the chief medical officer were clearly stated around quality, safety, research, innovation and teaching.

Our findings

There had been several changes in membership of the executive team over recent years, which had made it difficult to adopt and take forward previous plans. This volume of change had not allowed time to pause and reflect on what had been successfully implemented, was working well and could therefore continue. Instead, frequent resetting and implementation of new initiatives and solutions caused instability, not just for the leadership team but at lower staffing levels too.

During our core service inspections, staff spoke positively of their immediate line managers. However, staff told us the changes in the executive leadership team had been unsettling. As part of our staff survey, we asked staff "I have confidence in the executive team", and just over 54% of those that responded disagreed or strongly disagreed, with just over 30% responding neither agree or disagree.

The board members met every month. The trust published a monthly board report on its website. This provided both the board and the public an overview of performance such as for staffing, estates, incidents and cancer waiting times. The report included summary versions of quarterly reports submitted to other committees, which were in greater detail about patient experience, patient safety, clinical effectiveness and outcomes, and infection prevention.

Services were managed in 8 care groups. The divisional management team consisted of a divisional clinical director, divisional director of operations and divisional head of nursing or professions. The clinical divisions reported to the chief operating officer. However, the trust was in the process of restructuring the care groups, reducing them from 8 to 6.

Staff views remained mixed regarding the visibility and how approachable trust leaders were. Some staff told us the senior leadership team were visible and approachable, but some felt there was a disconnect between the executives and frontline staff. They told us they did not see senior leaders such as the board of directors, so they were unsure if their voices or feedback was heard at that level.

The executive director of infection prevention and control (DIPC) was a non-voting member of the board.

As an NHS Foundation Trust, the trust board was accountable to local people through a council of governors which represented the local community. There was also governor representation on several of the committees which fed into the board of directors.

The trust had 15 governors on its council: 9 public governors (with 2 vacant posts), 3 staff governors and 3 partnership governors (representing volunteers, local authorities and universities). Prior to the pandemic, the trust held a programme of public events each year to enable governors to meet and recruit members of the wider public. The trust gave us a schedule of joint visits undertaken by the non-executive directors and governors between January and September 2023. We saw that there were 12 visits scheduled with 8 visits prior to the inspection. However, the governors told us that since the pandemic, they had not had as much contact with the public as previously. They told us they had been told they could not go out to the wards to meet with staff, patients and visitors. Their role and contact was publicised on the bed-side TV screens, and in the trust magazine. The director of communications told us this had resulted in an uptake of people applying to become a public governor.

The chief pharmacist (CP) was an experienced leader with the skills, abilities and commitment to provide high-quality pharmacy services to people. The CP was visible and accessible to all staff. Staff were provided with appropriate development opportunities which contributed to effective succession planning of the pharmacy team.

Fit and proper person

Our findings

We reviewed the personnel files of 7 members of the executive team. Appropriate checks had been carried out in accordance with 'Fit and Proper Person' requirements. The executive team had an appropriate range of skills, knowledge and experience.

Vision and Strategy

The executive team were reviewing the existing vision, values and strategy. The strategy would then need time to be developed fully and put into action. There were plans to ensure a structured planning process in collaboration with people who use the service, staff and external partners.

The executive team were reviewing the existing trust vision and mission alongside the development of the trust's strategic plans. The strategy needed time to be developed fully and there was work underway with external consultants to consider the best approach, with an ambition to ensure staff and patients were engaged in its development. The executive team were determined to ensure the strategy had an equality and diversity focus to make identified improvements. The importance of having a meaningful strategy which staff at all levels were able to track and contribute to was also recognised.

Leaders spoke about the existing trust mission to improve health and wellbeing across both staff and patients and their vision to deliver great healthcare from great people (the staff). Themes to support the mission and vision were defined around quality and safety, the patients, people, partnerships and sustainability, and the trusts values.

Underpinning these points were five pillars of change and strategic objectives, which the trust said were driven by its response to national report 'Reading the Signals', including the importance of meeting national standards for planned, cancer and emergency care and the need to be financially sustainable by providing better care and reducing waste.

The five pillars were:

- Quality and safety – reducing harm and delivering safe services
- Patients – patients, family and community voices; timely access to care
- People – care and compassion; engagement listening, and leadership
- Partnerships – organisational development
- Sustainability – financial sustainability

These pillars were supported by the trust values: people feel cared for, safe, respected and confident we are making a difference.

Culture

Not all staff felt respected, supported and valued. Not all staff felt the service had an open culture where they could raise concerns without fear.

Our findings

We spoke to staff across most grades and disciplines. All staff we met during our inspection were welcoming, friendly and helpful. However, not all staff felt valued, respected, and supported. Some staff told us they felt 'traumatised', 'devalued' and 'damaged' because of the recent restructuring process. They told us not all staff affected had been consulted. They felt uncertain about their roles, and if they 'had a job to go to'. For example, staff in interim positions were unclear if there were jobs or roles for them, which increased anxiety within this staff group.

As part of our staff survey, we asked staff their opinion on the statement, "Communication between senior management and staff is effective", and just under 61% disagreed or strongly disagreed, with another 19.6% responding they neither agreed or disagreed. In addition, 61.6% disagreed or strongly disagreed with "This organisation values staff and provides them with effective support to do their jobs to the best of their ability".

During our core service inspections, we heard that staff did not like to move between sites, mainly the Queen Elizabeth the Queen Mother Hospital to the William Harvey Hospital to help with staffing, meaning they were unable to deliver effective and safe care. We were told this was due to working relationships and culture differences at the different sites. Matrons told us they were working to break down the barriers (such as taxis for staff who do not want to drive, and earlier finishes) and staff were becoming more motivated to work at other sites.

The trust was keen to create and embed a culture where staff felt comfortable and safe to speak up. The trust had 2 full time and 2 part time Freedom to Speak Up Guardians (FTSUGs). The FTSUGs were supported by a team of 60 freedom to speak up connectors, spread across the 3 main sites. They were very knowledgeable and keen to promote the value of speaking up across the trust. One of the priorities of the FTSUG had been to increase awareness of the importance of speaking up. Information was provided at the new employee induction, and the trust was also rolling out mandatory training on speaking up. We saw the team was promoted in October 2022 edition of the staff magazine. The FTSUG had an email inbox, but staff could contact them directly.

The chief people officer was the lead for freedom to speak up, who provided senior support for the speaking up guardians, and who was responsible for reviewing the effectiveness of the FTSU arrangements. There was a designated non-executive director responsible for speaking up, who provided independent support for the speaking up guardians, ensured investigations were conducted with rigor and help escalate issues appropriately.

As part of our staff survey, we asked staff their opinion on the statement, "I feel confident raising concerns through the organisation's freedom to speak up process", and 35.6% of those who responded agreed or strongly agreed, with another 29% responding neither agree or disagree. This meant the trust could not be confident staff were raising concerns. This meant the trust could not be confident staff were raising concerns.

The service served a population which was predominantly White with some pockets of deprivation. The Workforce Race Equality Standard (WRES) data report for 2021-2022 showed most staff groups were predominantly White. The trust had increasing numbers of staff from ethnic minority groups due to recruitment of internationally educated nurses and doctors. However, the Workforce Race Equality Standard (WRES) data report for 2021-2022 showed staff from ethnic minority groups were underrepresented across clinical roles, particularly at band 6 and above.

The WRES report showed representation of staff from ethnic minority groups at board level was not representative of the workforce.

The Diversity and Equality section of the NHS staff survey showed the trust performed below the national average across all questions, indicating poorer experiences for staff from ethnic minority groups. For example, the percentage of staff believing the organisation provided equal opportunities for career progression or promotion for white staff was 52.6%

(nationally 58.6%) for White staff, compared to just over 42% (nationally 47%) for staff from all other ethnic minority groups at the trust. The percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months was 8.7% (nationally 6.5%) for White staff, compared to 18.4% (nationally 17.3%) for staff from all other ethnic minority groups at the trust.

This was similar to our findings when we asked staff their opinion on the statement "In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleagues" and just below 18% responded yes. The grounds for this included disability, ethnic background, gender, age and religion.

Discrimination from colleagues was a priority area for improvement for the trust, as well as career progression in clinical roles. We reviewed the trust's Workforce Race Equality Standard (WRES) Action Plan 2022/2023. We saw thee were clear actions to address areas that needed to improve. For example, "Continue to embed Just Culture Programme to promote and embed meaningful change", "Develop Staff Networks to support the People strategy and Agenda" and "Launch See ME First Campaign in early 2023. See ME First promotes Equality, Diversity and Inclusivity and says that we are an open, non-judgmental NHS organisation that treats all Black, Asian and Minority Ethnic staff with dignity and respect".

Changes in the senior leadership team has meant that not all the networks had an executive champion. The disability network chair told us that the chief medical officer was currently their sponsor, but they were aware that they are leaving. However, we were told the communication director was very involved in the disability network. Most of the chairs confirmed they have been involved in the development of the strategy, with the exception of 2 chairs. The 2 chairs that had not been involved were new to the role.

All the network chairs told us that they were not given dedicated time to undertake their role. They told us in the policy there is some mention of 15 hours protected time for undertaking this role. However, this is not a mandatory requirement and the network chairs confirmed they are not given this. In addition, the network chairs also felt that there should be protected time to attend meetings for each of the networks as this would improve attendance and make staff feel valuable.

The trust had 5 staff networks to champion equality, diversity and inclusion: Ethnic diversity engagement network (EDEN), LGBTQIA+, disability, women's and neurodiversity. There was a dedicated section on the trust's intranet system where staff could find out more information about each network.

The trust was working to reduce discrimination and bias in the recruitment process. Both the chairs for EDEN and LGBTQIA+ told us the trust was serious about reducing bias in recruitment processes. The chair for EDEN told us how their members were involved in this process, including as independent panel members. The LGBTQIA+ chair told us they had been more involved in the recruitment process.

However, we were told that there was still some work to do, challenges remained linked to gender, pay and promotion. We were told there has been some concerns around flexible working requests, and that promotional opportunities have not been available for staff as they are part time.

The Workforce Disability Equality Standard (WDES) is a set of measures which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

The WDES results for disabled staff were notably different to results for non-disabled staff at the trust, indicating poorer experiences for staff with long-term conditions or illnesses. Results also compared less favourably with the national average for these questions whether East Kent staff disabled or non-disabled.

Our findings

Almost a quarter of disabled staff stated they experienced harassment, bullying or abuse from managers in the 12 months prior to the survey, and this compares with just above 17% nationally. Of those non-disabled staff surveyed, 16% of staff without a LTC had also experienced this, which compared with just below 10% of non-disabled staff nationally.

We looked at the trusts WDES Action Plan (Workforce Disability Equality Standards) 2022, which is available on the trust website. The action plan had 19 actions which included "Developing the Neuro-diversity staff group to provide a safe and supportive space for staff with neurodivergence and also take forward actions to increase awareness and accessible information for staff", "Developing the Disability Staff Network to provide a safe and supportive space for staff who have disabilities" and "Empowering staff to share their lived experience stories to raise awareness and promote meaningful culture change, including at Executive Board level". Each action had an associated time scale. From review there were timescales that had passed but had not been updated.

For example, action 5 "Reasonable Adjustments Pilot to embed the Trust's legal responsibility to make workplace adjustments for staff with disabilities or those with long-term health conditions", had a timescale "Pilot to start in February 2023". However, this has not been updated to state if it started, been completed, or delayed. This meant that it was unclear where the trust was with their WDES action plan. The lead for equality and diversity at the trust told us that a session for the board on equality and diversity has been planned for September 2023.

The lead and network chairs confirmed that there were concerns around length of time it can take for reasonable adjustments for staff. For example, if someone needs reasonable adjustments to be able to undertake their role, the process is often slow and can feel process driven, and that the person at the heart of request who is struggling to do their role is forgotten. We were told often these adjustments can be simple, cheap or free to implement but by not implementing these can lead to people leaving, being redeployed or becoming unemployed.

Since 2018 the trust had recruited internationally educated nurses, with 540 recruited to the trust last year. The trust had a pastoral care matron to ensure they covered their needs. This included signposting people to make sure they were keeping themselves well and aiding them to find dentists and GPs. They also helped with setting up bank accounts, helped with exploring the local areas, using public transport and international food shops.

Governance

Governance arrangements lacked clarity and were not always effective at all levels. They needed streamlining and strengthening to be more effective. There was a plan to carry out a full governance review in September 2023, which would include identifying and addressing inconsistencies in existing governance arrangements.

The trust had a Quality and Safety Committee. They were responsible for obtaining information, reviewing, and monitoring this to gain assurance on the quality and safety of care in all areas. This included statutory and mandatory requirements relating to quality and safety of care. The committee were responsible for the oversight of any actions taken to make improvement and to escalate matters where required, to the board for consideration.

There were a range of sub-committees, with good representation by non-executive directors, which fed into the governance system. The trust was in the process of reviewing their governance processes to strengthen the organisational oversight on safety in its services. Some governance systems were therefore in development and not embedded at the time of inspection, which meant CQC were unable to fully assess the quality of the systems and risk oversight.

Our findings

The chief executive provided a monthly report to the board of directors, with information from various governance groups, NHS England (NHSE), Department of Health and other key stakeholders.

An annual report was produced and made publicly available each financial year. This included information on the trust processes for measuring performance.

Governance arrangements around Infection Prevention and Control (IPC) had been strengthened in quarter 4, with a change in structure. This included operationally focused site-based infection control groups at the main hospital sites and links at the 2 locations in Dover and Folkstone. Membership included clinical and non-clinical staff, enabling wider and varied discussion and shared learning. In addition to these groups, associated areas of decontamination, water safety, ventilation safety and antimicrobial stewardship reported into a quarterly Infection Prevention and Control and Antimicrobial Stewardship Committee (IPCAS). This committee had a strategic focus on any areas of concern, emerging themes and learning for sharing widely, both internally and with external stakeholders. The IPCAS Committee reported to the board via the Quality and Safety Committee, via the DIPC.

The DIPC reported formally to the trust board every quarter. It was noted in the most recent report and was confirmed by the DIPC in discussion with us, the targets for Clostridioides difficile (C. diff) not within had not been met. In addition, new targets had been set for reportable infections, which would make this a further challenge. Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements, leading to harm was identified as a risk on the board assurance framework (BAF).

There had been an independent review into maternity and neonatal services at the trust which looked at the care and treatment of women, babies and their families in the care of the trust between 2009 and 2020. The report Reading the signals: maternity and neonatal services in East Kent, was published in October 2022. The investigation looked at 202 cases where the families involved asked to participate and where their care fell within the scope of the investigation. The results of these case reviews drew on evidence from family listening sessions, clinical records and interviews with clinical staff and others.

The report identified times when the trust board missed opportunities to identify the scale and nature of the problems and put them right. Although action plans had been developed, they underestimated the recurring pattern of failure, often attributing blame to individuals or individual clinical error. Repeated staff turnover exacerbated the tendency to treat problems as a one-off.

Following publication, the trust issued a public statement and apology on the findings of the report. The trust stated they were committed to addressing the 4 key areas for action that were identified in the independent review, these are:

- Monitoring safe performance
- Standards of clinical behaviour
- Flawed team working
- A recommendation specifically for the trust to embark on a restorative process addressing the problems identified in partnership with families, publicly and with external input.

These 4 key areas were integral to the pillars of change within the trust mission, which were underpinned by the trust's values.

Our findings

‘The Pillars of Change’ set out the steps the trust had already taken and included further work to be delivered over the next 3 years.

We inspected maternity services in the trust in January 2023, following the publication of Reading the signals: maternity and neonatal services in East Kent – the report of our independent investigation. This inspection resulted in the ratings for the service to go down from ‘requires improvement’ to ‘inadequate’. This inspection resulted in conditions being placed on the trust’s registration in February 2023.

We inspected urgent and emergency care, medical care (including older people’s services) and children and young people core services in May 2023, because we received information giving us concerns about the safety and quality of these services. The inspection resulted in enforcement action by serving a warning notice in June 2023, which asked the trust to make significant improvements.

This included concerns around the completion of mandatory training, in the medical care (including older people’s care) and children and young people core services. Following this the trust has supplied us with more information that showed improvement in the mandatory training figures.

Patients, relatives and carers knew how to complain or raise concerns. There was information on the trust’s website signposting patients and members of the public on how to complain to the service. There was a centralised complaints team responsible for receiving and acknowledging complaints and obtaining consent (if required). The central complaints team were also responsible for registering the complaint on the electronic incident reporting system, allocated an initial red, amber, green rating to the complaint and allocated it to the appropriate care group. The chief nursing and midwifery officer was the responsible officer for complaints. There was a designated non-executive director champion for complaints.

Each care group was responsible for allocating an appropriate investigating manager to oversee the investigation of the complaint. The investigating manager coordinated a response with the relevant care group and all responses were reviewed by the chief nursing and midwifery officer. The care groups were responsible for any follow up actions and learning from the complaint.

All new complaints received were given a standard 45 working days response target, or an agreed timescale. The agreed timescales were allocated if the care groups identified they needed more time to complete the investigation. We saw between January and May 2023, the trust received 418 complaints. The trust monitored the response timescales. We saw for May 2023 that 69% of complaints were within the response timescales, which was below the trust target of 85%. This had improved from April 2023, where only 45% of complaints were responded to within the timescale.

The top 5 themes for complaints were: clinical management, nursing care, delays, discharge arrangements, communication and diagnosis. These were discussed at the Complaint and Feedback Steering Group. Learning from complaints occurred by sharing the responses with the relevant ward or teams for discussion at team meetings and speciality quality/audit meetings.

Between January and May 2023, the patient advice and liaison service (PALS), received 2,547 contacts from members of the public. The top themes of contacts with PALS within this period were general enquiries, delays, communication, appointments, and clinical contact. The general enquiries included contacts chasing appointments, surgery referrals and results.

Our findings

On inspection we looked at 10 complaints. We found inconsistencies with the completeness of the complaints, particularly around obtaining consent and the delays this caused in responding in a timely manner. For example, a complaint about a parent's care and treatment where the parent had died, and they were unable to obtain consent. Another example was where both a patient and relative raised a series of complaints, these had been combined into one complaint. Both complaints were held while a request from the relative was made to obtain consent from the patient. It was not clear why the complaints had been combined and therefore consent required held up the patient's complaint, which resulted in a breach of timescales.

Management of risk, issues and performance

There were systems and processes for managing risk; however, they were not always effective. Leaders and teams used systems to manage performance, but at times this was not effective. While known risks were identified and high-level risks escalated with identified actions to reduce their impact, there was variability and a lack of pace in the trust response to mitigate and manage these in some core services.

The trust had developed a means of assessing organisational performance against 5 overarching themes. The Integrated Performance Report (IPR) identified the themes of focus included: Reducing patient safety incidents resulting in harm, reducing time spent in the emergency departments, improving theatre capacity, improving scores for staff involvement and reducing premium pay spend.

The board were updated on progress of delivery of the Integrated Improvement Plan (IIP) and the associated performance metrics including the main risks impacting on delivery and linked to the BAF. Despite improvement director role holders changing in recent years and a third improvement plan in the last 2 years, NEDs told us the internal improvement plan was stabilising performance and was transformative.

The Strategic Improvement Committee was chaired by the CEO, with responsibility for overseeing the delivery of the IIP. The Strategic Improvement Committee was planned to meet every 2 weeks, reviewing 3 out of 6 programmes of work at each meeting.

The IPC team was reported to be stable, since recruiting to vacant posts, with succession planning arranged for the replacement of the current DIPC. The trust had been notified that it was an outlier for low levels of reported infection during 2022-2023 and the IPC team recognised the audit processes needed to improve. To support this, the trust had appointed a specialist surveillance nurse. This would enable the trust to review and develop its surveillance activity, with a view to improving this.

Risks relating to medicines optimisation were centralised on a risk register managed by the Medicines Safety Assurance Group. Each month 1 risk was reviewed in detail, working towards closure. Whilst not all wards received a clinical pharmacy service, wards were aware of this and had raised this as a risk.

The trust's safeguarding team was led by an interim head of safeguarding, they had been in post since March 2022. The purpose of the interim post was to bring together all aspects of the safeguarding portfolio under 1 service. The trust's safeguarding team consisted of all the appropriate roles as identified by NHSE Safeguarding Accountability and Assurance Framework (2018). There appeared to be sufficient resource within the team to deliver an all-age safeguarding service across this large organisation. However, the deputy safeguarding lead, was also in an interim position.

Our findings

The safeguarding lead reported to the chief nurse. They provided expert advice on complex issues including consent, mental capacity and deprivation of liberty. They played a key role in managing complex safeguarding cases, coordinating actions to be taken and acting as a point of contact for external agencies. The safeguarding lead worked closely with senior clinical staff, human resources and had direct access to the executive leads.

The safeguarding lead developed a safeguarding reporting structure which linked directly to each care group, who had their own Safeguarding Operational Committee. The individual care group Safeguarding Operational Committee, reported to a trust wide Assurance Committee. In turn, this reported to the trust board via the Quality and Safety Committee.

The board received monthly reports to provide adequate assurance around their safeguarding responsibilities. The monthly reports for safeguarding adults and children were received by the Fundamentals of Care Committee and trust board. We reviewed the reports for April, May and June 2023 and found they contained relevant information and data to provide adequate assurance to the board. We noted there was a focus on the results of a thematic review into the use of physical and chemical restraint.

There was mandatory training at appropriate levels for all staff. Staff were trained to various levels of safeguarding children and vulnerable adults, dependent on their role in line with national guidance. However, training compliance was low in level 2 and level 3 for both safeguarding adults and children. The trust had decided to retain the face-to-face training in level 3 safeguarding training which impacted on the compliance.

The trust had clearly defined processes for staff to raise safeguarding concerns set out in its safeguarding policies, which were readily available via the trust intranet. Safeguarding alerts were managed by the safeguarding team and information was shared with external partners as needed. There were arrangements to manage alerts made about the trust in partnership with relevant local authorities.

There was a process to deal with reported incidents. This included those which were open and overdue. Incidents were reported through the electronic report system. During our core service inspections, we found staff knew what incidents to report and how to report them. All staff could access the incident reporting system and could describe what they would consider an incident. Staff received feedback directly to any incidents they raised depending on the severity. Staff raised concerns and reported incidents and near misses in line with trust policy.

During our core service inspections, we found some staff were not always reporting near misses, including those which had potential for harm. Nursing staff told us doctors had prescribed adult doses of medicines to children and felt they relied on nurses to pick this up. We were told these situations had not been reported as near misses and was a missed opportunity for learning.

The trust had a backlog of incidents to review, investigate and close. There was a target set to close, following review and investigation, 500 overdue incidents. In addition, the trust informed us they had reviewed the validation process of serious incidents to be more efficient and had resolved the backlog for these incidents.

People who raised concerns or complaints involving medicines were invited to the pharmacy to describe their experience and concerns at the start of the investigation.

The Medicines Safety Assurance Group and medication safety officer led on the learning from incidents involving medicines. Their focus was looking at themes and trends across these incidents.

Our findings

NHSE Financial Governance Report

Leadership

The trust was aware of risk associated with its financial position. The financial plan had not yet been achieved. In 2019/20, prior to the COVID pandemic, the trust reported a deficit of £36.6m on a turnover of £658m. Due to the COVID pandemic, during 2020/21-2021/22, the NHS operated under temporary national financial frameworks, where costs incurred were largely funded via envelope and top-up payments. The trust reported a £6.5m deficit and £0.1m surplus respectively for these years. In the financial year 2022/23, the trust submitted a breakeven plan; however, reported a deficit of £19.3m (subject to accounts finalisation) on a turnover of £927m. The key causes of the deficit were reported as costs of escalation capacity (due to demand and poor flow), clinical pressures driving increased agency and bank expenditure and under delivery of the efficiency programme. The 2022/23 position was achieved through material levels of non-recurrent measures and income from the Kent & Medway ICB, which reduced the scale of the deficit.

The 2023/24 financial plan is for a deficit of £71.9m on a turnover of £866m. Therefore, the financial outlook has deteriorated as non-recurrent measures applied in 2023/24 can no longer offset the growth in underlying costs. At month 2 2023/24, the trust reported a £19.7m deficit, £1.9m adverse to plan, caused by under delivery against its efficiency programme. To achieve its financial plan, the trust will need to deliver a stretching efficiency programme of £40m (4.6% of turnover); this compares to savings delivered of £19.6m in 2022/23. The trust overspent its £23.5m capital allocation by £2.3m in 2022/23. The trust allocation for 2023/24 is of a similar magnitude at £20.1m, and at month 2, it has spent £3.1m capital; an overspend against plan of £0.2m", as stated in the report to trust board, June 2023.

Of note, there is a significant backlog of maintenance issues and an estate that it reports as being in generally poor condition. To address this the trust developed a pre-consultation business case to reconfigure its services and upgrade facilities. The case required significant capital funding (in excess of £400m) and was submitted for consideration by the New Hospital Development program team and, although the case was supported as its key priority for the NHSE Southeast Regional team, it was not approved to proceed. The trust believes c£140m of additional funding over its base capital allocation is needed to maintain essential services over the next 5 years and it is currently developing an alternative solution. The trust is formally part of the Kent & Medway Integrated Care System (the ICS).

At the time of the inspection the trust did not have a substantive chief finance officer (CFO), the previous post holder left the trust in March 2023. The substantive deputy director of finance who joined the trust in 2022, was the interim chief finance officer. The Interim CFO was previously director of finance at a small specialist trust. The Interim CFO was supported by an experienced finance improvement director on a part time basis. The finance improvement director was previously NHSE London Regional Finance Director.

There was an unsuccessful recruitment process for a substantive director of finance in April 2023, with the decision made to maintain the current temporary financial leadership arrangements for a period of 6 months (with reduced input from financial improvement director), before a further round of recruitment will be initiated. The main concerns in relation to these arrangements were the instability in financial leadership and the capacity of the Interim CFO, who did not have a deputy backfilling their post, to drive through the wide range of initiatives that underpin the trust's financial improvement plan.

Governance and Risks Management

A theme which emerged during interviews held with the inspection team was that financial performance has not been prioritised within the trust for a significant period. The focus had been on the COVID 19 pandemic recovery and

addressing material quality and operational performance issues. It was reported in interviews that a consequence of this was a lack of basic financial grip and control including limited structured financial oversight at care group level, which the current CFO and executive team were in the process of reinstating. The trust's internal audit report includes findings which showed this as an area of concern; highlighting lack of engagement and accountability of budget holders in financial management as well as cases of core controls not being followed (in relation to Single Tender Waivers).

The trust acknowledged it had been slow to reintroduce financial controls since the pandemic, but the situation was now being addressed as part of the trust's Integrated Improvement Plan finance workstream; with actions being taken to improve financial governance including reinstating regular formal care group financial oversight meetings, refreshing SFIs and restarting budget manager finance training. A separate "financial consciousness" workstream was also in progress to improve financial awareness with clinicians and staff across the trust. The trust's External Auditors indicated the 2021/22 accounts gave a true and fair view of the financial position. At the time of the inspection 2022/23 accounts were delayed and had not been submitted to NHS England for consolidation. The trust reported at this time the external auditors had indicated it was content that the trust's group accounts were expected to be unqualified; however, the trust and its subsidiary accounts needed to be revised. The trust CFO acknowledged that a review was needed to assess how this situation had arisen. The trusts internal audit report for 2022/23 concluded the trust had an adequate and effective framework for risk management, governance and internal controls. It did, however, highlight areas where enhancements should be made due to partial assurance including the financial controls outlined above, as well as in operational and quality areas such as job planning.

The chair of the Audit Committee commended the internal audit team as being experienced and thorough. The chair also described a sensible approach in setting the internal audit program of work bringing in several stakeholder views including Audit Committee members and the executive team. The chair of the Audit Committee and the chair of the Finance Committee were both chartered accountants with considerable relevant experience to the committees they lead. The chair of the Audit Committee had over 25 years of experience in the NHS, primarily working in audit and governance, and demonstrated a good depth of insight. The chair was open and candid and offered a rounded view, flagging significant weaknesses in the trust's governance and risk management issues had been identified, and were now in process of being addressed. Issues raised included risk identification, the consistency of reporting of risks across committee papers and gaps in corporate risk management and governance posts within the trust. It was apparent from wider interviews the members of the board had inconsistent views on the executive lead responsible for the Board Assurance Framework. The chair of the Audit Committee reported that an "assurance map" had been commissioned as means to address risk and governance issues and improve reporting, and this was being followed by a full-scale governance review due to commence in September to further strengthen internal governance.

Throughout the interviews there was consistency in relation to key risks the trust faced, notably; quality and safety (in light of recent Kirkup and CQC report findings), workforce and cultural change challenges, and from a financial perspective, lack of capital resource to improve the trust's estate. Delivery of the trust's efficiency programme was considered a significant risk (with most schemes still to be identified at the time of the inspection) and was a concern as it was a key factor in terms of the trust's ability to achieve its 2023/24 financial operating plan. The trust's Integrated Improvement Plan financial workstream is in place to mitigate this risk. It was reported the new executive team were now more actively engaged to mitigate the risk and there was a recognition more was needed to be done quickly to catch up from slow initial progress. However, there were limited assurances that the risk would be mitigated. The risk of achieving the trust's financial plan, which was rated as a high risk on the Trust's BAF; based on information gathered as part of the inspection it would not be unreasonable to increase this to a severe risk.

Information Management

Our findings

The trust board received integrated performance reports for key local and national targets, monthly. This included those related to: patient waiting times, emergency care standards, quality, patient experience and cancer targets. Outcomes were RAG rated and trends were clearly stated. Trust board minutes demonstrated the report and data within was discussed along with the financial information.

The trust had reviewed and evaluated the system used to capture a wealth of information including incidents and complaints and was in the process of introducing a new system identified as better able to meet their needs. The system would enable the trust to monitor incidents and performance. The plan was to link safety issues with audits and risk. We were told the incident reporting system was in the process of being upgraded. Because of this, there was a concern this would lead to an increased backlog of incidents.

Leaders and staff did not always receive information to enable them to challenge and improve performance. Information management systems were not always joined up and the trust was running multiple IT systems to record the same data. Training data, for example, was recorded on multiple systems including electronic staff record, health roster and information portal. During our core service inspection, we found mandatory training compliance rates varied and were not in line with the trusts targets. Staff told us this was due to the database used to record the training lagging behind up-to-date local training data.

The trust understood the negative impact of activities on the environment and strived to make a positive contribution in reducing it and support people to do the same. The trust had developed a green strategy in line with the national requirement for the trust to be net zero for the emissions it controls by 2040 (80% by 2028 to 2032). Some of the strategies the trust had already implemented were the installation of solar panels at the hospitals to generate electricity, changed lightbulbs to LED bulbs and improved insulation. The installation of solar panels at WHH had saved 159 tonnes of carbon per year, and at the QEQM, will mean that the hospital may not need to draw electricity from the national grid during the summer months. The trust told us they were working towards the reduction of waste in other areas and had asked staff to send in ideas on how to do this as part of a 'hands up if you hate waste' campaign.

Electronic prescribing and medicines administration (ePMA) had been rolled out across most services. Clinical pharmacy staff were allocated to clinical areas using a risk-based deployment tool incorporating a focus towards hospital admission areas. Therefore, patients on some wards were not reviewed by the pharmacy team.

Once the roll out of ePMA was embedded, the pharmacy service intended to review the risk-based deployment tool. This review would inform an updated pharmacy workforce plan to deliver a safe, effective, and responsive medicines optimisation service.

Engagement

There was a limited approach to engage with patients, staff and the public to plan and manage services. Patients, relatives and carers were not always encouraged to contribute to the running of the service through feedback. Staff were not always actively engaged, and their views reflected, in the planning and delivery of the service.

The most recent trust board report acknowledged more work was required to embed research, education, and innovation into the organisation. There was recognition of the need to do more to encourage and enable more multi-professional staff, across all clinical specialities, to engage with research and innovation to deliver excellence.

Several completed improvement projects were highlighted to the board, and we saw some listed which were in progress, including those with revised timelines.

Our findings

There had been improvements in how patients and service users were involved in the business of the organisation. 'Your voice is heard' was an initiative launched in May 2022, that was co-produced to ensure families voices were heard and their feedback used to inform and shape maternity services. People who used the service were called 6 weeks following giving birth. Between May 2022 and June 2023, 4,842 people had been listened to. We saw almost 91% of people were positive about their antenatal care, 91.5% of people were positive about labour care and 84.4% of people were positive about their postnatal care. We were told about improvements to the service because of feedback, such as comfortable chairs and food for birthing partners, introduction of 'soft close' bins to reduce the noise in maternity wards and improved pain relief during labour.

The was a trust-wide communications strategy. The trust website had been reviewed and refreshed, to make it easy to navigate, and improve accessibility. Following review by an outside company we were told these improvements had resulted in the trust website ranking improving from 137, to one of the top 10 in the country for accessibility.

The trust worked appropriately with trade unions. The trust had a positive, collaborative working relationship with the staff side and recognised the vital role they played in the organisation. 'Staff side' was made up of representatives from recognised trade unions. Discussions with 'staff side' did not identify any concerns. The 'staff side' representatives met with a senior member of the trust every 6 weeks. We were told there was a standard agenda, and any consultations were added to this as necessary. Issues such as parking remained high on the agenda, along with new policies. The staff committee was described as good natured and friendly, and most of the representatives have been a member for over 10 years. Staff side representatives generally felt they had enough time to undertake the role.

There were 2 guardians of safe working hours, that worked trust wide. The guardian of safe working hours ensured issues of compliance with safe working hours were addressed by the doctor and the employer as appropriate. It provided assurance to the board of the employing organisation that doctors' working hours were safe. Each guardian was appointed 1 programmed activities (PA) to undertake this role. A PA is a block of time, typically equivalent to 4 hours in which a consultant's contractual duties were performed. It was felt the resources were not enough to enable the guardian to fulfil the role.

The guardians of safe working hours did not report directly to the board, but report to the People and Culture Committee, twice a year. There is a requirement for guardians of safe working hours to send quarterly reports to the board, but this was not happening. There had been no mention of the guardian of safe working hours in the board papers for the last 9 months. In addition, they did not produce an annual report for the board. Although the guardians of safe working hours did not meet regularly with the chief medical officer to discuss their issues or concerns, they told us they would approach the chief medical officer if needed.

Medical staff had fed back to the guardians of safe working hours that they did not know how to exception report and felt it was a 'tedious system', 'didn't always work' and 'took too long' to complete. As a result, the trust was unable to address any immediate or serious risks to safety and make sure the organisation at local level was able to address the concerns which led to the exception report being made.

A consultants' forum was also arranged as part of our inspection. Consultants told us they often felt they were identified as not engaging with the trust as a staff group. Consultants felt they did not have enough opportunity or the right avenues to engage effectively. They felt more clinical and medical input to the board would improve engagement.

The Council of Governors are an integral part of a foundation trust. The council ensured the views and interests of the public, patients, carers, staff and other stakeholders were heard and reflected in the strategy for the hospital. During our

conversations with governors, they told us that since the pandemic they had not had as much contact with the public as previously. They had been told by the trust they were not able to visit the wards, to meet with staff, patients and visitors to get their views or concerns. In addition, governors told us staff did not always feel comfortable about contacting them, as all email correspondence went via the trust.

Learning, continuous improvement and innovation

Although there were systems and processes for learning, continuous improvement and innovation, the most recent trust board report acknowledged more work was required to embed research, education and innovation into the organisation.

There was a focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.

There was improved participation in research. Since 2019/20 the trust had recruited 11,651 participants into 222 studies, across 26 discreet speciality areas, including: haemophilia, blood pressure, paediatrics, gastroenterology, anaesthetics, haem-oncology, neurology, neonatal, genetics, cardiology, autism, vascular surgery and maternity. Clinicians at the trust had launched 125 new projects. There were currently 77 interventional trials open to patients.

All staff were committed to continually learning and improving services. This included the matron development programme. The programme lasted 6 months, with 40 matrons and helped them look at, and explore, their roles. Following the programme NHSE asked the trust to review the competency framework handbook for matrons.

The trust had introduced a 'ready to care' programme for new healthcare support workers (HCSW), to teach them key skills and help prepare them for their role in the trust. This had improved turnover rates for HCSW from 21% to 8%.

The pastoral care for international nurses was awarded the 'NHSE Pastoral Care Quality Award' in July 2023.

The trust was part of the NHE/I Getting to outstanding palliative and end of life beds project. They joined the project in September 2022, along with 8 other trusts. The aim was to have a dedicated ward for palliative and end of life patients. This included dedicated staff with additional training and making changes to the ward environment.

Staff told us about the ward accreditation quality improvement scheme which was introduced in September 2022. This initially involved 30 wards across the trust using 12 quality measures, such as nutrition and oral hygiene, patient experience, fall prevention, tissue viability and pressure ulcers and sepsis and deteriorating patient. We saw the 22 wards had achieved bronze in their accreditation and 8 silver. There were another 20 wards who would have their first accreditation by January 2024.

The trust had 14 advanced practitioners in Urgent and Emergency Care and Frailty. Advanced clinical practitioners worked at the level of a middle grade doctor. They supported existing and clinical care to enhance the capacity and capability within multi-professional teams. Their primary roles include improving clinical continuity, providing more patient-focused care.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. Staff were encouraged through 'hands up if you hate waste' campaign to submit ideas and activities for improving the quality of the workplace and patient care. This was promoted through email and via the trust bulletin on the intranet.

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 →← Dec 2023	Requires Improvement →← Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement →← Dec 2023	Requires Improvement →← Dec 2023	Requires Improvement →← Dec 2023

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
William Harvey Hospital	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔ Dec 2023	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023
Buckland Hospital	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Royal Victoria Hospital	Good Nov 2015	Not rated	Good Nov 2015	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015
Queen Elizabeth The Queen Mother Hospital	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023	Good ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023
Kent & Canterbury Hospital	Requires improvement Sep 2018	Requires improvement Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018	Requires improvement Aug 2021
Overall trust	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔ Dec 2023	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023

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 William Harvey Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement → ← Dec 2023	Good → ← Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement → ← Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement → ← Dec 2023
Services for children and young people	Good → ← Dec 2023	Requires Improvement → ← Dec 2023	Good → ← Dec 2023	Requires Improvement → ← Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement → ← Dec 2023
Critical care	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
End of life care	Requires improvement Sep 2018	Requires improvement Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018
Outpatients and diagnostic imaging	Good Nov 2015	Not rated	Good Nov 2015	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015
Surgery	Good Sep 2018	Good Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Good Sep 2018	Good Sep 2018
Urgent and emergency services	Not rated	Not rated	Good Jul 2020	Not rated	Not rated	Not rated
Maternity	Inadequate May 2023	Requires improvement May 2023	Requires improvement May 2023	Inadequate May 2023	Inadequate May 2023	Inadequate May 2023
Overall	Requires Improvement → ← Dec 2023	Requires Improvement → ← Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement → ← Dec 2023	Requires Improvement → ← Dec 2023	Requires Improvement → ← Dec 2023

Rating for Buckland Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for children & young people	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Minor injuries unit	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Outpatients and diagnostic imaging	Good Nov 2015	Not rated	Good Nov 2015	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015
Overall	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015

Rating for Royal Victoria Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Nov 2015	Not rated	Good Nov 2015	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015
Overall	Good Nov 2015	Not rated	Good Nov 2015	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015

Rating for Queen Elizabeth The Queen Mother Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ➔➔ Dec 2023	Good ➔➔ Dec 2023	Good ➔➔ Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement ↓ Dec 2023	Requires Improvement ↓ Dec 2023
Services for children and young people	Good ➔➔ Dec 2023	Good ↑ Dec 2023	Good ➔➔ Dec 2023	Good ↑ Dec 2023	Requires Improvement ↓ Dec 2023	Good ↑ Dec 2023
Critical care	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
End of life care	Requires improvement Sep 2018	Requires improvement Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018
Outpatients and diagnostic imaging	Good Nov 2015	Not rated	Good Nov 2015	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015
Surgery	Requires improvement Sep 2018	Good Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018
Urgent and emergency services	Not rated	Not rated	Good Jul 2020	Not rated	Not rated	Not rated
Maternity	Inadequate May 2023	Requires improvement May 2023	Requires improvement May 2023	Good May 2023	Inadequate May 2023	Inadequate May 2023
Overall	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023	Good ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023	Requires Improvement ➔➔ Dec 2023

Rating for Kent & Canterbury Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Aug 2021	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Requires improvement Aug 2021
Services for children & young people	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Critical care	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
End of life care	Requires improvement Sep 2018	Requires improvement Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018
Outpatients and diagnostic imaging	Good Nov 2015	Not rated	Good Nov 2015	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015
Surgery	Requires improvement Sep 2018	Good Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018
Urgent and emergency services	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Maternity and gynaecology	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall	Requires improvement Sep 2018	Requires improvement Sep 2018	Good Sep 2018	Requires improvement Sep 2018	Requires improvement Sep 2018	Requires improvement Aug 2021

Queen Elizabeth The Queen Mother Hospital

St Peter's Road
Margate
CT9 4AN
Tel: 01227766877
www.ekhuft.nhs.uk

Description of this hospital

Medical care (including older people's care)

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

- The service did not ensure staff at all levels completed the necessary mandatory and statutory training to enable them to carry out the duties they are employed to perform.
- The service did not always have enough staff to care for patients. Staff did not always make sure equipment, such as resuscitation trolleys, were checked accurately and safe to use.
- Staff did not always report near misses or potential harm.
- The service did not ensure systems and processes to mitigate risk including fire safety, infection prevention and control and patients' privacy and dignity; relating to the environment, premises, and equipment, were safe.
- The service did not always ensure they followed their Standard Operating Procedure when placing patients in escalation areas.
- The service did not provide enough space for allied health professionals to conduct patient assessments. The service did not ensure staff working in escalation areas had easy access to the equipment they needed, to care for patients safely and effectively.
- The service did not always ensure chemicals that are hazardous to health were stored safely and securely. The service did not always keep patient records secure.

However:

- Staff understood how to protect patients from abuse. Staff acted on risks to patients and kept good care records.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Most key services were available 7 days a week.
- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.

Our findings

- 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. People could access the service when they needed it.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Services for children and young people

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

- Staff assessed risks to children and young people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave children and young people enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated children and young people with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to children and young people, families, and carers.
- The service planned care to meet the needs of local people, took account of children and young people's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- The service had information systems for governance. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were 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.

However:

- The service did not always have enough medical staff to care for children and young people and keep them safe.
- Staff did not have training in key skills including the required training to protect children and young people from abuse.
- The service did not always have reliable information systems covering risk management processes.

Urgent and emergency services

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

- The service did not have enough emergency department (ED) or paediatric emergency medicine (PEM) consultants to safely meet the Royal College of Emergency Medicine (RCEM) or The Royal College of Paediatrics and Child Health (RCPCH) guidelines.

Our findings

- The service did not have an effective handover process of patients who had been in ED for more than 24 hours, which led to a delay in treatment and lack of continuity of care in some cases.
- Staff did not always report near misses, including those that had potential for harm.
- Staff had varied compliance with training in key skills. Safeguarding training was below trust targets for medical staff. Staff did not always receive appraisals and there was limited clinical supervision was in place for nursing staff.

However:

- The service had enough nursing staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed infection risks well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Key services were available 7 days a week.
- 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. People could access the service when they needed it and did not have to wait too long for treatment.
- 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. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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. However, not all staff had completed it.

Nursing and medical staff did not always keep up to date with their statutory and mandatory training. However, the trust had implemented action plans to improve compliance. The trust had a target of 91% for the completion of statutory and mandatory safety related training. Data from the trust showed a good compliance rate for nursing staff within the medical core service, for some training subjects. This included fire safety, health and safety, diversity awareness and moving and handling. Other subjects required improvement. For example, 72% of nursing staff had completed resuscitation level 2 adult basic life support training and 73% had completed safeguarding adults' level 2 training.

There were low completion rates for doctors working in the medical core service for several statutory and mandatory training areas. This included for example, 34% having completed adult basic life support, 55% having completed safeguarding children level 2 and infection prevention and control level 2 at 68%.

The trust told us compliance rates for statutory and mandatory training were behind due to time constraints, low staffing levels, and lack of availability for resuscitation training during the COVID-19 pandemic. The trust was working to improve its compliance scores and had added this issue to the risk register. The Compliance and Standards team were working with the medical team to identify barriers to training completion.

When asked about safety-related subjects, staff were clear about what to do. For example, staff in the Acute Medical Unit (AMU) explained the deteriorating patient policy, and staff on all wards knew how to escalate safeguarding concerns. Therefore, although nursing and medical staff were not up to date with their statutory and mandatory training, this did not imply they did not have the right skills and competencies for their roles.

Following our inspection we issued a warning notice, which included concerns around the completion of mandatory training, such as basic life support training, safeguarding adults' level 2 and safeguarding children level 2 training. The trust has supplied us with more information that showed improvement in the mandatory training figures.

The mandatory training was designed to ensure staff were safe in their work and could meet the needs of patients in a safe manner. The mandatory and statutory training provided to staff included all subjects within the Core Skills Training Framework for NHS Trusts in England. This included fire safety, infection prevention and control, moving and handling, resuscitation, safeguarding and others.

There were systems in place to monitor mandatory training. However, these were not effective. Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers told us they had assistants who helped them monitor and track staff training records. Assistants sent reminders to staff to book their

training and followed up with those who did not attend. Ward managers and matrons were required to attend Compliance and Standards Clinics to provide assurance their wards were meeting mandatory training compliance metrics. They were expected to have a clear action plan in place for staff who did not meet these requirements. One ward manager showed a list of their staff and who required training in which areas. Assistants told us they supported staff with booking onto any training that needed updating.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff were up to date with safeguarding training on how to recognise and report abuse.

Staff had access to training specific for their role on how to recognise and report abuse. Despite this, not all staff were up to date with the required safeguarding training. Nursing staff were 73% compliant with level 2 adult safeguarding training, and medical staff were 63% compliant. The trust target was 91%. Safeguarding training is a rolling programme that must be completed annually. Therefore, these compliance statistics reflected a low completion rate over the past year.

The intercollegiate guidance for adult safeguarding states all staff who have regular contact with patients, their families, carers, or the public should be trained at level 2. This is a document produced by healthcare professionals to provide guidance and standards in a particular area, such as safeguarding. The guidance for safeguarding children stated a minimum of level 2 training is required for clinical and non-clinical staff who may have contact with children and young people. However, only 69% of nursing staff and 55% of medical staff had completed level 2 training. EKHUFT had policies for safeguarding adults and children. The training strategy was aligned with the intercollegiate document. The trust had recognised lower training rates than expected. An action plan had been implemented to ensure 85% of staff to have completed Safeguarding Adults and Children by July 2023.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us they knew how to refer to other agencies, such as local authorities, to protect these individuals.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff at all levels of the organisation had a good understanding of the safeguarding process. Staff provided us with examples of referring to safeguarding leads and making a Kent Adult Safeguarding Team referral. Staff told us the reporting process for safeguarding referrals was clear and easy to follow. Referrals were made on an electronic system.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, staff told us a transgender patient was recently admitted who identified as a woman. The patient told staff they felt apprehensive about being in a bay with other patients and were therefore placed in a side room and staff allowed the patient to use staff toilets. This helped ensure this individual was treated fairly and with respect.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.

Ward areas were not always clean and did not always have suitable furnishings which were well-maintained. The hospital had processes in place to ensure wards were clean, but these systems were not always effective. We saw wards were visibly clean and domestic staff undertaking their duties. Staff told us they completed daily cleaning checklists and

the trust had Infection Prevention and Control (IPC) policies and procedures in place. However, data from environmental audits did not always show good infection control and hygiene practices. We did not see infection risk controlled well on some of the wards we visited. For example, on St Augustine's Ward, manholes were lifting off the floor in a clinical area and were held in place by black tape. This had been identified as a hazard by the IPC team. On an environmental audit conducted by the IPC team, it was noted wood from a sink cabinet in the sluice was rotting away and handwashing sinks for patients and staff were dirty, not draining or harboured limescale. We did see evidence of action plans in place for wards who performed badly for IPC, and the trust told us these wards had been highlighted to the Infection Control Committee. However, there were a number of ongoing issues in clinical areas that had not yet been resolved.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). During inspection, we observed staff on the AMU did not always wear PPE when entering patients' side rooms where there was an infection risk, and they did not always dispose of their PPE correctly. In some cases, we saw contaminated waste bins outside cubicles. However, the trust policy for "Putting on and Removing PPE (Donning and Doffing)" stated these bins should be placed inside the room. Additionally, there was not always the correct signage displayed to inform other people about infection risk. For example, on the AMU, there was no signage indicating a toilet outside a patient's room was for that patient's use only. We saw doors to patient's rooms left open who had or were suspected of having an infectious illness, with no completed risk assessment to determine whether the door should be open. However, this was not a widespread concern and we saw staff on other medical wards using PPE correctly.

On Deal Ward, all bays and side rooms had PPE available and there were clinical sinks in each bay. However, we observed staff did not always decontaminate their hands before interacting with patients. Data from the trust's hand hygiene audit conducted from February to April 2023, showed most medical wards had good hand hygiene practices. The audit identified 7 out of 9 wards had a compliance score for hand decontamination of 83% or more. However, it was also noted 67% of staff on Sandwich Bay decontaminated their hands in February, 69% of staff on St Augustine's Ward and 73% of staff on Cheerful Sparrow Male Ward decontaminated their hands correctly in March. Lack of compliance with hand hygiene increases the risk of spreading infection. The trust told us they had introduced Compliance and Standards Clinics since May 2023. In these clinics, ward managers presented data around IPC issues, such as hand hygiene, to the Head of Nursing. This allowed areas of concern to be closely monitored with a wider team oversight. Clinical nurse educators had also been enrolled to support areas with low compliance in terms of hand hygiene. The compliance and standards team held ad hoc hand hygiene days across the trust in support of this, and to improve staff compliance with hand decontamination.

Staff did not always clean equipment after patient contact or label equipment to show when it was last cleaned. During inspection, we did observe staff cleaning equipment after patient use and equipment we observed looked visibly clean. However, we did not see "I am clean" stickers used consistently. Data from an environmental audit conducted in January 2023 on Cheerful Sparrow Male Ward, identified "I am clean" stickers were not always used, and commodes in the sluice area were sometimes dirty. Therefore, staff would not know whether equipment had been cleaned and was ready for use or not.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not manage clinical waste well.

Medical care (including older people's care)

Patients could reach call bells, but staff did not always respond quickly when called. We observed call bells ringing for long periods of time before being answered. On the AMU, a call bell rang for more than 5 minutes without being answered. Staff attributed this to being overstretched. One patient said they felt there were not enough staff, as they often had to wait a long time for their call bell to be answered. However, on other medical wards, patients said they did not have to wait long, and staff could not do enough to help them.

Hazardous substances were not always stored safely and securely. On the AMU, we found chlorine tablets in the sluice area in an unlocked cupboard. Chlorine is a Control of Substances Hazardous to Health (COSHH) product, which means it is dangerous and can cause harm if it is not handled properly. We were told the tablets were no longer in use and needed to be disposed of. As a result, staff removed the COSHH products immediately after we raised the matter.

An environmental audit on St Augustine's Ward in May 2023 found evidence of poor estates maintenance that could impact on patient safety. In this audit, a board was used to cover leaking pipes behind a patient's bed and burst pipes in a bay of patients needed replacing. We saw towels used to soak up water from a leaking radiator in a patient area. Staff told us this had been reported and escalated.

The toilet facilities on Cheerful Sparrow Male Ward were located outside the patient area, behind a set of double doors. This made it difficult for some patients to use the toilet, especially those who needed assistance from staff. For example, 1 patient who used a frame to mobilise told us they found it challenging to use the toilet because they needed someone to hold the door open. However, staff were not always available immediately to assist them. Similarly, hand hygiene facilities were not easily accessible on Cheerful Sparrow Male Ward. Clinical sinks were next to the toilet outside the patient area. When we questioned this, staff told us this was on the risk register and was considered to be low risk. Staff told us there were no plans to install additional sinks in the patient area, as it was a temporary escalation ward. The Cheerful Sparrow Male Ward had been an escalation area since 2022 and had been unable to close due to continued service pressures.

Staff told us the cramped environment of some wards made it difficult to carry out daily tasks, such as assisting patients and moving beds. There were a number of concerns around fire safety identified. For example, on Deal Ward, the narrow corridor was cluttered with equipment, such as computers on wheels and moving and handling equipment. This posed a fire hazard and would make it difficult to evacuate patients in such an event. Similarly, we found a fire door on the AMU propped open with a bin and a fire door in the main hospital corridor propped open with a chair. Nursing staff raised concerns with us about fire safety, as some boarded patients' bedspaces would block fire escape routes. Boarding patients meant additional bedspaces could sometimes be in corridors in the ward and staff had to use privacy screens to help maintain patient dignity. The delay in evacuation of patients in a fire or emergency situation due to patients boarding in inappropriate areas was identified and added to the risk register in February 2020. The trust's environmental and clinical audits identified similar issues. For example, a clinical audit in February 2023 found fire escape routes on the AMU were not always accessible and corridors were sometimes cluttered. A wheelchair was blocking access to an escape route on the AMU B, and a cleaning trolley was blocking a fire escape route on the AMU C. Also, an environmental audit conducted in January 2023 on the Cheerful Sparrow Male Ward, found a coffee machine and clinical trolley in the way of a fire escape route. These concerns were immediately raised with senior leaders and the fire team within the hospital.

Staff did not always carry out daily safety checks of specialist equipment. We found some emergency trolleys were well-maintained, locked with completed checklists and most equipment was up to date with servicing requirements. However, on 1 ward we found ECG (electrocardiogram) electrodes on the emergency trolley were out of date and had

not been removed, despite daily checks. Out of date ECG electrodes may not work properly. On another ward, we found a resuscitation trolley unsecured on both days of inspection, even though the checking sheet had been signed by overnight staff. This was raised to staff on day 1 of inspection and again to the ward manager on day 2 of inspection. The contents of the trolley were at risk of being tampered with or missing when required in an emergency.

The service did not always have enough suitable equipment to help them to safely care for patients. For example, 1 patient told us they required a hoist to transfer out of bed and it took staff a long time to obtain this from another ward. Staff working in the escalation area for patients who were awaiting discharge told us resources were limited as it was unfunded. This meant patients could not always receive the care they needed in a timely way as staff had to search for equipment, which took time away from patient care.

Staff did not always dispose of clinical waste safely. On the AMU, we found PPE in domestic and recycling bins, which did not conform with safe practice and national guidelines. However, we did see safe disposal of clinical waste in other medical wards. This meant staff collecting and storing waste could be exposed to infectious materials. Furthermore, contaminated waste may not always be destroyed safely, as it was not following the correct pathway for disposal.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) is a tool used to identify deteriorating patients and included observations such as blood pressure, pulse, pain, and temperature. This information was recorded and stored electronically on a portable vital sign monitoring system, and this calculates a NEWS2 score. The higher the score, the more unwell the patient is. Its purpose is to identify acutely unwell patients, including those with sepsis. Staff told us they knew when they needed to call for a medical review for a patient. All records we reviewed where escalation was required, were clearly recorded. In the AMU, we were told new patients were assessed by a nurse and had their vital signs checked within 5 minutes of arrival. Senior nurses told us they were confident staff could use their clinical judgement as well as using the NEWS2 scores when assessing patients. Staff told us they knew when to escalate a deteriorating patient and use their clinical judgement, without solely relying on the NEWS2 scores. These findings suggested the hospital had a good system in place for identifying and managing deteriorating patients and staff were competent to do so.

However, when we analysed data related to the identification of patients at risk of sepsis or deterioration, we found some inconsistent results. For example, the AMU data from March 2023, suggested not all staff were aware of the sepsis screening tool or knew how to use it. Additionally, there was not always documented evidence of actions taking place for deteriorating patients. Despite this, other actions were taken appropriately and in a timely manner. For example, 90% of patients who had a NEWS2 score of more than 5 were seen by a doctor within 30 minutes, and 100% of patients who were identified to be septic had treatment started within 1 hour, which is within the National Institute for Clinical Excellence (NICE) guidelines.

The hospital had a protocol for the management of sepsis. This protocol included a designated pathway for suspected sepsis, which outlined the required actions and escalations for staff. The protocol was displayed on information boards on multiple medical wards throughout the hospital. The board also included contact information for staff who needed additional help, such as the hospitals outreach team. The outreach team was a group of healthcare professionals who provided support to ward nurses and doctors who were caring for acutely unwell patients.

Medical care (including older people's care)

Sepsis management training was taught as part of the General and Specialist Medicine Care Group Fundamentals of Care course. This course provided an overall presentation on the deteriorating patient. Data from the trust showed 75% of all patient-facing staff had completed this training. Additionally, the trust had initiated a deteriorating patient improvement plan, which was an education programme pilot commencing in June 2023.

Staff did not always complete risk assessments for each patient on admission, and on arrival to the ward. Staff were required to use nationally recognised tools to complete risk assessments for patients. These tools included falls, nutrition and hydration assessments, and pressure ulcer risk assessments. We reviewed 6 patient records. Of these, 5 patients had falls assessments, 6 patients had nutritional risk assessments, and 4 patients had pressure ulcer risk assessments completed within 6 hours of admission to the AMU. Ward staff told us these assessments were reviewed a second time when the patient arrived on the ward. One staff member on the AMU told us they had a number of mitigations for patients who were at risk of falling in hospital. For example, yellow blankets and yellow non-slip socks were used to signify patients at risk of falling. This helped to make other members of the team aware and more vigilant. Patients could also be placed in an observable area near the nurses' station, where they could be more easily monitored. However, data from a review of patient risk assessments identified not all wards had completed all of the required risk assessments. Specifically, some wards had not completed falls assessments, lying and standing blood pressures, use of bed rails and size of hoist slings.

Staff knew about and dealt with any specific risk issues. For example, we saw a patient who had multiple additional care needs related to their skin integrity and nutritional status. A laminated sheet was placed at the bottom of the patient's bed that contained information about the patient's individual needs, so any staff member could care for them appropriately.

The service had implemented a Standard Operating Procedure (SOP) for staff to follow with criteria for the type of patient that could use the escalation areas. An SOP is a written document that describes how a specific task or process is to be performed. Staff told us they did not feel the SOP was always followed in terms of this criteria, and sometimes patients were inappropriately placed into escalation areas. Several staff members told us patients with psychiatric needs or patients living with dementia were sometimes placed into these bedspaces. Ward staff told us the decision-makers were the site coordinators and these decisions were not always made in conjunction with the wards. We attended an operational site meeting where patient allocation was discussed. We were informed the decision to place patients in escalation areas was made based on patient safety and with criteria from the SOP.

Nursing staff told us it was sometimes difficult to provide day-to-day patient care as beds were placed close together in one-up spaces. For example, Deal Ward normally had 28 beds. However, during inspection, they had 31 beds which had been in use since November 2022. Nursing staff told us moving and handling was difficult due to the lack of space around the beds. During the inspection, we saw first-hand how difficult it was for staff to move and handle patients. We saw a patient who was residing in a one-up bedspace and required the assistance of 2 people and a frame to transfer. Both the staff and the patient told us this was challenging and impacted on the dignity of both patients who were next to each other.

The trust told us they had a risk assessment form for placing extra beds in wards. This risk assessment form required staff to complete a patient mobility assessment that highlighted the equipment needed for the patient and whether or not there was enough space for this equipment. According to this guidance, it was discouraged to place any patient who was unable to transfer themselves or required assistive equipment to transfer, into these bedspaces. We were told appropriate patients were generally moved into one up bedspaces but when bed capacity was challenged, it could not always be adhered to.

The service had 24-hour access to psychiatry liaison who provided a range of services, including assessment, treatment, and support for patients with mental health conditions. Staff were able to refer patients for onward specialist treatment as required.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff completed ligature risk assessments for patients who were at risk of self-harm or suicide and escalated the need for enhanced care if necessary. The trust had a ligature risk assessment that had clear pathways for staff to follow. These pathways involved identifying potential ligatures and assessing furnishings.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers between shifts happened on every ward. During inspection, we observed 2 board rounds, where staff shared detailed information that allowed them to safely carry out their responsibilities. Board round attendees often included groups of professionals, such as, doctors, nurses, social workers, physiotherapists, occupational therapists (OT's) and discharge planning teams. This is often referred to as a Multidisciplinary Team (MDT). The MDT worked together to assess patient's needs, develop a treatment plan, and monitor progress. The MDT board round we observed provided an opportunity to discuss each patient in detail, including their discharge plans and continuing health and social needs. We saw new patients admitted who had undergone full investigations, and risk information was shared, such as the need to escalate a patient to the mental health team who was in crisis.

Similarly, nurses conducted a detailed handover process, which involved a verbal handover as well as a handover sheet that included information such as the patient's mobility, skin integrity, nutritional status, and the patient's social history. This overview of the patient's needs helped to keep them safe, as other staff members were given all the information they needed to care for them.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix but could not always adjust this in alignment with patient's needs. Managers gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. One manager told us they were regularly the only senior nurse working on the ward on most shifts. They said it was difficult to roster staff due to the skill mix and number of junior nurses who required continuous support and supervision. As a result, agency staff were often required, especially at night. We were told this led to some patients not always receiving the enhanced care they needed.

Ward managers acknowledged the challenges of staffing on patient acuity and dependency. Managers told us their new nurses were all mentored and able to safely manage a bay of patients. They could identify a deteriorating patient. Junior nurses were sent out with specialist teams, such as the outreach team to learn and gain experience caring for acutely unwell patients. Respiratory nurses would receive training in tracheostomy care and BiPAP (Bilevel Positive Airway Pressure). Staffing was allocated based on skill mix and ward managers told us they were happy with the competencies of their staff.

Medical care (including older people's care)

National shortages of nursing and support staff, as well as high levels of staff absence, meant some medical wards often did not have enough staff to keep patients safe. To address this, the trust recently recruited over 700 internationally educated nurses. This was a positive step forward for a developing team, and ward managers ensured the nurses received the right support with their induction training. However, it meant there were a high number of new nurses who required additional support during shifts. This support included supervision.

The trust's SOP for opening escalation areas, stated the nurse-to-patient ratio should remain the same even if an extra bed is opened. However, staff we spoke to said this rarely happened and they had to be responsible for caring for extra patients. Nursing staff told us an increased workload meant patients did not always receive the necessary care they needed in a timely manner.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Ward managers were responsible for creating the rota. They had ward manager assistants to help with this task. The rota was created in line with national guidance, which specified the number and grade of staff needed for each shift. However, ward managers often relied on bank staff to cover shifts.

The ward manager could not always adjust staffing levels daily according to the needs of patients. They used a staffing tool called the Safer Nursing Care Tool (SNCT), which is an evidence-based tool used in the NHS to determine staffing levels based on patient acuity and dependency. However, staffing levels were not always increased, even when needed. Bank shifts were put out with enhanced pay to encourage safer staffing, however staff reported shortages on a regular basis. Ward managers stated the biggest challenge they faced was staffing the ward in line with patient acuity and dependency. For example, we were told a confused patient had previously tried to leave and became aggressive, and this was difficult to manage due to lack of staff. Mitigations had been put in place, such as, the use of observational bedspaces and increased intentional rounding. Intentional rounding means how often a member of staff would check on a patient.

Safer staffing meetings were held every day to discuss staffing levels and aimed to ensure wards with higher patient acuity and dependency were adequately supported. The matron oversaw these meetings and provided management support outside of regular hours. Staff were moved around to balance risk, and leaders did their best to ensure wards had the necessary care. By working closely with NHS Professionals, the matron was able to put shifts out to a pool of nurses to respond to staffing challenges. However, these shifts did not always get filled.

The number of nurses and healthcare assistants did not always match the planned numbers. Several ward managers told us staffing was a problem. They reported having to often provide direct patient care for entire shifts. While managers told us they enjoyed caring for patients, it took time away from their management duties. For example, over a 1-month period, from March to April 2023, Cheerful Sparrow Male Ward had 5615.98 planned hours for nursing staff to fill, however, the actual number of hours worked was 2336.48. Therefore, senior leaders would put shifts out to be covered by bank and agency staff, but they did not always get filled. This meant there were less staff to patient ratio than expected. Additionally, staff told us wards that had more patients than usual due to increased demand were not always given additional staff to help care for them. This meant staffing levels could not always be adjusted to meet the needs of patients. This made it difficult for managers to plan ahead or backfill gaps when resources were limited.

The service had variable turnover rates. Our review of data from the trust for medical wards showed some areas had higher turnover rates than others. For example, the staff turnover rates in Fordwich and Quex Wards were 11.34% and 21.82%, respectively, in April 2023. Three staff members in total left working in these departments within 1 year. The staff turnover rates in Deal Ward and St Augustine's Ward were slightly lower, at 7.44% and 8.34%, respectively. However, 5 staff members in total left working in these wards within 1 year.

The service had high rates of bank and agency nurses used on the wards. Data from the trust showed from 1 June 2022 to 31 May 2023, nursing bank staff worked 434,514 hours and nursing agency staff worked 225,210 hours on medical wards. Nursing bank staff were employed by the hospital, while nursing agency staff are employed by a third-party agency. Ward managers told us they were heavily reliant on temporary nursing staff because they did not always have enough permanent staff or could not always ensure there was a safe skill mix with their permanent staff. For example, over a 1-month period from March to April 2023, Cheerful Sparrow Male Ward used bank and agency staff 47.65% of the time. Over the same time period, Fordwich Ward used bank and agency staff 38.76% of the time.

Managers tried to limit their use of bank and agency staff, but they had no choice due to the increasing needs of patients. Ward managers told us they tried to request bank and agency staff who were familiar with the ward, although this was not always possible.

Managers made sure bank and agency staff had a full induction and understood the service. Managers told us they gave an orientation to bank and agency staff. We saw documented evidence of this on the AMU, titled "Local Induction Checklist for Agency & Temporary Staff". This included a checklist that had to be completed for individuals working on the AMU for the first time. It included familiarisation with fire procedures, location of the resuscitation trolley, incident reporting, and others. This had to be signed by both the agency staff member and the nurse in charge to ensure patients could remain safe while being looked after by nurses who do not normally work there. However, even though staff on other medical wards told us they carried out the same process for bank and agency workers, they did not have the same checklist to evidence this.

Medical staffing

The service did not always have enough medical staff to keep patients safe. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not always have enough medical staff to keep patients safe. For example, Fordwich Ward had no consultant cover over 2 weekends between February and June 2023. Quex Ward had no consultant cover for 10 days in March 2023. However, efforts were made to secure agency medical staff in this eventuality, with on-call consultant cover as a back-up. Consultants were able to travel to the site within 30 minutes if required. Healthcare of the Elderly Patients (HCOOP) on AMU were reviewed daily with weekend cover by locums. Acute medical patients on the AMU were reviewed 5 days per week with weekend cover provided by the on-call General Internal Medicine rota doctors.

The service had low vacancy, turnover and sickness rates for medical staff. Doctors told us they generally had enough staff. Records showed that the service had low vacancy, turnover and sickness rates for junior doctors and a recruitment campaign was in place to recruit medical consultants.

The service did not always have a consultant on call during evenings and weekends. The general medicine rota was a 1 in 12 weekend rota with a mixture of substantive consultants and internal locums. Internal locums are medical consultants doing additional shifts. The weekdays were covered by an on-call team. While most wards had an on-call consultant, there was 1 week between February and June 2022 when there was no on-call consultant cover. This meant doctors on the ward did not have an allocated clinician to escalate their concerns to.

Medical care (including older people's care)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, and easily available to all staff providing care; however, they were not always stored securely.

Patient notes were comprehensive, and all staff could access them easily. Records were available in both paper and electronic form. Of the 6 patient records we reviewed, we saw completed and detailed information on the patient's mental health, as well as their medical needs, and there were documented discussions with family members. We reviewed care plans which matched the needs of patients.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff told us the notes were clear and easy to navigate, although 1 staff member mentioned it could sometimes be difficult to find embedded text. Staff stated this could be problematic when searching for a telephone number.

Records were not always stored securely. Some staff did not comply with legislation to protect patient privacy and confidential information. While computers on wheels and notes trolleys were locked, we saw 8 folders with patient information in an unlocked area where anyone could view them.

Medicines

The service did not always follow systems and processes when safely prescribing, administering, recording, and storing medicines.

The service did not always have systems and processes in place to safely administer and record medicines use. Clinical pharmacy services and medicines storage was not always available on the escalation wards where medically fit patients resided. For example, bedside medicines cupboards were available, but staff lacked the keys and whilst a controlled drugs cupboard was available, the unit lacked a controlled drugs register. Similarly, staff on St Augustine's Ward told us it was sometimes difficult to reconstitute intravenous medicines due to the lack of space needed.

Some staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. However, staff told us they were concerned that escalation wards did not receive clinical pharmacy support. This was a concern as it may increase the risk of medicine errors going unreported. Without clinical pharmacy support, staff may not be aware of all the potential risks associated with medicines.

Staff could not always store and manage all medicines and prescribing documents in line with the provider's policy. While medicines were stored and managed safely on general medical wards, appropriate medicines storage was not consistently available on escalation wards. Where an escalation area lacked appropriate storage, for example a controlled drugs register, or medicines fridge, staff would access these medicines from another ward. Staff were also concerned about the lack of space in clinical rooms to prepare medicines and retaining access to the prescription once the e-prescribing and medicines administration system (ePMAS) had been rolled out.

On Cheerful Sparrow Male Ward, there were POD (Patients Own Drugs) lockers on the walls. We were told they were not accessible because they had no keys. Staff told us the medicine storage cupboards had recently been put in place.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff told us they knew where to find the appropriate policy for administering medicines that may impact on a person's behaviour. Staff gave us recent examples of when they had to follow this policy and administer a sedative to a patient showing signs of challenging behaviour. The trust had a Conscious Sedation Policy outlining clear pathways for staff to follow.

Medical care (including older people's care)

Incidents

The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff told us they were confident in their ability to report incidents, either directly or by seeking advice. They understood the online reporting system and said they were comfortable using it.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. The trust had a clear incident management policy that explained how to report, categorise, and investigate incidents. Staff told us they knew how to follow this policy and who to contact if they had any questions or concerns.

Staff reported serious incidents clearly and in line with trust policy. Leaders for the medical care group met weekly to discuss serious incidents and incidents of serious potential harm. They highlighted areas for immediate action and created longer-term action plans to impact staff on a larger scale, such as additional risk assessments. The trust used a "hot complaints" process for urgent issues requiring immediate action, such as a safeguarding concern.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We observed the duty of candour had been completed in all the incidents we reviewed. The service had a dashboard that tracked compliance with the duty of candour requirements.

Staff received feedback from investigation of incidents, both internal and external to the service. This feedback was shared via email, newsletters, or meeting minutes. However, some staff said they did not always have time to check their emails, read newsletters, or attend meetings. Ward managers told us serious incidents were discussed during handovers so as many staff as possible could receive feedback, given the time constraints of their shift. However, during the inspection, ward staff were unable to tell us about any recent incidents where they had received feedback. We did see evidence of change as a result of incidents that had occurred. For example, 1 ward manager told us they used food charts for all patients to ensure patient food intake could be monitored.

We saw safety data openly displayed in all wards. Staff used an electronic database to collect, analyse, and report on safety data. The data was then benchmarked across the medical division and monitored by matrons. This allowed for early identification of safety issues and the development of action plans to drive improvement.

There was evidence that changes had been made as a result of feedback. For example, we were informed about an incident where a patient was wearing mittens, which resulted in bruising on their hands. The ward held a meeting to discuss the concerns and lessons learned. As a result, the ward created a mittens checklist to prevent this from happening again. The mittens checklist was shared with other ward managers across the medical care group.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Ward managers would meet weekly to discuss any incidents that had occurred. They would then escalate their concerns to matrons and complete a root cause analysis (RCA) to try to understand why certain incidents happened. We saw evidence the duty of candour was being carried out and families were involved in investigations when we reviewed RCA's.

Medical care (including older people's care)

Managers debriefed and supported staff after any serious incident. Staff told us they received a debrief after serious incidents.

Is the service effective?

Good  

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. The trust had a policy for the implementation of NICE guidance and quality standards. When new guidance was identified on the NICE website that was relevant to EKHUFT, it was submitted to the relevant care group leads and medical director for approval. If they decided to implement it, it was forwarded to governance for appropriate assessment. For example, one ward manager told us there was new guidance on chest drain management, and this was shared at a recent team meeting. For staff who could not attend, the information was disseminated by email and a notice in the staff room.

Similarly, the trust implemented a NICE Local Audit Programme to align NICE guidance with audits in the hospital. This was done to meet goals and make improvements based on evidence-based care and treatment. For example, NICE guidance recommends patients admitted with acute inflammatory bowel disease (IBD) be assessed for venous thromboembolism (VTE) prophylaxis. This recommendation was added to the NICE Local Audit Programme, and action plans have been put in place to improve VTE prophylaxis in patients with IBD within the hospital.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. For patients suffering with mental illness, we saw input from mental health teams and/or psychiatrists in patient notes. Staff told us patients who were admitted with alcohol and substance abuse were referred to the Alcohol and Substance Misuse Team (ASMT). We were told the ASMT spent a lot of time on the wards and explained to patients all options for discharge. Patients who had accessed mental health services were supported by the ward staff. One patient said they felt the ward staff were amazing and had supported them with their depression. The patient was due to be transferred to a mental health facility and the ward staff chased this every day.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They knew when to use special feeding and hydration techniques but did not always have the competency to administer them. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were able to choose from a variety of food, and staff were able to accommodate patients with special dietary

needs. For example, halal meals were available. These are meals that are permissible to eat according to Islamic law. Nursing staff communicated with kitchen staff to ensure these meals could be ordered. A red tray system was used to identify patients who needed help to eat and drink. This system helped to ensure patients who needed assistance received it. Food and fluid charts were completed, and weights were monitored.

Staff accurately completed patients' fluid and nutrition charts, but nursing care plans were not always updated to reflect changes implemented by doctors. Food and fluid charts we reviewed were completed fully and accurately, which showed staff were taking the time to document patient intake and output. However, we noticed that care plans were not always updated to reflect changes implemented by doctors. For example, we reviewed the records of a patient who was placed on a fluid restriction. This information was documented in the medical notes but had not been updated in the nursing care plan. However, the nurse looking after the patient had been verbally informed and the patient received the necessary change in their care. When we investigated this further, we found this update had been made on the nursing handover sheet.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The Malnutrition Universal Screening Tool (MUST) was used to identify patients who were at risk of malnutrition. All records we reviewed were completed fully and with relevant details. This showed staff were taking the time to document patients' risk of malnutrition accurately.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. However, not all staff were competent to administer specialist feeding regimes. Staff on all medical wards were aware of how to make referrals to specialists. We saw entries from dieticians for patients who were fed via Percutaneous Endoscopic Gastrostomy (PEG). This is a method of providing nutrition to people who cannot eat or drink normally. These entries included advice for ward staff on how to care for these patients. However, 1 carer informed us staff did not know how to administer medication via a PEG and the ward manager had to provide extra staff training and support.

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.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a recognised tool to assess patients' pain. The tool is built into the NEWS2 system on the electronic monitoring system. Staff also used other methods of assessing pain, particularly in patients who could not communicate their needs. For example, end-of-life patients' pathways included pain assessments that looked at changes in breathing, agitation, grimacing and others. We saw pain assessments consistently recorded for a patient who was receiving end of life care and could not communicate their needs.

Patients received pain relief soon after requesting it. Patients told us staff regularly asked them if they were in pain and that they received pain relief immediately if it was needed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Medical care (including older people's care)

The service participated in relevant national clinical audits. Data from the trust evidenced the participation in national clinical audits such as heart failure outcomes, AKI (Acute Kidney Injury) audits and national dementia audits. The national dementia audit covers guidelines for diagnosing and treating delirium in people aged 18 and over and aims to improve patient experience. It also covered diagnosing dementia and makes recommendations for training staff. This meant the trust was involved in national initiatives to help to improve the quality of care given in specific areas.

An audit of the neurology progress of Parkinson's Disease recommended that motor and non-motor assessments, including Activities of Daily Living (ADL's), be documented. As a result, a proforma was created and incorporated into clinics, which ensured patients received holistic assessments that considered their day-to-day activities. Similarly, another audit recommended a bone health assessment be conducted on all patients who fall, and proformas have been sent to clinicians for use.

Managers and staff used the results to improve patients' outcomes. For example, an online course for safe insulin prescription and administration was developed and implemented after an audit found there was room for improvement in these areas. The course was now available to all staff, and it has helped to ensure patients receive safe and effective insulin therapy. Similarly, podiatry input was introduced after an audit found there were delays in the diagnosis and treatment of diabetic foot complications. Podiatry input now takes place at least once a week, and it has helped to reduce the number of diabetic foot complications.

Managers used information from the audits to improve care and treatment. For example, the trust audited delirium screening in dementia patients and developed a policy for staff to use an appropriate screening tool. This policy is now available on the trust's policy page.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. The hospital tracked the number of outliers and who was responsible for their care. The hospital operations team had oversight of where outliers were and aimed to get these patients back to their correct specialities when a bed was available. Ward staff told us outliers were reviewed daily by the doctors on the ward, and if they required further specialist review, the ward staff would contact the appropriate doctor for that speciality. The trust told us they wanted to reduce the number of times patients were moved to different wards during their hospital stay. Managers told us they wanted patients to be able to go directly to their correct speciality ward. However, this was difficult due to the high number of patients requiring specialized care, such as cardiology or stroke care. This meant some general medical wards were caring for patients who needed that care, which was outside of their speciality. For example, staff on Deal Ward told us they had a number of stroke patients, which was outside of their speciality.

Managers shared and made sure staff understood information from the audits. Managers told us this information was shared at handovers and staff meetings.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were qualified but did not always have the experience and right skills and knowledge to meet the needs of patients. We were told not all staff were trained in how to manage patients who presented with challenging behaviour, such as verbal or physical aggression. For example, there was a recent incident where a confused patient tried to leave

and became aggressive. Staff told us they did not know how to manage this. Managers and nurse educators were taking steps to equip staff with the knowledge and skills they needed by the way of preceptorship and induction training, however, there were still very high numbers of junior staff dominating medical wards. This was a concern for the trust and on the risk register.

Managers gave all new staff a full induction tailored to their role before they started work and clinical educators supported the learning and development needs of staff. For example, a clinical nurse educator told us staff would initially complete their OSCE (Objective Structured Clinical Examination) training and hospital induction programme. OCSE is a type of assessment used to evaluate the clinical skills of healthcare professionals. Alongside this, new staff were given competency sign off sheets and a practice supervisor. This included bank staff. Staff told us the induction was helpful and met their needs. This process helped to ensure all new staff were prepared for their roles and they had the skills and knowledge they needed to provide safe and effective care to patients. One nurse we spoke to who was still completing their induction told us they felt very supported from the education team.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisals were conducted twice a year. We were told ward managers monitored when appraisals were due. The appraisal process also included compliance with mandatory training and nursing registrations. However, the monthly workforce performance report for April 2023 identified a number of wards where appraisal compliance was low. For example, St Augustine's Ward were 15% compliant and Quex Ward was 54% compliant. Similarly, the compliance percentage for doctors that have had an appraisal in the last 12 months was 68%. However, 1 staff member told us they were encouraged and supported into their current role through the appraisal process. They spent time shadowing specialist teams within the hospital, such as the respiratory team, for learning purposes and development. One ward manager gave us 2 examples of when they supported 2 members of staff apply for their master's degrees to further their career. This process was initiated by their appraisals.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw examples of meeting minutes documented and for staff to read if they could not attend team meetings. However, some staff told us they did not always have the time to read them.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. New nurses were assigned a mentor and had 3 months of protected time. This meant they were not included in the staffing numbers, which allowed them to focus on learning without the pressure of time constraints. Experienced nurses said they felt supported by their ward managers and were given opportunities to develop their skills and knowledge, such as, taking on link nurse roles. A link nurse is responsible for providing support and education to other nurses in a particular area of practice, for example, tissue viability. This gave more experienced nurses development opportunities while providing junior staff with the support they needed to learn.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us this could be done by informal discussions, or during their appraisal.

Managers made sure staff received any specialist training for their role. For example, in the Palliative Pilot scheme on Sandwich Bay, where there were 5 beds dedicated to patients receiving End of Life care. We were told all staff who worked there received additional training in palliative care which involved an end-of-life study day. Managers also ensured staff were competent in using syringe drivers which was imperative to their role.

Managers identified poor staff performance promptly and supported staff to improve. Action plans were in place for poor performance, including the possibility of transferring staff to less acute areas. This appraisal process ensured staff were given regular feedback on their performance and they had the opportunity to develop their skills and knowledge. It also helped to identify any areas where staff needed additional support.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However, there was limited Allied Health Professional (AHP) coverage in areas where medically fit patients resided.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. On Deal Ward, a multidisciplinary (MDT) meeting was held that included the Matron, Ward Manager, Discharge Coordinator, Occupational Therapist (OT) (representing AHP's), and junior doctors. Consultants had already reviewed patients on a separate ward round. Each patient's medical and social history was discussed, current interventions needed were identified, an estimated date of discharge (EDD) plan was made, and discharge pathway needs were discussed. On Quex Ward, which is a Gastroenterology ward, an MDT board round was held every morning which also included the Nutrition team and the Palliative care team. Staff told us they had a voluntary chaplain who visited the wards once a week and aimed to speak to all patients. These meetings helped to ensure good outcomes for patients and a detailed assessment of patient's individual needs which involved speciality teams.

Patients had their care pathway reviewed by relevant consultants. We saw good working between consultants. For example, some patients on medical wards required a speciality review such as a cardiology or a stroke review. These reviews were documented in the patient's notes, which ensured patients were on the correct pathways for their care.

However, we were told there were no regular physio's or OT's to cover Cheerful Sparrow Male Ward. This meant AHP's had to come from other wards to provide ongoing care needs to patients, such as daily physiotherapy. Staff told us this put additional pressure on the AHP workforce, as they had to constantly prioritise their workload and were sometimes pressured to focus on reviewing patients who could be discharged quickly, rather than patients who required daily input to support their recovery. As a result, there was a risk patients could become deconditioned if there were not always staff available to provide their care needs.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Consultants did not always lead daily ward rounds on all wards, including weekends. There were significant gaps in rotas covering weekends and bank holidays on several medical wards. For example, the gastroenterology rota had no consultant cover on Sundays from 1 March to 30 June 2023. There was an on-call consultant available to escalate concerns to, however this meant patients were not always reviewed in-person by a consultant every day. We also identified 10 gaps in consultant cover on Quex Ward in March 2023, as well as on-call gaps, meaning junior doctors did not have a nominated person to escalate their concerns to and not all patients were reviewed by a consultant every day.

Staff could not always call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Managers we spoke with told us they received support from clinical in-reach services, for example, physiotherapy, palliative care, acute oncology, the nutritional team and speech and

language therapy. However, some services, such as AHP's were not available 7 days a week and had limited availability on Saturdays. For example, AHP's worked on a Saturday and could only review patients who were acutely unwell or ready for discharge. There was no AHP service on a Sunday. This also meant that stroke patients who were awaiting a Speech and Language Therapy review, could not be seen until Monday, if they were admitted at the weekend.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. We observed information boards on smoking cessation and living a more active lifestyle on medical wards.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. This included completing a comprehensive assessment, making referrals to other specialist nursing teams, such as the diabetic team, and providing information and resources about healthy living.

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. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us they would have a discussion with a doctor if they had concerns about a patient's capacity, to have this formally assessed and documented.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff conducting observations and asking patients for their consent prior to do doing so. We discussed consent with nursing staff and their understanding of the different kinds of consent, such as informed or passive consent. One staff member gave an example of asking consent from a stroke patient to insert a feeding tube to assist them with their nutritional intake. They told us they explained the reasons why it was needed, the patient then verbally consented, and the relevant paperwork was completed to evidence this discussion.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We saw documented evidence of advanced care planning for a palliative patient who was unable to consent. These advanced care plans included the patient's wishes, such as having their family present. Staff also told us they would consider culture and traditions by having open conversations with relatives when patients were unable to consent.

Medical staff did not always keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Staff attendance at training covering mental health conditions, learning disability, autism and dementia was low at a compliance rate of 60%. This included the Mental Capacity Act and DoLS. However, when we reviewed patients who were being treated under the MCA and DoLS, all relevant paperwork was completed and up to date.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff told us they escalated their concerns around consent and decision-making to the medical team, nurse in charge, or the duty matron.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Ward managers told us they knew which patients on their ward were being treated under DoLS and they would be extra vigilant in caring for these patients due to the level of risk and vulnerability.

The trust's safeguarding team received a weekly report from the Local Authority DoLS office with a running total number of patients for who they had received a DoLS application for. This report was cross referenced against the Safeguarding team's inpatient database and for those who are no longer an inpatient, or the DoLS is no longer required. All patients who required DoLS were expected to have a DoLS Checklist completed which was saved on their electronic patient records. Completion of these checklists were audited. The trust had a plan to have an electronic DoLS Tracker Board to further evidence patients who have a DoLS in place, and what the status of that DoLS is.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us they could access policies via the hospital's intranet page and could contact the safeguarding team to get accurate advice.

The trust has worked collaboratively with the Integrated Care Board (ICB) and NHS England from August 2022 to July 2023, creating an MCA/DoLS Task and Finish Group to oversee the implementation of actions identified following a trust-wide audit. This has included the creation of a dedicated MCA Policy, a review of MCA documentation, the provision of training and Independent Mental Capacity Advocate's being available on the wards. The MCA Steering Group has recently been established (supported by the ICB) to provide continued oversight of MCA and DoLS.

Is the service caring?

Good 

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

Compassionate care

Staff treated patients with compassion and kindness.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. The staff were responsive to patient needs. Inpatient experience data for April 2023 showed patients felt they were treated with dignity and respect, received assistance in a timely manner, received enough help from staff to wash, and received help from staff to eat their meals. This was evident in practice, where a staff member got a blanket for a patient who asked for one, and they helped a patient to shower who needed assistance.

The staff were respectful and considerate of patients and their loved ones. They spoke to patients in a kind and gentle manner, and they took the time to answer any questions patients had. This helped to create a positive and supportive environment for patients.

Patients said staff treated them well and with kindness. One patient told us they felt looked after, the staff were lovely, and the environment was calm. On Sandwich Bay, a relative whose mother was receiving end of life (EOL) care was very impressed with the staff's kindness and compassion. Acute Oncology patients told us they received outstanding care, and nothing was too much trouble.

Staff followed policy to keep patient care and treatment confidential. For example, conversations were kept quiet and, where necessary, took place in private. Patients who were to receive end-of-life care were nursed in side-rooms to help maintain their privacy and dignity. This also allowed family members open access to visit their loved ones at any time.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff told us they were aware of which patients they were looking after who had mental health needs. They were able to provide the appropriate care and support to these patients. We saw empathy and kindness demonstrated when patients were in distress. For example, we saw a nurse walking around the ward with a confused patient and talking to them in a kind and compassionate way. We also saw 1 patient asked for another pillow and the nurse got it immediately and assisted the patient into a more comfortable position.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients and their loved ones told us they felt cared for and supported emotionally by staff. They said the staff were always willing to listen and to offer help and advice. Inpatient experience data reflected this, with most medical wards receiving 100% compliance in terms of patients feeling able to talk to hospital staff about their worries and fears.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. St Augustine's Ward had a day room with old-fashioned décor. The dayroom was designed to be a calming and relaxing environment. The décor was nostalgic. Staff told us they would sit and talk to patients who became distressed or go for a walk around the ward. Staff also had privacy screens for times when patients became distressed in open environments to uphold their privacy and dignity. We saw privacy screens used on arrival to St Augustine's Ward for the purpose of maintaining privacy and dignity to a number of confused patients.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. All staff we spoke with understood and were sensitive to the emotional and social impact a person's condition can have on their wellbeing.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We saw evidence of this in handover sheets and care plans. We observed kind and friendly interactions between staff and patients, including those with mental health conditions. We were told a long-term patient who had received input from the mental health team sadly passed away on the ward. The patient's family bought a present for every member of staff to thank them for their care.

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. Staff took time to explain care and treatment before they consented to treatment. One patient told us doctors kept them up to date with their plans and care, and they felt included in decision making.

Medical care (including older people's care)

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The service offered information leaflets in different languages, and staff had access to telephone translation and interpreting services. Staff told us they used picture flashcards to support communication when required. A flashcard is a non-verbal communication tool with images such as a plate of food to represent hunger. We saw staff showing understanding, and they took the time to make sure patients understood what was being said.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and their relatives were encouraged to give feedback via the Friends and Family Test (FFT). The FFT is a national survey that asks patients and their families about their experience of care in the NHS. Staff were available to support patients and their families in providing feedback, either verbally, electronically or in writing. Most patients gave positive feedback and felt the staff were very organised and caring.

Staff supported patients to make advanced and informed decisions about their care. This included providing information about different treatment options and the potential risks and benefits of each option. Inpatient experience data showed that most patients on medical wards felt involved in making decisions about their care.

Is the service responsive?

Requires Improvement

Our rating of responsive went down. 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 worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The trust had a plan to manage operational pressures. This plan included a protocol for when the hospital was at full capacity, and triggers for managers to use to assess whether or not mitigating actions needed to be put into place. For example, when the hospital was on OPEL 4, 2 of the triggers would be no bed capacity within the hospital and severe ambulance handover delays. This protocol helped to ensure senior staff could follow guidelines in response to service pressures to try and achieve better outcomes for patients.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. According to data from the trust, QEQM had 10 mixed sex breaches from October 2021 to April 2023. A mixed sex breach is when a patient of one sex is placed in a ward or room with a patient of the opposite sex. The trust monitored this via a mixed sex breach dashboard. We were told this was due to the hospital running at full capacity. Privacy screens were used to mitigate this breach.

Facilities and premises were not always appropriate for the services being delivered. The discharge lounge sometimes had patients residing overnight. However, there were no shower facilities available. The hospital's criteria for transferring patients to the discharge lounge required they be either discharged the next day or within 48 hours. Staff told us these discharges were sometimes delayed due to transport or community care issues. This meant during their stay in the discharge lounge, they would not have access to shower facilities. This could have a negative impact on patient experience and comfort. Some adjustments had been made, such as the installation of call bells and curtains.

Similarly, OT's told us it was difficult to conduct kitchen assessments in patient areas. They had to take patients to the therapy gym. However, the therapy gym was often full of equipment and beds, which made it difficult for OT's to conduct assessments.

Staff could access Liaison Psychiatry support 24 hours a day 7 days a week for patients with mental health needs. The hospital has a learning disabilities specialist within the safeguarding team and a team of dementia nurse specialists who can provide additional input and support to patients with dementia (in hours).

Managers monitored and took action to minimise missed appointments and ensured patients who did not attend their appointments were contacted. Ward clerks supported the team by contacting patients who missed their appointments, and leaders asked patients why they missed their appointments to see if they could improve their services to better support patients. For example, patients provided feedback that transportation assistance was an issue, so the trust provided transportation assistance for outpatients to attend their appointments.

The service relieved pressure on other departments when they could treat patients in a day. For example, SDEC (Same Day Emergency Care) and Ambulatory care which provided a same day service to patients.

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 had suitable facilities to meet the needs of patients' families. Wards were open to visitors, and most medical wards had specific visiting hours in the afternoon due nursing tasks and doctors' rounds taking place in the morning. Ward staff also told us they allowed flexible/compassionate visiting for some patients. For example, patients who were receiving end of life care or for patients who had additional care needs, such as learning disabilities or dementia.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff told us they made referrals to specialist services, such as the mental health team, learning disability team or the dementia team for patients who needed it. The trust told us they conducted detailed assessments for patients with complex needs and long-term conditions. On inspection, we spoke to the mental health team who came to review a patient, and to ensure the patient received all the necessary care to meet their needs. We saw a detailed review and clear instructions for ward staff to follow in order to care for this patient.

Enhanced care is a type of care that provides one-on-one attention to patients who have complex needs. This included patients who were confused and might be a danger to themselves or others, or patients who had expressed thoughts of self-harm or suicide. One staff member said they often cared for patients who required enhanced observation with input from the hospital psychiatry and dementia teams. However, several staff members we spoke to said patients who required enhanced care, did not always receive it and this was due to a lack of staff. We have also reviewed a number of incident reports where patients who were supposed to receive enhanced care did not receive it.

Some wards were designed to meet the needs of patients living with dementia. Some wards had features specifically designed for dementia patients, such as a day room, including a comfortable sofa, flowery wallpaper, a piano, television and kitchenette. We also saw a dementia trolley containing dementia-friendly items, such as puzzles, games and sensory items.

Medical care (including older people's care)

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. These documents provide information about a patient's individual needs and preferences. Staff told us they would refer to these documents to identify the patient's individual needs and they knew where to find it.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us the policy could be found on the intranet, and the service had access to information in large print, easy read, and braille format. This allowed staff to provide information and communicate with patients in a way that was accessible and understandable.

The service had information leaflets available in languages spoken by the patients and local community. These leaflets were available on request.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. They made sure staff had access to an interpretation service for patients. Managers told us many staff members spoke multiple languages, which was helpful for interpretation purposes. For example, a Russian doctor was able to interpret for a Russian patient.

Patients were given a choice of food and drink to meet their cultural and religious preferences. There were alternative food options available, including vegetarian and halal dishes.

Access and flow

People could access the service when they needed it but could not always 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.

Managers monitored waiting times, but patients could not always access services when needed or received treatment within agreed timeframes and national targets. During a board round in the ED, we looked at patients who had been accepted under the medical team and were awaiting transfer to a medical bed. These patients were identified for escalation to senior leaders and flow teams to find a medical bed as soon as possible to ensure they could receive their ongoing treatment plans within agreed timeframes. Due to the shortage of medical beds, these patients would sometimes remain in the ED for as long as 3 days. Concerns had been raised about which medical team would take responsibility for these patients, as they no longer fell under the ED bracket. Staff told us there were "hot" and "cold" medical teams who would care for these patients. Some were based in the ED and some in the AMU. However, we found patients in the ED who had been admitted under the medical care team and had not been reviewed regularly by medical doctors, and pressure was put on the ED doctors to provide day-to-day care.

Due to capacity and bed availability pressures, some patients were cared for in escalation areas. As defined in EKHUFT's Standard Operating Procedure (SOP) for opening escalation areas, "escalation is a set of procedures set in place to deal with potential problems with a surge in demand for services". These are spaces within the hospital that were not originally intended to be used as bedspaces and are sometimes referred to as "one-up" spaces. This meant patients were placed in areas within the ward that have been converted into a bedspace, with the use of curtains and call bells. However, staff told us it was sometimes difficult to protect patients' privacy and dignity when they were boarded or in a plus-one bedspace. Staff informed us patients who were boarded, were sometimes examined by doctors in corridors and had to eat their meals in the corridor where staff and relatives were walking by. Similarly, a patient in a plus-one bedspace told us they felt embarrassed to use the commode as their bed was very close to their neighbouring patient.

Medical care (including older people's care)

Managers and staff worked to make sure patients did not stay longer than they needed to. However, social care bed shortages sometimes meant patients had to stay in hospital longer than they needed to. The nurse in charge was responsible for overseeing patients who were medically fit for discharge. Patients who did not have any ongoing community care needs could be discharged quickly. However, patients who were awaiting a package of care, nursing home placement, or a bed in a rehabilitation unit, could take longer to discharge. These patients were highlighted daily at MDT board rounds. Some medical wards had allocated physiotherapists, OT's, and discharge planning teams who could help facilitate the discharge process. This often took a long time, and one patient told us they had been in hospital for over 117 days awaiting a nursing home placement. As a result, the hospital had opened a bedded area for medically fit patients. This meant patients had to stay in hospital due to insufficient resources in the community.

Staff told us they pro-actively escalated discharge dependant tests for patients who could be discharged quickly. Daily improvement huddles were held by site coordinators and speciality leads to examine hospital flow and identify and address any bottlenecks in the discharge process.

The service did not always move patients when there was a clear medical reason or in their best interest. Managers monitored patient moves between wards/services were kept to a minimum. Staff used a symbol on the Patient Transfer List board for patients who had reached a high number of bed moves. This symbol was used to remind staff not to move these patients unless necessary. However, 3 patients we spoke to told us they had been moved several times before reaching the ward they needed to be on.

Patients reported being moved to different beds multiple times before being assigned to the correct ward. Some patients were woken up in the middle of the night to be moved to a different ward outside of their speciality. Data from the trust reflecting April 2023, indicated there were 672 out of hours (22:00 – 06:00) bed moves. One patient told us they had been in hospital for over 100 days and could not understand why it was taking so long to be discharged.

Allied health professionals told us it was sometimes difficult to keep track of a patient's location due to the number of times they were moved to different wards during their hospital stay, especially on weekends.

Staff moved patients between wards at night. Staff told us patients were sometimes inappropriately moved overnight. Managers told us they tried not to move patients who had dementia or a mental health condition. Data from the trust showed high numbers of patient moves between 22:00 and 06:00 from May 2022 to April 2023. However, these numbers have improved over time.

Managers and staff started planning each patient's discharge as early as possible. Staff told us they begin discharge planning on patient arrival to the ward. For example, some wards had an allocated discharge planning team. This helped to facilitate a holistic assessment of patients' needs on admission and to ensure patients can be discharged as soon as they are medically stable and able to go home.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number but did not always take action to prevent them. The hospital was taking steps to address the issue of delayed discharges by holding weekly length of stay meetings. These meetings focused on patients who had been in hospital for more than 7 days and involved the discharge planning team. However, we spoke to 1 patient who had been in hospital for 3 months because they needed a full package of care at home before they could be discharged. Their wife slept next to them in the hospital for the entirety because she wanted to be with him until they were able to go home. Similar issues were identified on Quex Ward where the main delays to discharge were patients awaiting a package of care.

Managers monitored patient transfers but did not always follow national standards. This led to some patients being inappropriately transferred to unsuitable ward areas or in unsuitable spaces within the ward area. For example, on inspection, an unwell patient was transferred to Cheerful Sparrow Male Ward. This patient had to be transferred back to an acute area to receive appropriate care. It was unclear who made this decision despite there being an admission criterion to Cheerful Sparrow Male Ward.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Patients were sometimes cared for on a ward that did not specialise in their condition. For example, one ward that did not specialise in cardiology had a number of cardiology patients. Staff told us these patients would be looked after by the medical team on the ward they are on, and if they require a specialist review, the specialist team would be informed. Therefore, managers had made sure medical staff were reviewing all patients on their ward, regardless of the ward's speciality.

Managers worked to minimise the number of medical patients on non-medical wards. Ward managers told us they tried to keep medical patients within their speciality. If patients had to be moved to a non-medical ward, flow teams would be informed and try and place them back to the correct ward. However, this did mean patients sometimes had multiple bed moves during their stay before getting to the correct speciality for their needs.

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 service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. This information included contact details for the Patient Advice and Liaison Service (PALS). One patient we spoke to told us they knew how to complain but had not needed to.

Patients did not always give positive feedback about the service. One patient said they did not have a positive experience due to the number of confused patients on the ward. They said they could not sleep and found a patient wandering around their bed at night. This was supported by the inpatient experience survey, where one of the lowest scoring factors on medical wards was patients feeling like they were prevented from sleeping at night. Other areas for improvement where patients did not always get answers from doctors they could understand, and they were not given enough notice when they were leaving hospital.

Staff understood the policy on complaints and knew how to handle them. Staff told us they knew how to find the complaints policy, which is available on the hospital's intranet page. In the first instance, the ward manager tried to resolve the issue straight away with a conversation. If the issue could not be resolved at this level, it was then escalated to the matron or to PALS.

Managers investigated complaints and identified themes. They looked at the patterns of complaints to see if there were any common issues. This helped to identify areas where improvements could be made. The hospital has a clinical governance team who monitor risk and investigate incidents. PALS investigated complaints and provided a service to support patients, relatives, and carers who had concerns about the hospital. Senior nurses have meetings on Thursdays to discuss complaints from incidents and via PALS to identify themes, areas for improvement and communicate these across the trust, if necessary.

Medical care (including older people's care)

Managers did not always share feedback from complaints with staff, but learning was used to improve the service. Staff told us they did not always receive feedback from complaints they had been involved in.

Staff could give examples of how they used patient feedback to improve daily practice. Staff told us they now held safety huddles in the mornings with matron attendance to escalate any concerns. Drug charts were checked by an oncoming nurse and nurse finishing their shift to ensure continuity of care and vital medicines are not missed.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were not always visible in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership team consisted of a Head of Nursing, an Operations Director and a Clinical Director for medical services across the trust. They held a huddle every morning, either in person or online to discuss any issues covering the 3 main sites. As leaders were based at different sites, they were not always visible to staff. Leaders told us they attended bed meetings when they could, to link in with staff. Individual services had a lead or named point of contact for staff to escalate their concerns to. Leaders told us they aimed to gain soft intelligence by observing wards by walking around and talking to staff and patients.

On inspection, we were told there had been a lot of turnover within the executive team, with multiple interim members and a number of vacant posts. This had a direct impact on clinical care group leaders, with a disjointed approach to improvement plans and lack of oversight of some ongoing issues within the trust. This can be evidenced by some of the issues identified on the risk register for medical core services at the QEQM. For example, there was no action plan in place for the concern of evacuating patients in the event of a fire or emergency situation, due to patients being boarded in inappropriate areas. Similarly, there was no action plan or accountable person to investigate the inadequate skill mix due to a junior workforce.

Vision and Strategy

The service had a vision for what it wanted to achieve but did not have a formal strategy to turn it into action. The vision was focused on sustainability of services and aligned to local plans within the wider health economy.

The trust had a vision that involved working with staff, patients and relevant stakeholders. The leadership team were working with specialities to develop new ways of working. For example, leaders informed us they were having workshops with key stakeholders to develop a plan for improving the use of endoscopy rooms and that they had drafted an improvement plan with the Operating Planning and Support team.

Leaders told us they were working with the diabetes community team to help decrease unnecessary hospital admissions which could be managed in the community. This involved joined-up working between in-hospital and community teams. Similarly, patient feedback was being used to inform decisions around change, vision, and strategy. For example, patient surveys were being used to identify areas where improvements could be made.

Leaders told us they envisioned wards taking ownership of audits and associated action plans to help improve patient care and safety. Ward managers told us regular safety audits were conducted and reviewed, such as falls, hospital-acquired pressure ulcers, and ward cleanliness. Managers told us new strategies or learnings were shared with other wards.

Leaders also told us they had investigated training programs for ward managers and senior nurses to develop their management skills.

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 patients, their families and staff could raise concerns without fear. However, improvements needed to be made on reporting near misses and potential harms.

The culture at the hospital was centred on the needs and experience of patients and staff. Individual service leads created a culture of improvement, and staff told us they felt their voice was counted. They were happy to challenge decisions they were not comfortable with, and they were supported by their managers. This was evident in the example of 1 member of staff who refused to move a nurse to another area, as the patient acuity was too high.

Leaders described their relationship with the executive team as positive and supportive. They held a monthly meeting with the executive team. However, as they were a new team, they were still getting to understand the organisation. Therefore, leaders would make recommendations and take clinical ownership to best make decisions.

Staff also told us they felt comfortable being themselves at work, and managers tried to get to know their home lives and culture. They regularly organised events such as food festival days and listening events, which were supported by managers. They provided information and support to staff, to help integrate them into the team.

There was a positive culture of teamwork at the hospital. Staff told us they would share tasks, such as bathing or feeding patients, and were quick to help colleagues who were struggling. This meant the team were working towards a common goal.

We observed friendly interactions between staff and patients, and staff with each other. Staff told us they were supportive of each other's successes and achievements. On 1 ward, we saw an employee of the month award for May 2023. We also saw friendly MDT interactions and positive challenge at board rounds.

The hospital had a clear system for reporting incidents and complaints. Staff were encouraged to report any concerns they had, and these were investigated. Incidents were sometimes fed back to staff and meeting minutes were recorded and lessons were learned.

However, the triumvirate for medical care at the QEQM told us they needed to improve on reporting near misses and establish a culture of reporting potential harms. They told us they held governance meetings to focus on near miss incidents and aim to ensure staff learn from them as well as incidents with harm.

The hospital also had several initiatives in place to support staff well-being. These included a Freedom to Speak Up Guardian, connector roles and a pastoral team. Connectors were members of staff who promoted health and well-being and could signpost people in the right direction for support. Pastoral teams were available to support international nurses who may be unfamiliar with some processes in this country, such as setting up a bank account.

Leaders told us they tried to have their lunch with staff at all levels, as they believed this helped build better relationships; “If you sit down and eat with staff, your working relationship is better”.

Overall, the hospital had a positive culture where staff felt valued and respected. They were focused on providing the best possible care for patients, and they were supported by their colleagues and managers.

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.

Managers held monthly meetings covering key aspects of performance and safety monitoring. Good staff attendance was recorded, and meeting minutes were documented with associated action plans put in place when required. At ward level, managers had weekly ward managers meetings to discuss any safety incidents or learning that needed to be shared across the trust. We saw one of these meetings take place while on inspection. Overall, the leaders of the hospital had a good, developing governance structure in place. This helped to ensure staff at all levels were clear about their roles and accountabilities, and that there were regular opportunities for learning and improvement.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and/or identify 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.

Leaders told us escalation areas for medically fit patients were an area of concern. They said they were unfunded, so they had to use substantive staff from other wards. This was on the risk register. We were told they had no choice due to the volume of patients coming into the hospital. Leaders told us the increased pressures had an impact on their longer-term work. For example, the hospital spent all winter on OPEL 4. OPEL 4 stands for Operational Pressure Level 4 and is declared when there are significant pressures on the system, such as the volume of patients and staff shortages. As a result, the hospital was required to cancel non-urgent patient appointments, divert patients to other hospitals, increase the number of staff on duty and use temporary beds.

Leaders used dashboards to monitor performance and risk. They were easily accessed and provided a good overview of the key issues and challenges within the hospital. For example, the endoscopy backlog was easily tracked. Ward managers ensured they had enough staff by checking their rosters for 2 days in advance. Matrons monitored SNCT daily and had discussions with staff regarding patient safety and safer staffing levels. They also had daily safety huddles for all staff to escalate any concerns. Safety crosses were displayed on medical wards. Safety crosses are a visual tool used in hospitals to monitor patient safety. Each day, staff members recorded any safety incidents that had occurred. We saw safety crosses were up to date on most wards.

The trust used their Datix system for audit purposes. For example, every pressure ulcer was reported through Datix, whether it was hospital acquired or not. This meant they could have clear oversight of risks for patients with additional care needs in terms of skin integrity.

Medical care (including older people's care)

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.

Staff could access the data they needed in order to understand performance. For example, they used dashboards to track key metrics, such as patient satisfaction and staff turnover. They used the data to identify trends and patterns, which could be used to make decisions about service delivery and resource allocation. However, we were told the data systems used did not always match the actual data. For example, when the trust reviewed reattendance rates at the ED using their dashboards, this did not align with the actual rates when manually reviewing them. This could impact on the accuracy and reliability of the systems used.

Data security was a priority for the service. Staff were trained on the importance of data security and were aware of the risks associated with data breaches. The hospital had an internal electronic system which stored patient information and these systems were password protected.

The business IT team had a good relationship with the clinical teams. If there was a need for a new system or report, the IT team would work with the clinical teams to create it. Leaders told us the IT team were also good at analysing data to give accurate feedback.

Engagement

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

The hospital regularly collected feedback from staff, patients, and relatives. They used this feedback to improve the quality of care and the working environment.

The hospital conducted annual staff surveys to get feedback on a variety of topics, including patient care, working conditions, and training opportunities. Staff were also encouraged to provide informal feedback to their managers.

Team meetings were held regularly, and we saw evidence of ward meeting minutes on inspection. Electronic communication, such as emails, were used to keep staff informed about new policies, procedures, incidents, and events.

The hospital encouraged patients and relatives to complete friends and family surveys. These surveys asked about their experience of care, if they would recommend the service to others and what the trust can do to improve patient experience.

Information was also passed down from committees for improvement projects to keep staff informed about the work being done to improve services.

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.

Medical care (including older people's care)

Leaders and staff were committed to continuous learning, improvement, and innovation. For example, the Richard Stevens project was developed to reduce the number of unnecessary referrals to physiotherapists. Nurses were given a document produced by physiotherapists so they could appropriately assess a patient's mobility on admission. This helped to reduce the number of patients who were referred to physiotherapists when they did not need to be. This project was developed at the William Harvey Hospital and had been shared across the trust and rolled out to the Queen Elizabeth the Queen Mother Hospital.

Discharge planning began on admission. This helped to ensure patients were put on the correct pathways and could be discharged when their medical needs had been met. It also helped to reduce the length of time patients spent in hospital.

Leaders told us staff survey results had improved. Results showed that staff were feeling more supported.

Leaders told us speciality medical wards and flow teams proactively allocated patients from the ED to the correct ward based on their needs. This meant patients were not just assigned to any available bed, but rather to a bed on the ward that was best suited to their care needs. For example, a patient in the ED requiring gastroenterology care would be allocated to a bed on the gastroenterology ward, assuming there was a bed available and that there was a patient on that ward who was due to be discharged. This proactive approach to patient allocation could help to improve patient flow, reduce the number of times patients are moved within the hospital, and improve patient experience.

Services for children and young people

Good ↑

Is the service safe?

Good →←

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

Mandatory training

The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.

Nursing staff had access to mandatory safety related training, although it had been difficult for expected targets to be met. The completion rate for some courses was low, for example, resuscitation training had a 67% completion rate. This was below the target completion rate of 91%.

The overall completion rate for mandatory training across all modules was 80% which was below the trust target of 91% We asked managers about these figures, and they told us that there were challenges with releasing staff to complete face to face training which affected specific modules including resuscitation. Managers also told us that a high number of new international nurses and long-term staff leave were contributing factors.

Managers provided more training figures associated with nursing paediatric training needs. This included sepsis recognition which was 94% for the QEQM site and all other courses met the compliance targets for the trust, except two modules which managers told us were not individually allocated on staff training profiles.

Medical staff received but did not always complete their mandatory training. Medical staff were expected to complete a range of safety related subjects as mandated. The completion rate for some of these subjects was low. For example, resuscitation training had a 32% completion rate, which was below the target completion rate of 91%.

The overall completion rate for mandatory training across all modules was 75%, which was below the trust target. Medical staffing training compliance was low in fire safety, health and safety, information governance, diversity awareness, Infection control, PREVENT Level 3, and hand hygiene training modules and did not meet the trust target of 91%.

We asked managers about these figures, and they told us there were similar challenges with releasing staff to complete face to face training. Managers told us that safe staffing levels were always prioritised, and this also contributed to low completion rates.

The mandatory training was comprehensive and met the needs of children, young people and staff. Staff and managers told us they felt the training was suitable for the safety of patients. Managers also provided extra courses, which staff were expected to complete when working in paediatric environments.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. Managers told us that new courses for learning disability and autism had been added to

the mandatory training course curriculum. Managers also told us staff had to complete modules for mental health and the safe handling of patients. The courses did not include restraint training for mental health. Senior managers told us their policy was to reduce the use of restraint and that it was a deliberate choice for staff to not be trained in restraint and promote other forms of de-escalation when patients became aggressive or at risk to themselves.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had spreadsheets which helped them track completion rates for mandatory training. However, the spreadsheets did lack detail such as completion and renewal dates. Managers told us the central governance team handled sending out reminders to staff when they were due to renew their mandatory training and they held performance figures for the service. Managers acknowledged to us that it was difficult at times to show correct figures due to this. However, they could access a system which provided them with performance figures for their team.

Managers provided forecasts for Intermediate Life Support (ILS) and Paediatric Intermediate Life Support (PILS) training to be completed by December 2023 and had committed to running weekly sessions to achieve this.

Resuscitation rates were also below trust targets particularly in medical staffing. Managers told us there was a challenge for the resuscitation team due to the level of demand for all in house resuscitation training courses. Managers told us that tracking the course completion rate could be difficult as some staff attended the course externally and did not always notify the trust. Managers told us the resuscitation training courses for paediatrics were formal accredited courses and therefore the trust did not always have the ability to organise additional dates for this.

Following our inspection we issued a warning notice, which included concerns around the completion of mandatory training, such as European Paediatric Advanced Life support (EPALS) or Advanced Paediatric Life Support (APLS). The trust has supplied us with more information that showed improvement in the mandatory training figures.

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. Some staff had training on how to recognise and report abuse, but completion rates were low for medical staff. Staff knew how to apply the learning from this training in practice.

Nursing staff received training specific for their role on how to recognise and report abuse. Staff received safeguarding training at Level 3 for children and Level 2 for adults. The completion rate for safeguarding training for children at level 3 at the trust was 96% for nursing staff at the hospital. The completion rate for safeguarding training in adults at level 2 was 89% overall for nursing staff at the hospital.

Medical staff received training specific for their role on how to recognise and report abuse. Staff received safeguarding training at Level 3 for children and Level 2 for adults. The completion rate for safeguarding training for children at level 3 at the hospital was 55% for medical staff. The completion rate for safeguarding training in adults at level 2 was 49% overall for medical staff at the hospital. The trust could not be reasonably assured that medical staff had adequate knowledge in up to date safeguarding processes.

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 and managers told us safeguarding was managed by a central team who travelled to each site at the trust once a week. Each site had a nominated lead for safeguarding cases found and they met with the safeguarding team to discuss or report any new or existing concerns. Managers told us 16 safeguarding incidents in the past 12 months had been reported.

Services for children and young people

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give examples of concerning behaviour which they would report to the safeguarding lead of the department. Staff were aware of the reporting process and policy. Staff told us the central safeguarding team asked them to contribute when needed.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us who the safeguarding lead was for the location and what they would do if they had concerns. The process was aligned to the safeguarding policy of the trust.

Staff followed safe procedures for children visiting the ward. The ward had clear guidelines and restrictions for visiting parents. Siblings were allowed to attend the ward if they were accompanied by their parent or guardian.

Managers introduced a child protection information sharing system (CPIS) Assurance audit check for paediatric wards at the trust. This started in April 2022. A safeguarding children's advisor and a member of the nursing staff reviewed the nursing notes for all inpatients on children wards run by the trust. Each set of electronic records were reviewed to show if CPIS had been checked on admission. These audits which were conducted quarterly showed improvement in the checks being performed between 2021 and 2022.

Managers introduced a Red, Amber, Green (RAG) Tool Audit for paediatric wards associated with safeguarding. This was launched in January 2023 and redone in April 2023. The audit introduced a safeguarding screening tool which had to be filled in when a patient was admitted to the CYP ward environment at QEQM. Managers provided information associated with this new audit process and the audit highlighted some observations that needed action by the trust. This has led to the audit being continued on a quarterly basis and showed the trust's commitment to improve.

Cleanliness, infection control and hygiene

The service managed most infection risks 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. However, some equipment was not always present on cleaning checklists.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Ward areas were visibly clean and well presented. Both ward environments had a ward cleanliness compliance audit. However, the Special Care Baby Unit (SCBU) had air conditioning equipment that was secured using sticky tape, which was not in line with best practice guidelines for Infection Prevention and Control (IPC). Managers told us the equipment and areas identified were cleaned by an external company. They showed evidence of the electronic oversight of this cleaning programme for which the SCBU scored 100% in its most recent audit. However, the electronic report did not specifically list external air conditioner equipment.

Managers told us they had requested for the air conditioners to be added to the cleaning checklist. Managers told us the SCBU was a Level 1 facility which meant the SCBU was cleaned daily, and all external surfaces were cleaned as part of this process. Managers also confirmed the air conditioners did not fall under the remit of infection, prevention and control. However, the trust heatwave policy did identify air conditioners as an IPC concern. It specified the air conditioners should be risk assessed on a case-by-case basis in high-risk areas where immunocompromised patients received care. We did see a risk assessment for the air conditioners, but the risk assessment did not specify how the trust had reassured themselves regarding the infection control risk of the air conditioners, specifically their operation in relation to the babies who were premature and subsequently would be considered high risk.

The heatwave policy said “Fans may be used to assist in patient comfort or to regulate a person’s body temperature but have the potential to disperse dust and airborne transmitted microorganisms and alter air flow patterns. While use of portable fans has not been proven to transmit infection, these issues as well as lack of appropriate evidenced cleaning procedures are infection control concerns”.

Cleaning performance for the SCBU was good; however, the paperwork and risk assessments associated with the use of the air conditioners did not fully acknowledge or account for the risks associated with their usage and this requires attention from the trust.

The service generally performed well for cleanliness. The service scored well for Infection prevention and control audits. Managers managed hand hygiene audits at ward level. The most recent score was 96%. This was below the average score for the trust which was 98% for the same reporting month but performance was good over the previous six months. Managers also had ward cleanliness compliance, bare below the elbows observation, and commode audits. Results for these audits were between 99 – 100%

The SCBU unit had good compliance scores for IPC which included 100% for their recent ward cleanliness compliance and hand hygiene audits. An external company handled the cleaning of equipment at the SCBU unit. This was displayed in the SCBU area. Standalone air conditioning unit equipment that caused concern was not listed in these displays and there were unclear arrangements regarding who was responsible for cleaning this equipment.

An IPC team also completed extra IPC audits that covered cannulas, catheters and certain clinical processes.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Managers showed records that supported cleaning processes were completed, and that action was taken when cleaning may not have occurred. Staff were clear on their responsibilities regarding IPC and there was a nominated individual on the ward responsible for IPC compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were observed using PPE correctly and in line with IPC guidelines. Where isolation was required for patient safety, staff used the correct PPE to protect themselves and their patients. Nursing training rates for infection control were 96%. However medical training rates were only 63% at the hospital.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used labels to show when equipment had been recently cleaned at the ward, although we did not see evidence of labelling at the SCBU. Managers told us an external cleaning company was responsible for cleaning the environment at the unit daily and this was externally audited by the trust. The most recent audits awarded the SCBU 100% for cleanliness compliance and the environment was visually clean.

Environment and equipment

The design, maintenance and use of most facilities, premises and equipment kept people safe. However, there were concerns found in the SCBU and Paediatric Emergency Department that need further risk assessments and processes to ensure safety. Staff were trained to use equipment and managed clinical waste well.

Children, young people and their families could reach call bells and staff responded quickly when called. All care environments gave patients and their family easy access to call bells. Staff were observed responding promptly to call bells.

Services for children and young people

The design of the environment followed national guidance. The design of the ward was suitable for the services that were being provided. Risks were found in the Paediatric Emergency department due to some risks associated with patients who had mental health needs. This included ligature risk and abscondment risk. Concerns were also found in the SCBU unit due to the temperature of the unit. Managers told us room temperatures were checked, and we saw records to support this. However, targets for maximum room temperatures were often exceeded and there were unclear records and an absence of policies associated with how this was escalated to estates if intervention was needed.

It was unclear what arrangements would occur if the SCBU environment became unsuitable. We did not see any alternative arrangements underpinned by policy and the area was not referenced in the child health risk register. Staff told us they were unaware of any process for moving patients but did know who they would report concerns towards. Managers told us all risks we saw were documented on trust risk registers, but we did not see evidence of this when we reviewed trust level documents for child health.

Managers also told us that the department had been scheduled to be moved in December 2022 but that this was postponed due to a change in trust risk priorities. There was no new date set for any future move of the SCBU unit. We had concerns over the department when extreme heat occurred and how the trust was able to assure itself that all risks and processes had been considered in this potential situation.

Staff carried out daily safety checks of specialist equipment. Equipment at the location was mostly well maintained and evidence of safety checks were seen to support this. There was one concern however, found in the SCBU relating to air conditioners. These pieces of equipment had no maintenance checklists available to support their operation and unclear governance arrangements associated with who was responsible for them. It was unclear when the air conditioner's filters were last changed and when the equipment was last drained of condensation which builds up as part of their normal operating process. This caused concerns regarding their safety and reliability which was important as the SCBU was very warm, and the unit would be required to maintain a safe temperature. Of further concern, was the unclear alternative arrangements if the equipment did break down and the environment became unsuitable for patients.

Managers acknowledged our concerns and told us a risk assessment had been done and all areas of concerns were known to the trust. The trust provided a further action plan to us outlining the initial measures they had taken in response to our observations. These are covered in the well led section of this report.

The service had suitable facilities to meet the needs of children and young people's families. All facilities were suitable and met the needs of patients. However, some areas lacked risk assessments for their use. For example, a play area for children had no risk assessment despite there being environmental risks such as sharp edges and electronic equipment which could cause harm if children were not supervised. Managers told us signage clearly asked for children to be supervised by their parents but did acknowledge that a formal risk assessment of the area had not been completed. Managers showed us other health and safety risk assessments for the environment and told us they would start a risk assessment following our observations.

The service had enough suitable equipment to help them to safely care for Children and young people. The service in most areas had enough equipment to ensure patients were safe and well cared for. Managers told us when needed, more equipment could be resourced by the team and any shortfalls in equipment were noted on the risk register. We did not see any equipment listed on the risk register, which confirmed equipment was in good supply. Managers kept correct records for equipment including electronic calibration testing for all areas.

Staff disposed of clinical waste safely. Staff disposed of clinical waste in a suitable manner which followed IPC guidance. Clinical waste was collected and disposed of each day.

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 CYP at risk of deterioration. A recent incident had caused a review of sepsis identification procedures.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Staff told us that they used the Paediatric Early Warning Score (PEWS) and we saw examples of it being used to escalate concerns. The PEWS is a risk escalation scoring system that looks at key clinical parameters of a patient to assess their current risk and the need to escalate to a medical professional. However, there were concerns regarding the identification of sepsis which were raised due to a clinical incident that was being externally investigated at the time of our visit. This raised concerns about other measures or variables that were being considered when escalating concerns on the ward. However, we were reassured that sepsis training for staff was above the trust target for the hospital and that learning and supervision from the incident had been implemented.

Staff completed risk assessments for each child and young person on admission and arrival, using a recognised tool, and reviewed this regularly, including after any incident. We saw examples of care plans for patients on the ward during our visit and how these were reviewed. Examples were seen that included mental health and risk assessments that increased a patient's staffing allocation. This was underpinned by the trust's enhanced observation policy for CYP, linked to staffing. Please see under the staffing section below.

Staff knew about and dealt with any specific risk issues. Managers and staff took part in a daily safety huddle at 4pm, where they identified children who met a high-risk criteria. We reviewed the process and policy associated with this and saw examples of relevant paperwork during our visit to the CYP ward.

Staff were conscious of the learning from an incident which had occurred on the ward that involved sepsis was a contributory factor. Managers had shared initial learning from the experience and staff we spoke with had a good understanding of sepsis and the warning signs to look for. Nursing staff training for sepsis identification was 94%

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person's mental health). Managers told us a mental health facilitator visited the ward once per week to support staff with any queries associated with mental health. Staff were able to raise concerns with this individual as well as their manager to escalate concerns they may have.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. Managers told us that when a young person was thought to be at risk of self-harm, they were given enhanced monitoring which involved 1:1 staff allocation so their safety could be ensured. Psychosocial and risk assessments formed part of making this decision. Mental health training was provided for nursing staff and the completion rate for the ward was 86% in May 2023.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Managers told us there were 4 patients on the ward who were considered at risk due to their mental health at the time of our visit. Most patients identified as requiring mental health enhanced support were identified in the Paediatric Emergency Department and this information was then handed over to ward staff prior to their arrival on the ward.

Services for children and young people

Shift changes and handovers included all necessary key information to keep Children and young people safe. Staff showed us handover sheets which clearly outlined the information needed for staff to prioritise and plan their shifts in a suitable manner that ensured patient safety.

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. Managers told us they had recently recruited several new international nurses to the trust which had eased staffing concerns that the trust were experiencing. Managers told us staff were expected to work flexibly between the two sites of the trust and every effort was made to assist staff with arriving and getting home safely. When possible, staff were informed ahead of time when they would be working at a different site; however, managers told us that at times this was expected of staff at short notice, which they acknowledged was frustrating but unavoidable in certain situations.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, following national guidance. Staffing needs for the sites were calculated months in advance. Managers told us staffing to meet the required staffing levels were refined a further two weeks beforehand. They told us that when a shortage was seen, staff were asked if they would like to do overtime. This was initially offered for weekday shifts before weekend shifts became available to ensure staffing was consistent throughout the week. Managers acknowledged the staffing needs for the wards were not always met but this was reducing, and we saw rotas from the previous 6 months that supported the expected staffing levels.

The ward manager could adjust staffing levels daily according to the needs of children and young people. Managers told us the staffing skill mix was suitable to meet the needs of patients. When enhanced mental health support was shown, the trust used an agency to provide qualified staff to shadow patients assessed to be at risk.

The number of nurses and healthcare assistants matched the planned numbers. Managers showed us rotas that supported the expected staffing levels for the environment. Managers told us these rotas were planned eight weeks in advance to allow for flexibility.

The service had low vacancy rates. The vacancy rate for the ward environment at QEQM was 7.1% and 0.2% for the SCBU unit.

The service had reducing turnover rates. The turnover rate for the ward environment was 9% and 17% for the SCBU unit.

The service had low sickness rates. The sickness rate for the ward environment was 3% and 6% for the SCBU unit.

The service had moderate rates of bank and agency nurse usage. Managers told us bank or agency nursing staff were only used for enhanced observation where patients were assessed to need this. Agency use for nursing had increased slightly between February 2023 to April 2023 based on the figures provided by the trust.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers told us agency staff were only used for 1:1 staffing for mental health support and safety.

Managers made sure all bank and agency staff had a full induction and understood the service. Managers told us about the induction process for agency staff. This included showing us the paperwork and processes that would be expected to be followed. We reviewed this process with one agency staff member working on the day of the inspection, they confirmed they had received a brief induction as it was their first day and they expressed feeling supported and knew who to ask if they had any questions. However, we did see that agency staff shadowing mental health patients were expected to have a rest period every four hours due to the nature of their work duties and we observed that this was not occurring during our inspection visit.

Medical staffing

The service did not have enough medical staff in the Paediatric emergency department 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. Other departments had enough medical staff to keep people safe, but this was reinforced by locum use. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to keep children and young people safe. There were concerns found about the Paediatric Emergency Department which are covered in our Urgent and Emergency Care report for the trust.

Medical staffing at the ward was safe, but the trust highlighted difficulties with recruiting middle grade doctors. Despite this difficulty, rotas showed the staffing met the required levels for both ward and SCBU units at the hospital.

The medical staff matched the planned number. Managers supplied medical rosters for review. All rotas matched the planned number of staff.

The service had reducing vacancy rates for medical staff. The paediatric medical team for QEQM was 4.40 working time equivalent staff below their financed target for March 2023.

Sickness rates for medical staff were reducing but stayed a concern for the department. Medical staff at registrar level was lower than the trust wanted. Managers told us sickness was given as one of the reasons for this and it had impacted on post graduate training posts in the department.

The service had reducing rates of bank and locum staff. Managers told us medical staff at middle grade level were lower than they would like. We reviewed agency use for medical staff and found there was still a high use of locum staff. However, there was a reduction in usage in 2022/2023 compared to 2021/2022.

Managers could access locums when they needed additional medical staff. Managers told us there were arrangements with an external recruitment company who supplied locum staff. QEQM Paediatric services used locum medical staff on 51 occasions between February 2023 and April 2023.

Managers told us that the frequent rotation at middle grade levels and recruitment difficulties for full time positions meant that locum use was higher for medical staff. Data we reviewed confirmed these shortages. Managers told us that where possible they would look to keep regular locum doctors at the trust.

Managers made sure locums had a full induction to the service before they started work. Induction processes for locum staff were seen.

Services for children and young people

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Managers told us they were happy with the skill mix for medical staff. Rotas were reviewed eight weeks in advance to make sure this occurred. However, there were concerns found in paediatric ED which are covered in our Urgent and Emergency Care report.

The service always had a consultant on call during evenings and weekends. Consultant rotas reviewed showed that a consultant was always scheduled for on call purposes during the bank holidays and weekends.

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.

Patient notes were detailed, and all staff could access them easily. We reviewed 10 records as part of this inspection and found no concerns with their content or presentation. Records were stored on an electronic system where staff had individual login details that allowed them to access patient information easily and securely.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Staff used one system for patient records, and this provided them with an ability to access information ahead of any proposed transfer.

Records were stored securely. Records were stored on an electronic system where security was kept. Staff had individual login details that allowed them to access patient information easily. Staff were seen not leaving computers unattended and locking computers when stepping away from the desktop space.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff told us the processes they followed when administering medicines. Managers showed documentation which supported effective systems in prescribing and maintaining medicines safely. This included effective fridges, secure storage and accurate record keeping. However, our medicine team saw that medical staff and nursing prescribers did use different medicine formularies and found one example where an ad-hoc dose of medicine was delayed when administered. We explored this and found that medical staff referenced one formulary which was promoted on the trust intranet, while nurse prescribers referenced a different document. This was not found to be unsafe but required clearer guidance to staff in formulary use.

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people and their carers about their medicines. Managers told us a pharmacist dedicated to the paediatrics service was present once a week to review and ensure that all medicine requests and alterations were managed safely.

Staff completed medicines records accurately and kept them up-to-date. Managers showed medicines records to us, which were complete, accurate and stored securely.

Staff stored and managed all medicines and prescribing documents safely. Managers showed locations and storage areas where prescribing documents were stored. All areas had locking mechanisms. Staff checked controlled drugs medicines daily. Staff checked FP10 paper based prescribing forms and recorded changes accurately. Staff took fridge readings to ensure medicines were stored at the correct temperature where needed. Fridges were also centrally checked by the pharmacy at the hospital.

Services for children and young people

Staff followed national practice to check children and young people had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice. Managers told us the pharmacy team centrally managed safety alerts. Managers told us emails would be sent from a central team if a safety alert was assessed as right to be shared with their team. Managers would act where needed and share the information through bulletins and emails. Managers showed a recent example of this.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff were mostly sensible when prescribing medicines. Some medicines were used to calm patients, but records reviewed by our team did not consider this use excessive. In paediatric ED, one example was highlighted as concerning. Managers told us that initial holistic de-escalation was first tried with this patient which supported the policy and training the hospital ran for staff. Despite this, it was still considered above what was needed compared to national guidance.

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 gave us examples of incidents which they would report. Staff explained how they would report incidents and how they felt encouraged to report incidents.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff raised a total of 51 incidents in April 2023. The severity of harm associated with the incidents were low or no harm. Staff told us they raised near misses through the incident reporting process.

The service had one never event in the last 12 months. A child death occurred in December 2022. Managers told us staff were given support and supervision following the incident and a full investigation had taken place, which highlighted sepsis recognition as an area for improvement. Managers shared this learning widely and the report was being externally reviewed by another NHS trust to ensure the findings were both accurate and reflective of the incident.

Managers shared learning about never events with their staff and across the trust. Managers provided evidence that showed how the initial learning from the never event had been shared with staff in the department. Managers showed us various methods of how they shared learning which included emails, newsletters, and themes for each week that factored in previous incidents and the learning gained from them.

Managers shared learning with their staff about never events that happened elsewhere. Managers used the same processes for sharing learning across all sites run by the hospital trust.

Staff reported serious incidents clearly and in line with trust policy. Managers and staff told us serious incidents were reported in a prompt manner. CQC saw through our review of evidence and systems that serious incidents were reported by the trust. A total of 5 serious incidents were reported in the last 6 months associated with paediatrics. Only one of these incidents occurred at QEQM.

Services for children and young people

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. We reviewed 2 examples of duty of candour as part of our inspection. Both examples met the requirements associated with the process.

Staff met to discuss the feedback and look at improvements to children and young people's care. Managers told us that after any serious incident, a full debrief would occur with staff to ensure the initial lessons were learnt. Both managers and staff could give one example in the last 12 months where this occurred.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. Managers were involved in the review of incidents and followed infant death investigation pathways. We saw examples of 3 reviews which were conducted at the trust associated with ante-natal deaths where a suitable audit tool was used. We also reviewed 3 sets of meeting minutes associated with Morbidity and Mortality conferences. Significant events at the trust were investigated using the significant incident framework and we saw examples of active investigations.

Managers debriefed and supported staff after any serious incident. Managers told us staff wellbeing was addressed especially due to staff caring for children which managers acknowledged was more upsetting when things went wrong. Staff told us this did occur, and managers were attentive and offered support in these situations. Both managers and staff could give one example in the last 12 months when this occurred.

Is the service effective?

Good ↑

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Managers told us they conducted monthly audits called the "Fundamentals of Care". All departments and wards across the trust sites were measured on parameters associated with patient safety and care. The ward department at QEQM performed in the middle 50% of wards at the trust. The SCBU were in the top 5% of performing departments for the trust. The latest scores from April 2023 showed that the ward scored 93%, and the SCBU and Childrens Emergency Department scored 100% The audits have been newly introduced to children wards and departments since December 2022.

The wards for children also completed daily quality audits which were completed electronically. These included checks associated with resuscitation, medicine storage, control of substances hazardous to health (COSHH), and estates. The most recent audit score of the QEQM children's ward was 93%

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Managers and staff told us the processes that they followed when the service encountered patients that met the needs of the Mental Health Act. The processes mostly followed the policies of the trust.

Services for children and young people

The Paediatric Emergency Department had a dedicated room for patients who were initially triaged as needing enhanced mental health support. The room could only be used for one individual at a time and if this occurred, a second patient would be given a private booth in the paediatric emergency department. There were ligature risks associated with this approach. We did not see risk assessments that considered this but were aware that staff with enhanced mental health needs were given 1:1 staffing provision which would have mitigated some of the perceived risk as outlined in the trust enhanced observation framework.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. We reviewed handover sheets for staff working in the ward environments and saw good notes which took account of patients' emotional needs. Staff could tell us who they were concerned about and the reasons why. Staff told us they utilised private spaces for families when it was requested and took time to speak with their patients so they could understand what was happening and if they had any questions.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Managers told us meals were served three times a day with snacks available for children. We saw evidence of staff conducting advanced nutrition techniques which involved specialist equipment such as nasogastric (NG) tubes.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed. We reviewed notes from all environments inspected and saw nutrition charts were being completed accurately and at the appropriate time periods.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. Managers told us patients were screened using an evidence-based tool for the screening of malnourishment.

Specialist support from staff such as dietitians and speech and language therapists were available for children and young people who needed it. Managers told us support services associated with nutrition and hydration could be requested when needed. We did not see an example of this while we were inspecting but did see evidence of advanced nutrition techniques in terms of delivering nutrition to patients.

Pain relief

Staff assessed and monitored children and young people 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.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff told us pain assessments formed part of their regular observations for patients on the ward and SCBU. Staff at the SCBU told us they used specialised pain assessment tools for neonates, and we saw evidence of their use. The ward used suitable tools that covered both children who could verbalise and those who could not.

Services for children and young people

Children and young people received pain relief soon after requesting it. Staff told us pain medicines were promptly actioned when requested if prescribed by medical staff. Staff told us nurses would ensure the process was followed from administration to recording. Managers told us the ward were starting to consider patient controlled analgesia (PCA) pumps, but this was in the early stages.

Staff prescribed, administered and recorded pain relief accurately. Staff told us opioid use was only for patients aged 12 and over. Staff also confirmed that fentanyl and higher-level pain medicine were used in paediatric theatres.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people. The service had been accredited under relevant clinical accreditation schemes.

The service took part in relevant national clinical audits. Leaders and managers provided examples of audits that were monitored. For example, we saw audit results from the National Neonatal Audit Programme in 2020 and 2021. We also reviewed actions by the trust associated with these results.

Outcomes for children and young people were positive, consistent and met expectations, such as national standards. In national programmes, the trust performed well in most areas. Some sections did need improvement compared to the national average and action plans were available to see how this would be achieved.

Managers and staff used the results to improve children and young people's outcomes. Managers and Leaders told us all the national programmes fed into the trust's own audit programmes, which were designed to encourage improvement.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers told us the trust ran several audit programmes internally which looked at all factors associated with children and young people. One broad audit named the "Fundamentals of Care" compared care environments and wards across all three sites of the hospital trust ranking them against a criteria, which included but was not limited to health and safety, IPC, nutrition, pain relief, caring and dignity.

Managers used information from the audits to improve care and treatment. Managers told us all information from audits were continuously monitored for trends and themes, and this was fed back to staff in a variety of communication methods.

Managers shared and made sure staff understood information from the audits. Audit scores for each department were visually displayed in staff areas of the hospital. The displays showed a breakdown of the questions audited and where each individual ward ranked across the trust. Staff told us they had awareness of the audits and were informed through handovers and meetings where the priorities were for improvement and learning.

Improvement is checked and monitored. Audits conducted by the trust were completed on a monthly or quarterly basis depending on the subject. This was decided by the audit committee which set the schedule frequency of all audits associated with the trust both internally and externally.

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 clinical educators supported the learning and development needs of staff. Managers told us that support for learning and development was available at scheduled times. We saw learning educators in the ward environments we inspected.

Managers told us clinical educators played an important role with the new cohort of international nurses who had joined the hospital. Their primary focus was for these nurses to understand and pass their initial skills tests needed to work as a registered nurse in the England.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. Managers told us staff were recruited centrally by the trust and all staff had to provide proof of their registration, disclosure and barring service (DBS) checks, references and other needed recruitment information.

Managers gave all new staff a full induction tailored to their role before they started work. Managers showed us paperwork associated with staff inductions. The paperwork showed a consistent approach which allowed for all areas of the job and environment to be covered in a suitable manner. Managers told us new starters would be supported by a buddy who would support them initially. Staff told us that they were happy with their induction processes.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Managers conducted appraisals on a yearly cycle. Records reviewed showed 68% of nursing staff had completed their appraisals for this year at QEQM. However, the SCBU appraisal rate was only 52%. Managers told us they managed appraisals with a yearly review that was based on their first appraisal with the trust. Managers told us they were flexible with the approach if staff wanted more frequent meetings.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Managers conducted appraisals on a yearly cycle. However, records reviewed showed that only 33% of medical staff had completed their appraisals for this year.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers promoted meetings through a variety of communication methods. When staff were unable to attend, managers would note this in the minutes which were then sent to all staff by email.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Some staff we spoke with were developing different skills in preparation for higher level roles. This included taking on more responsibility, awaiting placement on courses for skill development and e-learning allocation.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. We saw records of staff appraisals which recorded the training needs for staff and where they would like their career to develop. Managers told us that besides the appraisal process, they took time with staff and asked them informally where they would like to develop and considered if staff were happy in their current positions and did not wish to develop further. Staff told us that they felt they could approach their managers when they wanted to develop.

Managers made sure staff received any specialist training for their role. Managers showed us specific modules that were expected of all paediatric staff at the trust. Completion rates for these modules were mostly in line with trust targets, however some needed improvement.

Services for children and young people

Managers identified poor staff performance promptly and supported staff to improve. Managers could not give us an example of this. However, they told us that if a staff member was performing poorly, they would approach the subject from a wellbeing perspective first to ensure they were aware of all potential factors associated with the performance. They told us that once they established this, they would work with staff to help them but where needed would follow the trust performance management processes.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Leaders ran a sequence of regular multidisciplinary committees which combined expertise across the spectrum of services and disciplines associated with CYP. Meetings ranged from clinical governance, CYP working groups, through to MDT's involving subject specific themes such as safeguarding, mental health, and infection control.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. Managers told us oncology and mental health was managed broadly across several services in the area which ranged in geographical distance due to specialist sites being involved. The service had standard operating procedures which underpinned this, and managers showed awareness of these arrangements.

Managers told us consultants for Paediatrics ran an outreach scheme for several GP practices. The visiting consultants performed clinics with the GP practice staff, which included the GP and trainee staff. Following their clinic, the Consultant met with the GP team to discuss the children seen and recommend onward care within primary care services. The clinics were held monthly at 5 GP practice locations geographically within QEQM.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health and depression. Managers told us the trust currently employ 7 clinical psychologists across the children services run by the trust.

Seven-day services

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

Consultants led daily ward rounds on all wards. Children and young people were reviewed by consultants depending on the care pathway. Managers provided rotas for medical staffing, which showed that consultants were on site 5 days a week and available on call at weekends.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week. Staff told us medical support was always available and there were clear processes followed if this was needed.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle. The children's diabetes team ran a support event for primary school children with diabetes who were moving into secondary education in July 2022. The event was well received by attendees and positive feedback for activities was recorded.

Services for children and young people

Managers shared an event from the diabetes centre of the trust where children were asked feedback associated with new equipment and optimal diabetic management.

Managers also shared details of a visit to a local animal park for diabetic children and their families. Feedback for the event was excellent and it presented children and their families with bonding opportunities with other families in similar situations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff we spoke with showed understanding of when it was suitable to assess capacity and what things to consider as part of this process. Staff told us mental health was the primary consideration they met when considering consent.

Staff made sure children, young people and their families consented to treatment based on all the information available. Staff we spoke with had knowledge and showed consideration about how they both discussed and confirmed consent especially on surgical procedures.

Staff clearly recorded consent in the children and young people's records. Staff told us this was done in line with pre surgical checks that were completed.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The Gillick Competence refers to a young person under 16 years of age with capacity to make any relevant decision for their treatment. Staff we spoke with understood what this meant but could not provide an example of this from the last 12 months.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Managers told us these subjects were covered as part of the trust's training module on the Mental Health Act called "We Can Talk". The staff completion rate for this module was 76%, which was below the trust target of 91%.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff told us about any concerns regarding a patient's ability to consent would be escalated to their line manager in the first instance.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust's target. In addition to these training modules, the trust had training on "Clinical holding" which was a form of restraint training for staff. The QEQM ward team had a completion rate of 55% and managers told us their goal was to improve this compliance score to the trust target of 91%

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. Managers told us the children's ward at QEQM had not made any applications for DoLs in the past 12 months.

Services for children and young people

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew where to find policies on these subjects. Staff told us they would escalate any concerns firstly to managers. Managers told us they would then engage specialist input where needed.

Managers monitored how well the service followed the Mental Capacity Act, but we did not see a direct process for this. We did not see a direct audit process associated with how well the Mental Capacity Act was checked. However, managers were knowledgeable on the subject and told us they individually checked the process.

Is the service caring?

Good 

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

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Staff were seen caring for children and their families in a kind manner consistently across our visits to the CYP environments at QEQM.

Children, young people and their families said staff treated them well and with kindness. Children and parents we spoke with praised the care they received, and the way staff treated them at the hospital. Patient feedback from the Friends and Family Test (FFT) in April 2023 found that from 102 responses, 89 people were either likely or extremely likely to recommend the service. FFT responses from the past two years were between 70 – 90% for recommending the service.

Managers conducted an inpatient experience inspection where they had scored above 80% between April 2022 and April 2023.

We reviewed a total of 27 pieces of feedback for the service and three cards which were on display.

Comments included:

“Thank you for looking after me and giving me so many cuddles. I feel so much better now”.

“Thank you for looking after my son and making us both comfortable. I really appreciate all you’ve done”.

“Doctors and nurses were amazing. Working so hard and saw my son in a kind, caring, and timely manner”.

Managers provided other positive feedback associated with the play therapy team and gift bundles that had been donated by parents.

Staff followed policy to keep care and treatment confidential. Computer screens were locked when not in use and a room was available if patients wished to have a more private conversation on arrival to the unit.

Services for children and young people

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. Patients with mental health needs had a dedicated member of staff to both support them and keep them safe. Interactions between these patients and their families were friendly, inclusive and kind.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Managers and staff were welcoming to patients and their families. Staff were available to answer any questions and families told us they felt comfortable to approach staff for support.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. We saw interactions where staff were quick and considerate to take children or their families to a designated private room. For example, a parent became distressed while on the ward and was promptly taken to a private room. The parent was supported for 10 minutes, and the child was supported and reassured during the time.

Staff understood the impact of breaking bad news and showed empathy when having difficult conversations. Although we did not see specific training modules for staff in breaking bad news, staff showed awareness of the impact bad news could have and the need to do this in a private location which was seen in all CYP environments. The trust had a policy for care after death which staff we spoke with understood and followed. Managers told us palliative care was managed in the community or in combination with other services.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. We reviewed 10 records as part of the inspection. All 10 records showed evidence of discussion with the patient and their family.

Staff talked with children, young people, and their families in a way they could understand, using communication aids where necessary. Managers told us the CYP environments had hearing loops for deaf patients and a communications book for those unable to speak. Managers told us language translation was available but that it needed to be booked in advance. This was in line with the Interpreting and translation policy we reviewed.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. As part of the inpatient experience audit, families could give feedback that was constructive. For example, one piece of feedback said they struggled to understand their doctor clearly. This feedback was shared with the consultant and the individual was advised they could speak to the nurse at any time to resolve communication concerns promptly.

Is the service responsive?

Good 

Services for children and young people

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

Service delivery to meet the needs of 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.

Managers planned and organised services so they met the changing needs of the local population. Leaders and managers told us the trust considered feedback from the local population when delivering services and this was central to how the service was developed.

Facilities and premises were mostly appropriate for the services being delivered. Facilities we saw were suitable for the services being delivered. However, we did have concerns over the environment of the SCBU. This was due to the warm temperatures and the equipment being used to mitigate this risk. We also found some risks for mental health patients in the paediatric emergency department due to ligature risk in some areas.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities. Staff confirmed they were able to access this but would report to their manager first, so they had oversight of the process.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. Managers confirmed the hospital followed trust policy in this area. Preparations for this process began two years before a patient's 18th birthday and this was in line with the policy we reviewed.

Managers monitored and took action to minimise missed appointments. Managers told us outpatient clinics for paediatrics were managed by a separate bookings team.

The service relieved pressure on other departments when they could treat children and young people in a day. Managers told us that when suitable, treatment of paediatric patients would be limited to a day when convenient. This was normally through attendance at the paediatric emergency department, an outpatient appointment, or a minor surgical procedure (Day surgery).

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. Managers and staff told us all patients had their needs assessed as part of their initial assessments when they attended a CYP area of the hospital. We saw this in patient records reviewed. Staff had the knowledge and understanding in mental health and learning disabilities to understand and implement the considerations for these health groups.

Wards were designed to meet the needs of children, young people and their families. Managers took us round the ward areas which were suitable for the services being provided. The ward held private rooms, bay areas, a play area, secure areas for medicine storage, and suitable washing facilities.

Services for children and young people

Staff used transition plans to support young people moving on to adult services. Managers told us that planning for transition of services was planned on an individual basis over the period of several years to allow for the patient to transition as smoothly as possible. This was verified by their Transition of Young People into Adult Care policy which we reviewed.

Staff supported children and young people living with complex health care needs by using 'This is me' documents and passports. Managers and staff knew what these documents were, although we did not see examples of documents or passports in use during our inspection.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. Managers highlighted their equality, diversity and inclusion policy for Patient's Carers, and Families, their interpreting and translation policy, and their accessible information standard policy which were reviewed as part of this inspection. Staff we spoke with knew where to find these policies and how to organise and start the services provided by the trust.

Managers made sure staff, children, young people, and their families could get help from interpreters or signers when needed. Managers told us that they had the ability to request translators. The interpreting and translation policy outlined different levels of need for translation services that included utilising any bilingual staff through to professional interpreters.

The service had information leaflets available in languages spoken by the children, young people, their families, and local community. Managers told us information leaflets were available on the trust web site and could be translated into different languages when asked. Managers told us information leaflets were still not displayed in CYP areas due to the IPC risks associated with this. However, notices in CYP environments were seen and laminated on notice boards.

Staff had access to communication aids to help children, young people and their families become partners in their care and treatment. Managers told us the trust worked with their accessible information standard policy which provided patients with a variety of ways to communicate. This included sign language, picture cards, hearing loops, and translation services. The trust also offered written communication in different sizes, fonts, languages, and in the form of braille for sight impaired children.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. Managers told us their target for stays in hospitals for acute wards was measured monthly. Managers provided data for the last 12 months associated with the ward environment of QEQM which found the target wasn't met in 10 out of the last 12 months. Managers told us this was due to children with eating disorders or similar conditions which contributed to this figure, as these patients required enhanced planning and social care considerations.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. Managers told us the referral to treatment times (RTT's) for the trust had been above the national target of 95% since December 2022 and we saw data to verify this. However, the CYP department had struggled prior to this date and had not met the target between April and November 2022.

Services for children and young people

The service moved children and young people only when there was a clear medical reason or in their best interest. Managers kept a log of transfers between services and this log outlined the reasons for a transfer. We did not see an audit process or trend analysis associated with themes for why patients were transferred.

Staff did not move children and young people between wards at night.

Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs. Staff had developed a clinical guideline for the hospital trust associated with the safe discharge of children and young people from hospital settings. The guideline considered the variables and safety considerations associated with discharge and the need to plan early for discharge processes. Staff we spoke with had awareness of the guideline and could name aspects of how they planned for a discharge. For example, staff told us patients identified as suitable for discharge were discussed and identified in a scheme called “The Golden Discharge”.

We saw systems which supported its implementation, but staff told us factors such as reviews external from the CYP department, including surgical reviews did contribute to delays to the discharge process on occasions. Staff told us they felt the responsibility to drive the discharge process but felt there were limitations to what they could achieve.

Managers monitored patient transfers and followed national standards. Managers showed logs associated with patient transfers which showed both locations and the reasons for the transfer.

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 service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. Managers provided information that confirmed the paediatric service at QEQM received 10 written complaints between June 2022 and May 2023. Complaints had a target response time of 45 days, and all received a response from the trust, with two complaints resolved through a local meeting. However, of the 10 complaints, only one was answered within the 45-day target.

We reviewed 4 complaints as part of our inspection and found all responses given by the trust to be suitable in terms of content. No written complaints had been escalated to the Parliamentary Ombudsman for Health. Managers followed the complaints policy of the trust, and we reviewed this as part of our inspection.

The service clearly displayed information about how to raise a concern in patient areas. We saw signs in the environment we inspected which displayed information on how to complain.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew the process for complaints. They were active in complaints management and wanted to see if the problem could be resolved before escalating the complaint further.

Managers investigated complaints and identified themes. Managers told us complaints were discussed in team meetings to share potential learning.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. We saw examples of response letters to complaints by the department which provided feedback into investigations and their outcome.

Services for children and young people

Is the service well-led?

Requires Improvement  

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

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.

The leadership team at the hospital was split across operations, nursing, and clinical directorates. Leadership positions ranged from director level which operated at a trust wide level down towards hospital level where more specific roles and responsibilities were designated by role.

Leaders we spoke with were clear about their role and responsibility and they showed good awareness of the priorities and challenges the Children and Young People service faced at the hospital. For example, they were knowledgeable in staffing concerns and were able to explain how they managed risk associated with this.

Staff told us they felt leadership at all services associated with Children and Young people was visible and patients also commented positively on this through the feedback we received.

Leaders developed staff. Staff told us they had opportunities to progress in their careers and we saw examples of leaders who had been with the trust for a long period of time and had followed development pathways. However, staff told us that being released for training was challenging due to how busy CYP environments currently were, but leaders did keep them up to date with how this was progressing which they found reassuring.

Medical staff told us they felt well supported by the medical leadership at the hospital and felt the department was run well.

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. 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 had a children's strategy which has provided a 5-year vision and strategy for the service until 2024. The trust vision statement was:

"To provide a holistic service that puts our infants, children, and young people at the heart of what we do. The service will be delivered by a well led, passionate and engaged team who seek innovation, which is financially viable and works in partnership across the service."

This vision was underpinned by 5 strategic aims that focused on a wide range of themes associated with this, including: quality of care and patient safety; participation and engagement of staff; workforce development, and business sustainability.

The strategy was focused on services and aligned to local plans. For example, the vision outlined specific requests from patients, their families and carers who had contributed to areas of need. The trust had also liaised internally at the trust asking all services where they should focus their efforts, this included community services.

The strategic direction for the service was clear. Leaders monitored progress associated with the strategy.

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 patients, their families and staff could raise concerns without fear.

Leaders and managers provided recognition to staff for their work. Leaders had long service awards which recognised staff at different intervals for their length of service. The trust also operated several other schemes to allow staff to recognise their colleagues, this included the golden hearts scheme which recognised staff on a dedicated trust intranet page, e-card creator so staff could receive recognition based on the trust's people promises, an awards ceremony which occurred yearly for contributions that leaders wanted to recognise and a support network for junior doctors wellbeing.

The service had a diverse workforce, and this was embraced by the trust leadership.

Staff we spoke with showed a strong team spirit and there was a supportive culture among peers. When things went wrong, staff were engaged to understand and fix any mistakes found. This was reinforced by good line managers who applied improvement schemes that shared learning. For example, CYP managers shared an improvement theme each week to encourage a positive culture for learning.

Leaders provided opportunities for staff to develop in their roles and we saw examples of staff who were working towards advanced roles within the service. However, appraisal completion scores for nursing and medical staff were lower in some areas.

Leaders and staff displayed their feedback and were proud of this. Patients and their families who we spoke with knew who to speak with if they wanted to raise concerns. Staff told us they felt safe to approach their line manager if they held concerns.

Governance

Leaders operated some effective governance processes, but they did not always evidence processes throughout the service. There were good governance processes with partner organisations. Staff at all levels were mostly clear about their roles and accountabilities but we did see examples where specific responsibilities were not clear. Leaders gave staff regular opportunities to meet, discuss and learn from the performance of the service.

Leaders at trust level oversaw a large governance structure. The governance structure was divided into clinical and non-clinical pathways.

Services for children and young people

Clinical governance included areas that included but were not limited to child health, deteriorating children and young people, perinatal, maternity, neonatal and other groups that were setup to support governance processes related to these subjects.

Operational governance for the trust covered further committees which included but were not limited to patient safety, integrated audits, serious incidents, infection control, and trust activity/performance. However, there were examples where the trust IPC governance did not cover some pieces of equipment. For example, air conditioner units in the SCBU.

The primary governance groups we looked at during our inspection were the Children and Young People Committee and the Child Health Clinical Governance. We found that staff of these committees were able to tell us what the role of the group or committee was and meeting minutes we reviewed were suitable in detail for the subjects that were covered.

Children and young people services at hospital level were effective. Managers delivered staff meetings monthly and there were other methods for messaging such as a weekly message of the week, emails, and newsletters.

Governance systems that looked at performance and incidents that occurred were frequent and there were examples of learning and how it was shared with staff. However, leaders had not addressed low rates of training for medical and nursing staff in key safety areas which we found in our previous inspection. There were some plans to address this, for example forecasts to meet the Intermediate Life Support (ILS) and Paediatric Intermediate Life Support (PILS) training targets were provided. However, operational staffing pressures were identified by managers as the primary reason for why training rates were low as they could not be released. We did not see evidence or plans for how staff would be provided protected time or be released for improved training rates to be achieved. This meant that some staff currently lacked key skills that are needed to maintain patient safety and the trust lacked a clear strategy for how they would achieve improved rates of compliance.

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 but this was not always completed with the needed detail to mitigate the risks. They did not always have plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders and teams had systems and processes to identify risks. Identification tools were evidenced based, and staff showed understanding of what they needed to escalate.

Clinical risk assessment processes including the use of clinical risk assessment tools were good. Staff knew how to assess clinical risk and we saw examples of completed clinical tools for both observations and pain assessment.

Leaders had a risk register for CYP which was updated monthly. This fed into a trust risk register. However, we found some examples where risk was either not assessed or the management or responsibility for the risk had not been clearly communicated or added to the CYP risk register. For example, the SCBU air conditioners were not found to have a documented maintenance process. They were designated the responsibility of the estates team by the nursing team. When this was queried, we found the estates team thought this was the other way round.

As there was no evidence for the maintenance and oversight of the equipment, potential risk was seen. The risks related to the temperature and environment in SCBU had not been identified and managed through the CYP trust risk register.

We did identify high risk associated with the lack of oversight and arrangements associated with their use. The trust has provided a new action plan since our inspection to mitigate some of the risks we identified.

Most areas of the hospital had suitable health and safety assessments. However, we did not see a risk assessment for the play area of the ward environment. The area held both sharp edges, fall hazards, and electronic devices which we would expect to be accompanied with a suitable risk assessment.

The arrangements for enhanced observation of mental health patients were not always implemented correctly. For example, we did not see evidence that staff responsible for shadowing mental health patients in the ward environment were being given sufficient rest every four hours which was outlined in the enhanced observation policy.

Trust leadership had arrangements and policies for the management of risk associated with patients who had mental health needs. However, we saw evidence of some ligature risks in the paediatric emergency department away from the designated room where patients with mental health needs were expected to go. Staff told us that, if the room was in use, then patients would need to be treated in the bays and this had not been considered on the trust risk register.

These examples meant that we were not able to confirm that all risks associated with the running of the CYP service were being identified and logged effectively.

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.

Managers collected data that was relevant to the service for performance purposes. Information was available and accessible from email, newsletters, reports, policies, and notices in staff areas. Leaders encouraged staff to be aware of data associated with incidents, complaints, and feedback.

The information systems used by the service were secure and the trust had policies and processes for the safe and secure storage of data. This included password protected staff accounts. Staff were conscious of data security and the trust had a named Caldicott guardian if they had any queries with data and confidentiality.

External information was triaged and allocated to the most suitable team by the central governance teams of the trust.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders were open to feedback from patients and used the feedback to make improvements. We saw displays in the ward and SCBU environment which showed how feedback was used.

Staff told us they were engaged with by leaders, and they felt comfortable with raising concerns with their line managers. However, we had received evidence that some staff felt unhappy with the trust policy associated with staff moving between sites at short notice. Leaders told us they understood the frustrations of some staff but had made every effort to ensure this did not occur regularly. We saw planning meetings which looked at staffing situations and leaders outlined the measures they took to ensure staff safety was supported and inconvenience was kept to a minimum.

Services for children and young people

Staff worked with other organisations to deliver services for children and young people with a big focus on diabetes management.

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.

Staff from Children and Young People had several projects that were focused on the management and support of children with Diabetes. Several initiatives focused on both experiences for patients such as visits to local attractions in the area for families with diabetic children, a peer review into diabetic hospital units, diabetes support for school age children through the development of a national guide with regional diabetes support networks, and initiatives focused on reducing hospital stays for newly diagnosed diabetic patients.

Staff had also recently launched a new bereavement service for families in response to learning from patient feedback and in conjunction with the maternity improvement project. A head of midwifery and a neonatal matron worked in co-production with bereaved families to scope and develop a maternity and neonatal bereavement service.

Urgent and emergency services

Inspected but not rated

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients 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. However, the service had not met the trusts target rate for safeguarding training.

Most staff had received training on how to recognise and report abuse and they knew how to apply it. Staff who spoke with us knew how to identify adults and children at risk of or suffering significant harm. At the time of the inspection, 21 members of Emergency Department (ED) staff were non-compliant with level 3 safeguarding training. Leaders told us all outstanding training were booked and the hospital were hoping to achieve a target of 80% by the end of next month and 92% by the end of October. The trust target was 91%.

Staff we spoke with knew how to recognise and report safeguarding issues and knew who to escalate their safeguarding concerns to. The trust had a designated safeguarding lead who staff had access to.

The trust had a People at Risk, Safeguarding Vulnerable Adults policy. This provided staff with guidance on how to identify abuse and the processes to follow if they needed to raise a safeguarding concern. There was a quick reference guide for staff, which gave details of how to make safeguarding referrals. The Safeguarding Children policy for the trust was in date and reflected current legislation and guidance and covered other elements of safeguarding such as female genital mutilation and child sexual exploitation.

Staff followed safe procedures for children visiting the ward. Access to the paediatric emergency department was via a door buzzer system, staff carried electronic passes and patients and families had to announce who they were before entering.

Staff told us children who presented with a safeguarding concern were treated and kept in the department. They told us that they would contact the safeguarding team and the police if a patient absconded.

The emergency department employed security officers through a third party 24-hours a day, 7 days a week. The security team had direct interactions with patients and relatives and received training in Adult and Child safeguarding.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

Self-presenting patients arrived at the main emergency reception, which was easy to find and well signposted. We found the entrance to be visibly clean and tidy and wheelchair stored to the side so that this did not cause an obstruction. The reception staff sat behind a protective screen and had oversight of the patients in the waiting area.

The main waiting area was visibly clean and tidy and there were plenty of chairs for patients to sit on.

Urgent and emergency services

Patients who arrived by ambulance were greeted by a senior nurse where they were triaged, and an initial assessment undertaken. Due to crowding and lack of space, assessments for these patients were carried out in the corridor next to the Rapid Assessment Treatment (RAT) area without any privacy and dignity.

There were adequate hand washing facilities within the department. We observed staff maintaining good hand hygiene on the day of the inspection.

Patient areas within the adult emergency department included a 4-bedded resuscitation area, one of which was for paediatric use; the RAT area, which had 19 cubicles; a major's area with 12 cubicles, fit to sit area and mental health rooms. The hospital had opened a new RAT side room which had 4 beds.

Most of these cubicles had oxygen, suction, monitors, trolleys, call bells and disposable curtains.

There was a workstation that was central to the RAT/majors area and had unobstructed views of all cubicles, so staff could observe the patients' condition.

We found the resus bays to be small and crowded with equipment and it lacked enough space for major resuscitation. However, the trust was managing this as best they could. We observed 3 seriously ill patients managed appropriately by the senior clinical team, all with a positive outcome on the day of the inspection.

Since our last inspection in 2021, the emergency department had completed phase 1 of the expansion and refurbishment to increase use the of space and to improve patient flow.

The department were undergoing phase 3 of the refurbishment work during the inspection. The entrance to the building had dust traps to ensure dust was kept to a minimum, along with noise. All works were behind temporary walls and access to this was restricted.

The cubicles within the new major's area had doors which was good for Infection Prevention Control, IPC precautions and magnets to display information. One of these cubicles had been made dementia friendly with calming colours and the tiles on the ceiling broken up with a pattern. The corridor within the area was wide, bright, and clean. Entry to this area was via secure access.

The new paediatric department consisted of 4 isolation cubicles, 3 bedded bays, 1 Child and Adolescent Mental Health Services (CAMHS) room and 1 isolation bay. There was a separate paediatric waiting area inside the department. This area was bright and colourfully decorated. The waiting room was directly supervised by a receptionist or a member of clinical staff, which meant a deteriorating patient or disturbance would not go unnoticed.

Clinical staff knew where to find the equipment they needed to respond to an emergency and had received appropriate training to enable effective use of it. Resuscitation equipment was readily available and easily accessible. The hospital had systems to ensure it was checked regularly, fully stocked, and ready for use.

Staff in the RAT area told us they had everything they needed to make sure they could provide safe care, treatment, and better patient experience.

Equipment and curtains were visibly clean and ready to use. All equipment was well maintained, and safety checked.

There were systems which ensured that clinical waste, including sharps, was appropriately segregated, and disposed of. During our inspection we observed sharps bins were correctly assembled and labelled in line with national guidelines.

The trust carried out ligature point inspection and risk assessments. We reviewed these for the month of January and March 2023 and found these to be thorough, with potential ligature points identified. Level of risk was identified by a colour code system of red, amber and green (RAG) level and whether additional controls were required.

The hospital kept a health and safety risk assessment inventory. We reviewed these for the last 12 months and found these to be complete and signed off.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. However, staff did not always identify and quickly acted upon patients at risk of deterioration.

All walk-in patients including children and referrals from GP were assessed using a nurse initial assessment sheet at the main entrance. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients were prioritised based on their Emergency Index Score as red, amber, yellow, green, or blue and moved to the appropriate area.

There was a good process to register and quickly assess the ambulance patients. However, due to crowding and lack of space, assessments were frequently carried out in the corridor without any privacy and dignity. This also led to observations not being done effectively and patients being left in inappropriate areas in the department, which we saw on the day of inspection.

All children and young people were streamed and triaged in the paediatrics emergency department. Staff used a Children's Emergency Department safety care plan when triaging children. This consisted of hourly observations, paediatric Sepsis 6 screening tool and a discharge checklist.

The hospital used National Early Warning System (NEWS2) to record patients' observations. NEWS2 is a recognised tool used as a guide which looks at a patient's vital signs such as respiration rate, blood pressure, oxygen saturation level, pulse, and pain levels. Any changes in these measures could indicate early deterioration and prompt actions would be indicated.

Patients taken through to paediatric ED were risk assessed and clinically observed using NEWS2 or the paediatric early warning score (PEWS) during their stay in the department to help staff identify unwell patients or signs of deterioration. All records we reviewed had accurately calculated PEWS scores. Where required, appropriate action was taken if the score was raised.

Staff we spoke with told us they did not carry out routine observations in the main ED as this took time and increased the backlog.

All patients streamed to the Urgent Treatment Centre (UTC) had an initial nursing assessment undertaken. However, on the day of the inspection staff told us that several inappropriate cases were sent to the department, and these included serious near misses. For example, a patient had arrived at the department with a history of allergic reaction of unknown origin. The patient was sent to UTC without detailed history and proper observations. The patient ended up having a serious anaphylactic reaction with significant difficulty in breathing and was moved to Resus for treatment.

Staff could describe the process for the management of sepsis. Clinical guidelines supported staff in managing sepsis. The guidelines were accessible from the trust intranet and the emergency department mobile app.

Staff were not reporting near misses, including those that have potential for harm. Several staff told us about doctors prescribing adult doses to children and relying on nurses to pick this up. So, they weren't reporting near misses. We raised this with the matron who was unaware of this and assured us that this would be looked at.

Staff shared key information to keep patients safe when handing over their care to others. This included sharing of key information during shift changes and handovers. There were 3 huddles throughout the day to monitor timeliness of patient identification and movement. Huddles were with the medical teams, nursing, and operational teams. Nursing staff had a handover between each shift, which included an update on all inpatients and highlighted any specific concerns such as infection risks or safeguarding concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had 24-hour access to mental health liaison and specialist mental health support.

Staff at the hospital completed adult basic life support or immediate life support training depending on their role. Data provided for this showed that only nursing staff had met the trust target of 91% in European Paediatric Life support training. The trust provided a training timeline and planned to run training every week on alternate sites.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Currently the department, including the paediatric ED, planned 21 registered nurses per shift, 1 registered mental health nurse, 2 enhanced support workers and 10 health care assistants.

The paediatric ED was staffed by registered children's nurses, with always a minimum of 2 on shift. Staff told us adult nurses worked within the paediatrics emergency department under the supervision of a paediatric senior staff member.

The hospital employed ED technicians who received additional training, which allowed them to do some duties such as plastering, wound care and gluing.

The hospital had low number of bank and agency nurses and used them to cover shortfalls in the rota. Bank and agency staff we spoke with said they were given a good induction to the department and the team were supportive and helpful.

The hospital had a vacancy for 4 Band 6s and 4 Band 7s and were actively recruiting.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Urgent and emergency services

The service did not have enough emergency department (ED) or paediatric emergency medicine (PEM) consultants to meet the Royal College of Emergency Medicine (RCEM) or The Royal College of Paediatrics and Child Health (RCPCH) guidelines.

Following the request of clarity on some points on the information provided, the trust stated that the hospital ED service was budgeted for 10 Whole Time Equivalent, (WTE) consultants; however, there were only 3 WTE in post. The hospital utilised 6 locum consultants, including 2 who previously held substantive posts. The information provided also stated that 7 PA's per week of ED consultant time was moved from William Harvey to Queen Elizabeth Queen Mother to ensure patient safety was maintained. Despite this there remained a shortfall, with consultant cover at the hospital below the RCEM guidelines. This left patients at risk of unsafe care and treatment.

In paediatrics emergency department, there was 1 PEM consultant with 1 allocated session (x1 PA, equating to 4 hours) every 2 weeks. This level of cover was insufficient to safely support PEM consultant cover at the service.

The consultants we spoke with on the day of the inspection told us they had raised concerns about maintaining a good rota due to lack of consultants. They stated that they didn't have enough permanent consultants to involve in clinical governance meetings.

The hospital had 21 middle grade and junior doctors. We spoke with 8 junior doctors, and they spoke highly of their regular teaching and training program.

Records

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.

Patient notes were detailed, and all staff could access patient records easily. The department used both paper and electronic patient records (EPR). Paper records included individualised plans of care; for example, falls prevention and nutrition. The EPR was used to register patients, monitor their movement through the department and request and review investigations.

Staff we spoke with told us patient care plans were accessible and kept with the patients' records, and felt they had access to information needed. Staff were familiar with the main sunrise IT system where most of the notes were written and navigated it well. Some staff told us this was clunky and not always straight forward to access.

Records were stored securely. Paper records were stored in the central area in trolleys. These were not locked; however, we did not see any patients notes left unattended.

Patient record completion was generally good. We reviewed 5 paper records and 14 electronic records and found all the electronic records to be complete.

Medicines

The service did not always have systems and processes to safely prescribe, administer, record and store medicines. For example, patient's medicines were not always recorded accurately which meant some people went without their regular medicines.

Urgent and emergency services

Staff followed systems and processes when safely prescribing, administering, recording, and storing medicines. The trust was in the process of introducing an electronic prescribing and medicines administration system (EPMA). This had not yet gone live at the site and records were paper based. Patients' notes were held alongside their medicine's administration records. We reviewed 5 drug charts along with computer records.

There were systems to ensure patients received their medicines when they were due, this included time sensitive medicines. Pharmacy staff provided a 5-day service to the rapid assessment and treatment RATs area and a 7-day service to the acute medical unit (AMU). This included, medicines reconciliation, medicines administration and ordering medicines. Outside of these hours staff could contact pharmacy working on AMU or the on-call pharmacy service.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Antibiotic prescriptions were reviewed after 72 hours and recorded the indication, for example, sepsis. A staff member was specifically assigned to review patients pain needs and ensure they received the medicines they needed.

On the acute medical unit, pharmacy staff provided a regular clinical review of all medicines prescribed. Medicines were dispensed on the ward by pharmacy; however, staff within the pharmacy department told us patients were not offered advice about their medicines on discharge.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines areas and electronic records could only be accessed by authorised staff using swipe cards, key pads and individual logs ins. Staff were not always locking computer terminals or removing their smart cards when the terminal was not in use, which meant unauthorised people could access patient information.

Medicines were stored in temperature-controlled areas to ensure they remained stable and effective to use. Staff knew what to do if temperatures went outside the recommended range.

FP10s prescriptions were kept in a locked cupboard and monitored by pharmacy. On the day of inspection, we found that both medicines fridges in the acute medical unit contained damaged and out of date medicines. Both fridges were dirty and 1 contained ice. We reported this to the lead pharmacist and the ward managers. This was resolved on the day of the inspection.

Staff followed current national practice/guidance to check patients had the correct medicines.

Staff completed a medicines reconciliation with patients when they entered the ED. Staff had access to a GP system to ensure they recorded accurate information about the patients' current medicines. We found errors and omissions on the records we looked at. These included a patient not being prescribed their weekly methotrexate dose (this is used to treat rheumatoid arthritis) and a patient who was diabetic not being prescribed 1 of their insulins. Not all staff knew how to check a patient's allergies status on the GP system.

Pharmacy staff on AMU provided a 7 day medicines service which included a medicines reconciliation for each patient and had access to the British National Formulary. Staff told us doctors were not always using the same medicines prescribing guidance when prescribing medicines for babies and children which meant nursing staff had to always check what had been prescribed.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The pharmacy had a system in place to monitor and cascade medicines safety alerts to the ED department where appropriate.

Urgent and emergency services

The trust had an incident reporting system to record near misses and errors. These incidents were analysed regularly, and learning was shared with staff across the trust. This included newsletters and bulletins from the pharmacy to highlight areas for improvement and ways to avoid repeating errors. A large amount of work had been done to reduce the antibiotic penicillin being prescribed for patients who were allergic to the medicine.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Patients were receiving medicines to control behaviour. Pharmacy staff told us they challenged staff about using these medicines and used a system to check if the patient needed support other than medicines, for example, a drink or pain relief. The pharmacy department had produced guidance for staff and were actively working towards reducing the use of these medicines.

Incidents

The service managed patient safety incidents well. Staff did not always recognise and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The hospital used an electronic system for reporting incidents. All staff could access the incident reporting system. Staff working in the ED said they knew what constituted as an incident and were encouraged to report incidents or near misses so that effective measures could be taken to minimise ongoing risk to people or the organisation. There was a no-blame culture and staff said they felt confident in reporting incidents.

Some staff were not always reporting near misses, including those that had potential for harm. Nursing staff told us doctors had prescribed adult doses to children and felt they relied on nurses to pick this up. We were told these situations had not been reported as near misses and was a missed opportunity for learning.

Sixteen incidents during this period had been recorded as serious incidents. The hospital had submitted 11 of these to the Integrated Care Board and 4 cases remained open.

The department considered each incident as a learning experience. They were proactive in reviewing incidents and making changes as a result, whether that be additional staff training or a change of a working practice or procedure. Staff told us learning from serious incidents was immediate and feedback from investigation of incidents was via monthly emails, face to face and team meetings.

Agency staff told us they received feedback from incidents and were able to provide us information about a recent incident involving a child and what learning had come out of this.

Post-inspection we reviewed clinical governance meeting minutes. We saw evidence incidents were discussed, investigations into incidents reviewed, actions taken to reduce risk and reduce the likelihood of reoccurrence. They also looked to see if there were any trends emerging.

The department held mortality and morbidity meetings to discuss patient deaths or adverse incidents affecting patients. These meetings gave an opportunity for the clinical team to review deaths as part of their professional learning and reflective practice in a safe space. Talking through patient case studies was seen to improve quality of care given to patients and their families in the department.

Urgent and emergency services

Is the service effective?

Inspected but not rated

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The trust participated in all relevant Royal College of Emergency Medicine (RCEM) audits and published reports were reviewed with local action taken. Some of these included IPC and pain in children audit. The hospital provided us with the paediatric pain audits from the previous quarter and stated this was moved off the audit programme and placed on a local watch due to compliance remaining good. An audit on the last quarter's performance was currently underway.

In addition to this, the trust participated in the Trauma Audit and Research network, (TARN) audit with data presented to the trauma board for discussion. We reviewed the meeting minutes for April 2023 and saw the agenda included topics such as work plan, data reports, frailty, training, and education.

The trust had previously participated in the SAMBA audits each year and local actions were taken. Actions were formulated from the 21-22 report but for the 22-23 cycle, due to clinical pressures meant they were unable to participate.

The ED had an ongoing programme of auditing, which took place daily, weekly and monthly. Audits included patient safety checklists, corridor care, falls risk assessment and medicines management.

The trust provided us with a local urgent and emergency local audit program for April 2023 which consisted of several projects which leaders took lead on. Out of the 26 projects, 10 of these had been completed with most of them on schedule. An example of this was the chest pain pilot which had been designed to improve the pathway for those presenting with chest pain and epigastric pain, ensuring they were in the right place being seen by the right person.

The children's emergency department completed a number of audits across site. Some of these included Paediatric Early Warning Score combined with blood pressure in children, pain in children, sepsis, and torsion in children. All audit results were sent to the senior management monthly for oversight.

Staff shared up-to-date information about effectiveness internally and externally. Staff understood the information and used it to improve care and treatment and people's outcomes.

Competent staff

The service made sure staff were competent for their roles. Although there were systems for managers to appraise staff's work performance, not all staff had a current appraisal.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. The trust made sure staff were competent for their roles. There were opportunities for staff to develop their clinical and other skills and there were programmes of leadership development. Staff competency was formally assessed in key areas.

Information received from the trust showed that 100% of eligible ED nursing staff had completed their Emergency Department Complex streaming training. Of these staff 86% were recorded as being assessed and signed as competent. The remaining staff were in the process of completing their training competencies.

Staff within the department were expected to complete a triage competency book. Information post inspection showed that all Children's ED nursing staff had completed their competency at initial assessment and triage.

The enhanced observation support workers completed additional training as part of their role and completed a development plan with the Liaison Psychiatry team. This included teaching and shadowing sessions.

Managers gave all new staff a full induction tailored to their role before they started work.

Although there were systems for managers to appraise staff's work performance, not all staff had a current appraisal. Information received post inspection showed that 78% of overall staff within the department had received their appraisal.

We spoke with junior doctors who told us they received regular supervision from the emergency department consultants as well as weekly teaching.

The emergency department employed security officers through a third party and the training matrix provided by the trust post inspection showed that all staff were compliant with the training.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and highlighted issues and outstanding tasks. The department held board rounds which were led by the consultant and senior nurse.

Staff we spoke with told us relationship with the liaison psychiatry team had improved and they had access to the team 24 hours a day, 7 days a week for advice.

We observed good collaboration and communication between all grades and professions within the department itself. However, medical and nursing staff highlighted concerns and challenges when contacting specialty doctors, for example when a patient required a specialist review. They said sometimes specialty doctors did not always respond to or pick up phone calls. ED doctors were unable to make the decision to admit a patient. Specialties needed to accept a patient and give the decision to admit. This created a power imbalance and was a patient safety issue, with ED doctors left with the burden of specialty patients in the ED due to ineffective communication.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We reviewed patients records and found this had been completed.

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. They used agreed personalised measures that limit patients' liberty.

Urgent and emergency services

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 (MCA). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. DoLS & MCA are included in the safeguarding training at levels 2 & 3.

Staff could access the liaison psychiatry service for advice and guidance. The team were based within the trust and provided a 24 hour, 7 day service at both hospitals.

Although the service aimed to provided mental health assessment within an hour for urgent referrals and 24 hours for routine referrals, staff told us there was always a long wait for CAMHS and sectioned beds. On the day of the inspection there were 4 mental health patients within the department and 1 of them had been waiting 2 days for an assessment.

The hospital provided teaching sessions to staff in order to help refresh their knowledge on capacity considerations. Topics included principles of capacity, Mental Capacity Act, police powers and a refresher on DoLS.

The hospital were in the process of recruiting more enhanced support workers who were supported by adult ED nurses.

The trust had a provision of enhanced care and supervision for adult patient policy which was in date. This provided staff with a framework to enable staff to follow a consistent approach in the planning and implementation of enhanced care and support for patients who are at risk of harming themselves or others. This policy also supported staff to achieve the clinical objective of providing safe and effective care to all adult patients by implementation of the appropriate level of enhanced care and support.

The clinical restraints policy covered protocols and guidance for staff when deciding and advising on the use of chemical restraint in both adult and children setting.

The all-age restraint, restrictive and safe holding practices policy was in date and provided staff with guidance on the legal framework of restraint and restrictive practice in adults and children.

The patient information and consent to examination or treatment policy which wasn't in date included information on the documentation process of the consent process, who was responsible for seeking consent and the Mental Capacity Act.

Nursing staff participated in reducing use of restraint MAYBO training sessions and the hospital currently had 45 staff members compliant in this training. Currently there were no additional training sessions available and the trust awaiting further dates. As soon as these dates were published from the health and safety team more staff members would be booked onto these sessions.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of 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.

Urgent and emergency services

The service was accessible and sign-posted from the main road. The emergency department (ED) could be accessed from a separate entrance which was signposted Accident and Emergency. Signage was also available throughout the hospital which helped visitors find their way to the department.

For patients who arrived at the ED via ambulance there was a different entrance. This gave direct access into the majors area of the department.

For patients self-presenting to ED, on entering the department the streaming desk was at the entrance which made it easy to find. The streaming nurse would assess patients depending on their clinical need and assigned them to different areas of the department.

Since our last inspection the department had built a new majors and paediatric ED within the department. The department were undergoing phase 2 of the refurbishment work during the inspection which comprised of the existing A&E and Paediatric waiting areas being refurbished to create new Rapid Assessment treatment bays and associated medical rooms that will provide much needed additional bed bays within the hospital. The third phase, due to start next year, would expand and renovate the resuscitation area, where some of the sickest patients could be treated.

During the inspection we saw there was adequate seating for patients and other visitors in the waiting areas we reviewed. There was signage throughout the department and signs to areas were clear and visible.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

Access and flow

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

The department was not meeting the national 4-hour performance target which meant patients could not always access emergency services when needed or receive treatment within agreed timeframes and national targets.

The hospital did not have an effective handover process of patients who had been in the department for more than 24 hours. For example, on the day of the inspection, there were patients who had been in the department for more than 24 hours.

Overcrowding within the ED departments was included as part of the Operational Pressures Escalation level (OPEL) Plan. The OPEL status of each site was recorded centrally (record for the last 3 months supplied). The QEQM was in OPEL 4 for 10.9 days during the last 3 months.

As part of the management of overcrowding within the department the hospital had a corridor standard operating procedure that described the risk mitigation for patients in non-clinical spaces.

Patient flow out of the department was monitored throughout the day in the site huddle, quality and flow meetings and the cross sit-rep call. The status and escalations were recorded on 2 site reports daily at 7am and 7pm.

The department used a flow coordinator to help with the onward movement within the department using an electronic medical recording system. The flow coordinators followed up diagnostic requests and results and highlighted them to the clinical team when received.

In addition to this, the emergency department flow coordinator recorded escalation against the ED escalation action card to the site team and/or UEC senior team. This was then recorded on their shift log. For the last 3 months the flow coordinators had escalated against the escalation action card 104 times at the QEQM site.

However due to the long process of front-end streaming, patients often had to wait for a long time to be streamed and assessed. This meant some of the safeguarding, mental health and infection control issues could be missed.

During the inspection, we interviewed staff of all grades who described a lack of collaboration from the specialty teams towards the ED team. This affected efficient flow of patients into and out of the ED, leading to longer wait times for patients.

Delayed transfer of patients from the ED to the wards was attributed to delayed discharges of patients from the wards, with the majority of discharges occurring later in the day. This meant patients could not be admitted from ED or the short stay units to the wards until beds were freed up. The trust had recognised this and were working at ways to discharge medically fit ward patients earlier in the day to improve patient flow.

The trust had standard operating procedures and pathways for children and young people into the different specialist areas.

Is the service well-led?

Inspected but not rated

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.

The department had a dedicated leadership team who were responsive to the needs of patients, developing staff and improving safety.

The department was managed by the urgent and emergency care group. The group was overseen by a clinical director who had been in post since September 2022. They held the responsibility for both the William Harvey Hospital and Queen Elizabeth The Queen Mother Hospital.

At the local ED level, the department had the ED head of nursing and the ED operational manager who were responsible for the running of the department. The department had 2 matrons who were responsible for the nursing aspects of the ED at the time of our inspection. The paediatric matron worked 4 days a week and split their time between the 2 sites, 80% QEQM and 20% WHH.

The triumvirate had multiple meetings together and linked with the clinical leads onsite regularly.

Urgent and emergency services

The ED leadership team understood and could describe the challenges to quality and sustainability within the department and had pro-active on-going plans in place to address them. They were aware of the challenges to meet ED targets and had plans to improve service delivery. They were working to create better patient facilities, patient flow and increase capacity. For example, the development of NEWS2 nurse through the deteriorating patient workstream.

The leadership team felt the trust-wide leadership did not fully understand the pressures in the ED, for example relating to overcrowding. The use of escalation area's, or 'corridor care', to deal with over-crowding had been normalised and there was an apparent lack of urgency or drive from senior leadership to resolve issues within the ED.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress. Staff spoke highly of the senior leadership and described them as approachable, knowledgeable, and supportive.

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 patients, their families and staff could raise concerns without fear.

Staff reported the team worked effectively together, with staff across all areas respecting each other and working together to provide the best possible care and treatment to patients. We observed positive and caring interactions between staff and their patients and their relatives who used the service. We also noted good collaboration and communication between ED staff of all grades and disciplines.

The junior doctors we spoke with told us they were happy to work in the unit. They spoke highly of their regular teaching and training program.

Staff within the paediatric emergency department told us they found the management team very approachable and easy to get hold of.

Staff told us they felt supported, respected, and valued. We observed strong teamwork across the department.

The service promoted equality and diversity and had an equality, diversity and inclusion policy and process. All policies and guidance had an equality and diversity statement.

Staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and responsibility for everyone. However, they also told us they had concerns when the department was overcrowded, as this adversely affected their ability to provide the standard of care they wanted to give.

Governance

Leaders did not always operate 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 lines of accountability from the department to the board, through the trust's governance structure wasn't always clear. All levels of governance and management did not always function effectively and interacted cohesively with each other.

Urgent and emergency services

At the time of the inspection, the hospital had vacant posts to be filled for the medical director and deputy chief medical officer. Leaders at the local level described this affected overall decision-making abilities and impacted accountability between services.

Due to constant executive changes, leaders told us they felt no connection with the board and found it challenging to establish relationships with them.

Clinical governance meetings were held monthly and were open to all staff who worked in ED. The meetings had a set agenda which included patient safety, patient experience, risks and clinical audit. An action plan was produced after every meeting and progress reviewed at the following meeting.

Senior ED staff told us information from these meetings was disseminated down to staff in various ways. For example, at staff meetings, during handovers and safety huddles. Information was escalated up to the trust board via the monthly divisional governance meeting.

The Urgent Treatment Centre, (UTC) was led in collaboration with the trust and the GP Alliance. The centre was open 24 hours a day with GP onsite at the site for all of those opening hours. As part of the governance arrangements there were a variety of meetings in place to ensure there was oversight of the safety and effective process to maintain patient safety and review of practice and shared improvement and learning.

The UTC board met monthly as a group where they discussed risks, incidents, complaints, training, policies, and pathways. UTC governance was discussed at the site-based governance meetings on a monthly basis. The hospital was in the process of recruiting a UTC matron and told us reporting between the care group and UTC at the hospital would be strengthened once the post had been filled.

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.

There were clear and effective processes for identifying, recording, managing and mitigating risks in the department. However, these were not always followed by clinical leaders. This led to capacity and staffing concerns, and a lack of flow through the ED. It was difficult to establish who had clinical ownership of patients who were waiting in ED for a hospital admission. While the trust's position was patients in ED who had been accepted by speciality teams, were the responsibility of the speciality team, clinical directors had failed to enforce it.

The department operated a local risk register, which was reviewed at the clinical governance meeting and was a standing item on the agenda. New risks were added to the register and risks already on the register were monitored and managed. If the risk was determined to be a high, it would be added to the divisional risk register.

At the time of the inspection, the top 3 risks on the risk register included staffing, overcrowding and length of stay for mental health patients.

There was a systematic corporate programme of clinical and internal audit to monitor quality, and operational processes in the department. This helped leaders understand and analyse performance issues and put measures in place to address them.

Urgent and emergency services

Hospital flow was recognised by the ED leadership team as a serious risk to the department's ability to provide safe care and treatment and achieve the performance standards required by both the royal colleges and NHS England. Senior clinical staff told us about the pressure they felt working in the department faced with the everyday overcrowding and capacity risks. These staff told us they did not always feel the trust leadership was aware of this pressure and had not tried to assure staff these risks belonged to the trust and the system and not to individual ED staff.

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.

The department used various IT systems to collect, analyse and share information within the department and the wider trust. Patients were tracked through their ED journey by an electronic computer system.

The department could monitor its performance on a live basis through an electronic patient dashboard. For example, monitoring the four-hour targets, patient waits in the department, and the patient decision to admit status. The dashboard was monitored by staff in the department who could see the department's live activity and operational performance. The information was also shared at the trust's bed management meetings which occurred throughout the day to monitor and coordinate patient flow through the hospital.

There were arrangements to ensure information was used to monitor, manage and report on quality and performance. Monthly reports were produced and discussed at the relevant governance meetings.

The service collated and submitted data to a range of national audits. This allowed the comparison of data against national averages and standards to help facilitate continuous improvement. There were arrangements to ensure data or notifications were submitted to external bodies as required.

William Harvey Hospital

Kennington Road
Willesborough
Ashford
TN24 0LZ
Tel: 01227886308
www.ekhuft.nhs.uk

Description of this hospital

Medical care (including older people's care)

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

- The service did not ensure staff at all levels completed the necessary mandatory and statutory training to enable them to carry out the duties they are employed to perform.
- The service did not always have enough staff to care for patients. Staff did not always make sure equipment, such as resuscitation trolleys, were accurately checked and safe to use.
- The service did not ensure systems and processes to mitigate risk including fire safety, infection prevention and control and patients' privacy and dignity; relating to the environment, premises, and equipment, were safe.
- The service did not ensure systems and processes to monitor cleanliness of the environment and equipment were sufficient to reduce infection prevention and control risk and staff did not always follow the infection prevention and control policy. Managers monitored the effectiveness of the service but did not always ensure staff were competent.
- Staff did not always complete patient risk assessments on admission to medical wards. Managers did not always feed back incident outcomes to staff and staff did not always report near misses or potential harms.
- The service did not always ensure they communicated effectively with patients when making decisions about patient care.
- The service did not always ensure chemicals that are hazardous to health were stored safely and securely. The service did not always keep patient records secure.
- Not all leaders ran services well and information systems were not reliable and did not always support staff to develop their skills.

However:

- Staff understood how to protect patients from abuse. Staff acted on risks to patients and kept good care records.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Most key services were available seven days a week.

Our findings

- Staff mostly treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- 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. People could access the service when they needed it.
- Staff were involved in developing the service's vision and values. Most staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to continually improving services.

Services for children and young people

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

- Staff had varied compliance with training in key skills. Medicines were not always managed well. Safeguarding training was below the trust targets for medical staff. Agency staff did not consistently have an induction.
- Managers did not ensure staff were competent in key skills and did not fully monitor the effectiveness of the service. Staff did not always receive appraisals and clinical supervision was not available for nursing staff. Key services were not available and there was no plan to address this at the time of inspection.
- The service did not always consider the individual needs of children and young people receiving treatment and care.
- Leaders ran services well using reliable information systems but did not support staff to develop their skills. Leaders did not always recognise and escalate concerns within the department.

However:

- The service had enough staff to care for children and young people and keep them safe. The service understood how to protect children and young people from avoidable harm, and managed safety well. The service managed infection risks well. Staff assessed risks to children and young people, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff gave children and young people enough to eat and drink and gave them pain relief when they needed it. Staff worked well together for the benefit of children and young people and supported them to make decisions about their care. They had access to information to help them provide treatment and care safely.
- Staff treated children and young people with compassion and kindness. They respected their privacy and dignity and helped them understand their conditions. Staff provided emotional support to children and young people, families and carers.
- The service made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were 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.

Urgent and emergency services

Our findings

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

- Safeguarding training was below trust targets for medical staff. Managers did not ensure staff were competent in key skills and did not fully monitor the effectiveness of the service. Staff did not always receive appraisals and there was limited clinical supervision was in place for nursing staff.
- The service did not have enough staff to care for patients and keep them safe. Staff assessed risks to patients, acted on them however they did not always re-assess patients or maintain good care records. Staff did not always report incidents or near misses in line with trust policy.
- Overcrowded departments meant patients privacy and dignity could not always be respected.
- Leaders of the service described a disconnect between the emergency department and services within the hospital. They described a lack of trust-wide ownership of the challenges faced by the emergency department.
- The lack of patient flow into and out of the emergency department, and into the hospital, had a significant impact on both staff and patients.

However:

- Doctors, nurses and other healthcare professionals within the emergency department worked together as a team to benefit patients.
- The service planned care to meet the needs of local people, took account of individual needs, and made it easy for people to give feedback.
- 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.

Services for children and young people

Requires Improvement 

Is the service safe?

Good 

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

Mandatory training

The service did not always provide mandatory training in key skills to all staff and could not provide specific lifesaving training to all staff when needed.

Mandatory training was comprehensive and met the needs of children, young people and staff. Training modules included key areas such as: health and safety, fire safety, manual handling, infection prevention and control, equality and diversity and information governance and were a combination of face to face and online learning.

Clinical staff completed training on recognising and responding to children and young people (CYP) with mental health needs, learning disabilities and autism. Mental health training was completed by 85% of nursing staff at the time of inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were alerted by email when training was due.

Nursing and medical staff did not keep up to date with mandatory training specific to CYP. Only 17% of medical staff had completed either European Paediatric Advanced Life Support (EPALS) or Advanced Paediatric Life Support (APLS). Furthermore, only 50% of nursing staff had completed this retraining within 4 years. The training was provided by the resuscitation team but there was high demand across the hospital and not enough training sessions were planned to ensure all staff had access to the training needed. More details can be found in the effective section of this report.

Resuscitation training was also worse than the trust target with resuscitation Level 2 (paediatric hospital life support training) completed by only 39% of medical staff and 62% of nursing staff. Resuscitation Level 3 (paediatric intermediate life support) had slightly better compliance with 58% of medical staff completed and 83% of nursing staff. The trust target for this training was 91%. More details can be found in the effective section of this report.

Following our inspection we issued a warning notice, which included concerns around the completion of mandatory training, such as European Paediatric Advanced Life support (EPALS) or Advanced Paediatric Life Support (APLS). The trust has supplied us with more information that showed improvement in the mandatory training figures.

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 staff received training specific for their role on how to recognise and report abuse. Nursing and midwifery staff had 100% compliance with safeguarding training at level 1 and 90% compliance with level 2 and 3.

Services for children and young people

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff were 100% compliant with safeguarding training level 1 but were below trust targets for level 2 and 3 safeguarding training, where only 76% had completed training.

There was a safeguarding team based off site and there was a series of safeguarding champions across the department. There were 3 band 6 nurses, 3 band 7 nurses and a senior band 8 within the team. Staff described a responsive and dedicated team who provided support via the telephone initially and on-site if needed. Staff gave 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. The safeguarding team contacted social services and other outside agencies as needed to ensure joined up working from admission through to discharge. All referrals were uploaded onto the patient's electronic medical records and a safeguarding tab was opened.

Safeguarding alerts were used as well as the Child Protection Information Sharing project (CP-IS) for those children receiving unscheduled care. The CP-IS project linked information systems used across health and social care so basic information could be shared securely between them.

The department audited these referrals to check for correct completion. The CP-IS tool audit from Oct 2022, showed there had been improvement from the previous quarter. On Padua ward 100% of patients had CP-IS accessed and recorded. The tool required a red, amber or green (RAG) assessment to be completed, and 89% of patients had this recorded. This equated to 17 patients out of 19. However, comparing the CP-IS tool audit from April 2023 there had been a decline in CP-IS being accessed and the RAG tool being completed. Of the 22 inpatients, results showed only 68% of patients had CP-IS accessed and a RAG completed. One of these patients was a long-term mental health patient with safeguarding concerns. On previous admissions the tool had been completed but not during the most recent admission.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff provided us with examples of where they had previously made safeguarding referrals for both children and adults. Details of local safeguarding arrangements were displayed in the department for staff to reference.

Data provided to us following our inspection showed there had been 22 safeguarding referrals. Of these 12 were because patients had absconded. The trust wide safeguarding team had oversight of safeguarding risks on the ward and the referrals made.

Staff were aware of risks to children in particular child trafficking and child sexual exploitation (CSE) due to the location of the hospital, and high migration numbers within the catchment area. Staff could describe what actions they would take in relation to female genital mutation (FGM) and the safeguarding policy had a clear process in relation to FGM and CSE.

The trust was represented at relevant external safeguarding meetings and sub health group meetings. Other external reports included contributions to serious case reviews, six monthly dashboards and section 11 audits. Section 11 of the 2004 Children Act sets out the provision for Local Children Safeguarding Partnerships to undertake a self-assessment audit of how organisations and services are meeting standards to safeguard children and young people. The trust understood their commitments to safeguarding and it was given high priority to keep people safe.

Services for children and young people

Cleanliness, infection control and hygiene

The service managed 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. The service did not monitor infection rates for children post-surgery.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up to date and demonstrated all areas were cleaned regularly.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The hospital used "I am clean" stickers, which indicated when equipment had last been cleaned and was ready for use by another patient. We checked 31 pieces of equipment across the service and all were labelled to say when they were last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). In all areas we visited we observed staff had access to a range of PPE.

Throughout the department there was good access to hand washbasins soap, and alcohol gel hand rub. Hand washing basins were available in rooms and at the entrance to bays on the ward. These had lever handles and taps positioned to cause the least amount of splash. Hand washing technique posters were on display to ensure staff used the correct technique. We observed staff washing their hands and following the World Health Organization's 5 moments for hand hygiene guidance.

All staff observed on inspection had bare skin below the elbows with long hair tied back, in line with the trust's policy. In April 2023 bare below elbow audits showed 100% compliance across both Padua and the Neonatal Intensive Care Unit (NICU) with hand hygiene reported at 100% on Padua and 97% in the NICU.

In the outpatient area there were portable sinks available as not all clinic rooms had sinks in. These were filled by housekeepers in the morning and emptied and refreshed by staff throughout the day.

A range of audits indicated good compliance with infection prevention and control policies and procedures, with appropriate actions taken where any issues or omissions were identified. In the past 12 months there have been no cases of Meticillin-resistant Staphylococcus aureus (MRSA) and one community onset healthcare associated case of Clostridium difficile.

We saw signs for parents on entering the NICU to ask them to remove coats and adhere to the trusts policy on preventing infection. We saw visiting parents had followed these instructions.

Side rooms were available on Padua ward, and within the NICU and Special Care Baby Unit (SCBU) for patients who had an infection and needed isolation. We spoke with staff who could explain circumstances when the rooms would be used.

A shower room on Padua ward had visible mould on the wall and the environment needed refurbishment. The trust did not have any current plans in place for refurbishment. We saw some scuffing of paintwork in the outpatient unit and within communal areas in NICU and SCBU. This could mean these areas were harder to keep clean.

We noted a lack of hand wash soap near to a handwash basin in the outpatient dirty utility. This could mean staff were unable to clean their hands correctly before leaving the room.

Services for children and young people

Environment and equipment

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

The design of the environment followed national guidance and access to the department was secure. The main entrance to Padua ward, NICU and SCBU could only be opened by a dedicated key card. Staff also had to electronically open doors for anyone without a swipe card to leave the ward. We saw staff use an intercom to check the identity of people requesting access to wards.

All doors to non-patient areas and store cupboards were electronic key card access only to prevent unauthorised access to items which could be harmful or confidential. The Childrens Assessment Unit (CAU) had a waiting area which was in the line of sight of the ward and reception, so nurses could monitor patients waiting.

Staff could use the ward areas flexibly to ensure that older children and adolescents were separated from younger children. Areas could be utilised to ensure male and female adolescents were separated. There were facilities for isolation which included ensuite facilities.

The environment was clear from clutter and had colourful walls, stickers and play equipment to help children feel at ease. We saw age-appropriate medical equipment for children and play equipment was available in all areas children were seen.

The recovery area in the theatres was separate for paediatric patients and contained two beds and was appropriately decorated. This was screened off from the area used by adults.

We were told the CYP department regularly updated equipment to ensure they were well equipped with the latest technologies. For example, we saw the NICU was trialling a new monitor to indicate early signs of sepsis.

Staff carried out daily safety checks of specialist equipment. Staff had access to specialist paediatric and neonatal emergency equipment in all areas we checked. We saw daily and weekly safety checks were up to date. Equipment on 3 emergency trolleys we checked were in good condition and in date. These contained equipment for children including an age-appropriate defibrillator.

The trust had a Medical Device Policy which provided a summary of roles and responsibilities for all staff involved in the use of medical devices. There was a band 7 technologist employed who was based in the NICU. They worked across the department to service and maintain equipment.

The service had suitable facilities to meet the needs of children and young people's families. There was room for 1 parent to stay with their child at all times. There were no restrictions on visiting for parents.

Children, young people and their families could reach call bells and staff responded quickly when called. Parents told us they knew staff were very busy so if there was a delay they would go and find a staff member and they were generally responsive. Patients who were unable or unlikely to use call bells, such as very young patients were kept under close observation of the nursing staff and had regular contact with other non-registered nursing staff.

Staff disposed of clinical waste safely. Waste segregation was used and PPE, such as aprons and gloves were disposed of in clinical waste bins. We saw sharps bins were available in treatment areas where sharps may be used. We saw labels on sharps bins had signatures of staff, which indicated the date it was constructed, by whom and on what date. One sharps bin on Padua ward was overfilled and could result in injury to staff when adding more items to the bin. All other sharps bin we saw were compliant.

The service had enough suitable equipment to help them to safely care for children and young people. We checked 31 pieces of equipment from across the department, all equipment had an asset barcode and log number which ensured it had been registered onto the trust's medical devices log. This then indicated to the facilities team when equipment was due to be serviced or replaced.

Four members of staff on Padua ward described frustration that sometimes equipment was moved and harder to locate as a result.

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.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Children were constantly assessed using the nationally recognised paediatric early warning systems (PEWS) escalation trigger protocol. This tool uses measures of the patient's condition, including for example, their blood pressure, respirations, temperature and respirations. A score is added to each measure and if indicated will result in the need to escalate to a member of the medical team. We reviewed 9 sets of patient records which all contained completed paediatric nursing assessments and completed PEWS charts. We saw escalation processes documented fully in patient notes when an increase in a PEWS score had required it.

An investigation into a recent serious incident within the department found there was an opportunity to have detected the deterioration earlier than occurred. There was a delay in treatment of antibiotics and staff did not recognise the deterioration of a child soon enough.

Staff raised concerns that although escalation of deterioration had improved some felt the process was not always escalated correctly. Staff reported an improvement in culture within the department.

Following on from recent escalation concerns in the NICU the service had started to trial an automated sepsis and deterioration machine. This would alert staff to any changes in babies' status, detecting the early signs of sepsis.

The World Health Organization (WHO) published the WHO Surgical Safety Checklist and Implementation Manual in 2008 to increase the safety of patients undergoing surgery. The WHO surgical checklist was fully completed in the notes we reviewed.

Staff completed risk assessments for each child and young person on arrival, using a recognised tool, and reviewed this regularly, including after any incident. We saw detailed risk assessments had been carried out on admission. These included background information on children's previous admissions and if they were known to social services or under any protection plan.

Systems were available to add an alert to electronic patient records should there be a safeguarding concern or specific actions to take. For example, to identify frequent attenders or record individualised safeguarding risks.

Staff knew about and dealt with any specific risk issues. The department used a paediatric procedure care pathway booklet. This documented a child pre and post-surgical journey. It was a detailed document with red boxes which highlighted patient safety and required mandatory responses. These included allergies, weight, consent and any special needs.

Children in recovery were monitored by 2 staff members who had specific paediatric training and were trained in paediatric life support. This training provided the knowledge and core skills required to intervene to prevent further deterioration towards respiratory or cardiorespiratory arrest.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person's mental health). The service employed a registered mental health nurse (RMN) and had a crisis team who generally responded within 4 hours to any children or young people who needed additional support. The department had employed a further RMN to work at the trust's other hospital QEQM. Staff described this support as invaluable.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. The RMN carried out a further assessment if there were any mental health concerns identified.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Ward rounds included all necessary key information to keep children and young people safe. Ward rounds were undertaken twice daily, where all new patients and existing patients were reviewed. These ward rounds were multidisciplinary, and we observed a good level of input from both nursing and medical staff. All records were reviewed including electronic records and paper records in making decisions about a patient's care and treatment during ward rounds.

We saw patients and their families were given clear information on discharge from the service and given contact details for help and advice following discharge. Children and young people with long term medical conditions also had open access to the department ensuring they could be seen promptly if any issues arose. We saw written information about any new medicines a child may have been given.

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. Some agency staff did not receive a full induction.

The service had enough nursing and support staff to keep children and young people safe. Agency nurses were used to ensure safe staffing numbers. Staff were relocated to different sites within the trust if staffing levels were not achieved.

Staff reported improvement in staffing levels. The introduction of new staff meant experienced staff were often working with new or internationally recruited staff, supporting them on shifts as well as carrying out their roles. Staff reported this had been difficult but had now improved as these new staff were becoming more independent.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. We reviewed the staffing rota for the previous three months and saw that it was mostly compliant with national guidance. Staffing levels were often achieved by using bank and agency nurses. Staff reported universally that staffing levels had improved in the department and that they felt able to have breaks and complete training, with some reporting it felt a safer place to work.

The ward manager could adjust staffing levels daily according to the needs of children and young people. Staffing was reviewed 3 times a day and staff were moved around as needed. There was a daily call at 9am (for ward management) and 9:30am (for the NICU and SCBU staff) to assess any emerging risks and staffing issues across the trust hospitals, as well as to forward plan any potential issues leading up to the weekend. This daily safety huddle call included acute wards and the paediatric emergency department and was cross site.

At the beginning of the early and night shift, the nurse in charge / ward manager completed a staffing acuity tool. This covered the 24 hours period including the early, late and night shift. Managers could adjust the staffing levels if they felt that the calculation did not show a true reflection of what the ward needed to ensure patient safety.

Every 6 months a safer nursing audit was undertaken by the ward manager and then reviewed by the associate director of nursing (professional workforce and CPD). It was last completed in April 2023 and the data was pending at the time of inspection.

The service had reducing vacancy rates. The current vacancy rate was 13.7% on Padua ward and 9.8% within the NICU. This had improved recently, and staff reported a positive difference within the service. There had been 5 incidents reported for staffing level difficulties in March 2023.

From April 2022 to April 2023 the trust reported a turnover rate of 11.3% on Padua ward and 16.8% on NICU. Staff told us several staff had left the NICU due to the loss of the community outreach service which had previously supported women and their babies.

From April 2022 to April 2023 the trust reported a sickness rate of 4.8 % on Padua ward and 9.1% in the NICU; this was higher than the trust target of 5%.

The department had a high use of agency nurses across the department and from February to April 2023, agency staff were used 120 times. This was an improvement on the previous 3 months. Whilst this figure seemed high, we analysed the previous 3 months of rotas and saw there had been significant use of agency and bank staff because of children requiring one to one care. As there was a shortfall of permanent staff the service often had to use agency and bank staff to ensure one to one care was maintained.

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.

We had concerns over medical staffing in the paediatric urgent and emergency care, this is detailed in the urgent and emergency care section of this report.

Services for children and young people

The children and young people's service had enough medical staff to keep children and young people safe. A ward consultant paediatrician was available 24 hours a day, 7 days a week. They were on site Monday to Friday 7am to 7pm, Saturday 9am to 4pm and Sunday 9am to 2pm. After these times a consultant was available on call from home.

The NICU had a separate consultant on site Monday to Friday 9am to 5pm and 9am to 12pm Saturday and Sunday. Consultants were available on call outside of these times. The NICU had 24 hours seven days a week registrar cover. When not on site, consultants could be contacted via mobile directly. Acute Children and Young People and both NICU/SCBU had a separate on call rota provided by ward managers and matrons so staff could ask questions and feel supported outside of daytime hours.

We were told that every child admitted to a paediatric department with an acute medical problem was seen within 4 hours by a tier 2 (middle grade doctor) or above. For example, we saw a paediatric admission to the emergency department was discussed with the paediatric registrar who ensured handover with the wards.

Out of hours the paediatric registrar was based in the emergency department and reviewed the patients directly.

Every child admitted to the paediatric department was reviewed by a consultant paediatrician within 14 hours. Children admitted in the daytime were seen before 5pm and any admitted after that were either seen by the night shift consultant paediatrician by the day shift consultant paediatrician the morning after during the 9am ward round. If there were concerns over night then a consultant on call would be called.

Out of hours the same consultant had to cover both the ED (Emergency Department) and the children's ward. There was a long distance between the children's emergency department and Padua ward. This could lead to delays in seeing children due to the time taken to walk between the units.

The service did not monitor or audit treatment delays out of hours. However, the service reviewed delays in pathways between the children's ED department and the ward. These were discussed daily at the 09:30 huddle.

The service had high rates of bank and locum staff. The service had a vacancy rate of 11.6% for medical staff. Managers could access locums when they needed additional medical staff. Locums were used 116 times from February 2023 to April 2023.

Managers made sure locums had a full induction to the service before they started work. Locums we spoke with were offered an induction and of the 3 we spoke with they had all attended the service multiple times, so felt they knew the service and staff well.

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.

Patient notes were detailed and all authorised staff could access them easily. Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date, and available to all staff providing care. There were several systems of records, some were electronic and some were paper based. Staff were trained in all systems and could demonstrate how they worked together.

Records were stored securely. Individual care records, including clinical data were held securely in trolleys. We saw several trolleys across the department and they were always locked when not in use.

The records system had a 'flag' system to alert staff to children with specific concerns, for example child protection plans and other confidential social information. Children with learning disabilities were also flagged via this system. Staff confirmed this was well established and widely understood.

We saw examples of completed WHO surgical checklists which recorded safety checks prior to surgery, during surgery and following surgery. We found these to be completed in accordance with the WHO guidelines.

When patients were moved between departments, services or back into the community we saw that discharge summaries and letters were available and distributed to the appropriate team. We witnessed 2 discharges and saw the relevant information was passed effectively between teams and the families.

However, we did witness a child who had been moved from an adult ward to Padua ward whose medication needs were not seen initially by staff. This was because on the adult ward, records were electronic, whereas on Padua ward they were paper. This had meant important information was not highlighted to staff during the handover as they were unable to access the electronic care record. Staff were able to identify this as they looked back through the patients notes, which could lead to them missing important information.

Staff told us parents were often frustrated that there were delays in discharge. This was often in relation to obtaining medicines and ensuring appropriate community support had been arranged. We saw no evidence of discharge planning starting on admission; however, there was a documented date of discharge noted on the site management board once a date had been confirmed.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff reviewed each child and young person's medicines regularly and provided advice to children, young people and their carers about their medicines.

Staff completed medicines records accurately and kept them up to date. The department had a monthly medicines audit. In April 2023, the department scored 93% overall. In the past 12 months all medicine audit results, apart from 1, were above 92% with the lowest at 89% recorded in March 2023.

The NICU had scored 100% in the medicines audit for the past 6 months, which meant they were ranked 1 out of a possible 57 areas across the hospital.

Staff stored and managed all medicines and prescribing documents safely. Staff took fridge readings to ensure that medicines were stored at the correct temperature where needed. Fridges were also centrally checked by the pharmacy at the hospital.

Staff learned from safety alerts and incidents to improve practice. Medicine errors and insights were used to form part of the governance report presentation. Recent examples indicated learning was shared amongst the team and between the South Thames Paediatric Network (STPN). Weekly medicines updates were emailed to relevant staff in relation to the NICU and any learning points shared.

There was currently no dedicated neonatal pharmacist working in the NICU. This was on the departments risk register and a role was due to be advertised.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We were aware the service had on occasions considered using rapid tranquilisation where a young person had presented with an acute mental health condition, and they were at risk of harm to themselves.

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 the actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. All staff could access the incident reporting system and could describe what they would consider an incident. Staff received feedback directly to any incidents they raised depending on the severity. Staff raised concerns and reported incidents and near misses in line with trust policy.

There had been 286 incidents reported from January to April 2023 and of these 6 were rated as moderate and the remaining low or no harm.

The service had no never events. Managers shared learning with their staff about never events that happened elsewhere. A never event is a serious incident that is wholly preventable.

The quality improvement matron and the quality lead reviewed and allocated all incident reports. They worked with teams across paediatric services. A monthly oversight meeting was held with staff from the paediatric accident and emergency, NICU and SCBU to discuss incidents and emerging risks.

The trust reported 7 serious incidents (SIs) in children's services which met the reporting criteria set by NHS England, from April 2022 to March 2023. We reviewed 2 of this post inspection and saw the process if investigating had been thorough. Serious incidents were discussed monthly, including progress on reports and learning (both immediate and longer term).

Serious incidents were discussed and any progress/actions in relation to the SI reports continually reviewed at governance meetings and presented by the service in the monthly governance presentation.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation when things went wrong. Duty of candour had been applied 11 times in the previous 12 months. Staff spoke knowledgeably about the duty of candour and could explain how this was put into practice. The duty of candour is a regulatory duty that relates to openness and transparency. It states that as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the person in relation to the incident and offer an apology.

Staff received feedback from investigation of incidents, both internal and external to the service. Mortality and morbidity meetings were held monthly by specialty. These were minuted and attended by ward management. In the NICU these were held separately, and the consultant lead also attended mortality and morbidity meeting with a group of local NHS trusts, to ensure learning was shared.

Services for children and young people

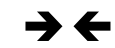
Staff met to discuss the feedback and look at improvements to children and young people's care. The department attended regional South Thames Paediatric meetings (STPM), which met monthly to discuss several aspects of patient care and share learning and improvement to the children's service offered across East Kent.

There was evidence of changes having been made as a result of feedback. The STPM recently made a change to the "Stop" tool and adapted it to work more specifically to children's accident and emergency and the children's ward. Stop and Watch is a tool that is used to help spot the warning signs that a patient's condition was deteriorating.

Managers debriefed and supported staff after any serious incident. Staff (medical and nursing) were provided with trauma and risk management (TRiM) and debrief sessions once they were made aware of the incident and these were well attended by both the medical and nursing team.

Managers acted in response to patient safety alerts within the deadline and monitored changes. The quality improvement matron and the quality lead reviewed national safety alerts and made sure these were passed to the correct team and implemented. These were included in newsletters and safety huddles to ensure staff were aware.

Is the service effective?

Requires Improvement  

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The quality and improvement matron and quality lead over saw the implementation of several new systems to record and keep track of all policies and guidelines to ensure they were up-to-date and reviewed in a timely manner.

There was a clear process to update and review policies. Policy updates formed part of the presentation at clinical governance meetings and the children's committee meetings. Staff were alerted to any changes through daily safety huddles and regular team meetings. The quality team managed all national guidance including recommendations from: National Institute for Health and Care Excellence (NICE), the confidential enquiries, other national clinical audits and studies from approved bodies like the Royal Colleges and for recommendations from major inquiries and national strategies.

A spreadsheet indicated clearly when updates were needed. This led to improvement in policies and guidance being accessible to staff through a new online matrix.

The trust participated in national clinical audits within. These audits were developed based on the NICE guidance recommendations. Outcomes from the national audits provided assurance that NICE guidance was being followed or if improvement plans were needed.

Services for children and young people

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families.

We reviewed several policies and saw they were within their review date. This included policies on consent, discharge and medicines management. Any guidelines that were out of date were presented at the child health clinical governance meetings monthly and progress on reviewing them discussed.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed. Staff were proactive in monitoring the nutrition and hydration needs of children and young people admitted to wards. All children admitted were assessed using the screening tool for the assessment of malnutrition in paediatrics (STAMP). The STAMP assessment was completed in patients records we looked at.

Staff ensured patients who required fasting before a procedure were timed and closely monitored in order that the patient would not go for too long a period without food or fluids. We saw this documented in the patient records. The trust had a 'Nil by Mouth' Guideline for Adults and children which contained flowcharts and up to date guidance in relation to fluid intake prior to surgery.

Milk rooms were located on wards and NICU provided numerous alternatives to breast and formula milk if a baby was lactose intolerant or had allergies. There were good systems to ensure expressed milk was stored correctly and given to the appropriate baby. We checked a sample of milk formula on the NICU and on Padua ward, all were sealed and within date. Bottles and teats were available to assist with feeding.

Strict guidelines supported mothers who could donate breast milk, as well as those babies who received it. Policies for alternative feeding methods were robust, followed clinical guidelines and provided step-by-step instructions. We saw detailed policies for gastro feeding, milk administration, nasogastric/orogastric feeding procedures and Naso jejunal tube feeding (an effective method of feeding babies with high reflux where you feed directly into the small bowel).

Staff were trained and could identify when total parenteral nutrition, a method of getting nutrition into the body which is given through a catheter into a vein, might be required. This meant babies who could not tolerate nutrition in their digestive tract still had their nutritional needs met.

All children we spoke with on the wards told us they liked the food and were regularly asked by staff if they had enough to eat and drink. Facilities were available for parents to make drinks and snacks. Families were welcome to bring food for their child.

There was a paediatric dietitian available for advice and carried out assessments on children if required.

Services for children and young people

Pain relief

Staff assessed and monitored children and young people 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.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain assessment formed part of the Paediatric Early Warning System (PEWS) chart which we observed being recorded during a patient review. Appropriate staff prescribed, administered and recorded pain relief accurately.

Children and young people received pain relief soon after requesting it. The department used many ways to determine pain levels including The Face, Legs, Activity, Cry, Consolability scale (FLACC) scale. This is a measurement used to assess pain for children between the ages of 2 months and 7 years or individuals that are unable to communicate their pain. The scale is scored in a range of 0–10 with 0 representing no pain. The scale has 5 criteria, which are each assigned a score of 0, 1 or 2.

Patients and carers we spoke with reported that pain was well managed. We observed pain management prescribing and administration of medicines, which was appropriate to patient need and staff were confident in the approach to pain management.

There was no pain nurse for paediatrics but we were told that if a patient required more complex pain management, the pain service would review and support the team to ensure they had the competencies required for example patient-controlled analgesia pumps.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

The service participated in relevant national clinical audits. Results from the most recent national neonatal audit programme (2022), showed they performed in line with or better for the national average for 50% of the metrics. For the metrics that fell below the national average an action plan and report were produced. Managers and staff used the results to improve children and young people's outcomes. These actions were monitored and committee meeting and the children’s health clinical governance meetings.

For example, for the question: Is a mother who delivers a baby below 30 weeks gestational age given magnesium sulphate in the 24 hours prior to delivery? There were 39 eligible mothers identified for inclusion in this audit measure. Of the mothers with a recorded outcome, 79.5% were given magnesium sulphate in the 24 hours prior to delivery. This was lower than for 2020 (87.5%) and below the national average, where 86.9% of eligible mothers were given magnesium sulphate. A 3 point action plan has been actioned including implementing the Peri Prem passport to help prompt the administration magnesium sulphate to eligible mothers and to empower mothers to remind clinicians to administer magnesium sulphate.

Outcomes for children and young people were positive, consistent and met expectations, such as national standards. The trust carried out monthly fundamentals of care inspections. These included 46 questions and included information across several areas of care. Examples included if vital signs are completed, were any patient records left unattended, information on patient diets, and questions for children around their care.

Results of these were analysed and a report produced with action plans for any metrics that fell below the standard expected. Ward areas were given an overall scored percentage and given a ranking trust wide. Padua ward had scored 90% or above for 6 months with 89% scored in March 2023. The NICU had scored above 90% for the past 6 months with the last month reported as 100% compliant and ensuring they were ranked first out of 57 areas. Managers used information from the audits to improve care and treatment.

Managers and staff carried out a programme of repeated audits to check improvement over time. Daily quality audits were completed electronically and consisted of 17 questions. This included resuscitation trolleys, controlled drugs, fridge locks, stock fluids and suction. These appeared on a dashboard and were reviewed at the daily huddle to ensure they were completed.

The department informed us they did not document or audit cases of surgical site infection for any child surgery. This could mean a lack of oversight and would not allow the service to identify any themes or trends occurring post-surgery.

Competent staff

The service did not make sure staff were competent for their roles. Managers did not always appraised staff's work performance. Staff did not have clinical supervision to provide support and development.

Only 17% of medical staff had completed either European Paediatric Advanced Life Support (EPALS) or Advanced Paediatric Life Support (APLS). Furthermore, only 50% of nursing staff had completed this vital retraining within 4 years. Managers told us this enabled at least 1 EPALS trained person on each shift. However, no formal audit for compliance of APLS and EPLS staff in the last 6 months had been undertaken.

Evidence gained by the trust from the triangulation of staff training records, health roster, and the daily safety huddles showed there were 13 registered nurses holding the EPLS competency and 5 advanced care practitioners. From April 2022 to April 2023 there was at least one shift completed without an EPLS/APLS trained member of staff every month and 3 being reported in January 2023. To mitigate this, we were told that staff would alert the medical staff to ensure they were on hand and aware. However, with the medical staff reporting much lower percentages of staff trained (17%) we could not get assurances that the right staff with up-to-date training was available to ensure safe emergency treatment.

Resuscitation training was also worse than the trust target with resuscitation Level 2 (paediatric hospital life support training) completed by only 39% of medical staff and 62% of nursing staff. Resuscitation Level 3 (paediatric intermediate life support) had slightly better compliance with 58% of medical staff completed and 83% of nursing staff.

The department had been raising this as an issue for many months but had been told there was not enough resource with the resuscitation team who provided the service.

Staff told us they were frustrated that this had been highlighted through several meetings, but no action plan had been developed to address the low compliance. We saw this documented in meeting minutes from across the department including the child health clinical governance meeting and the children and young person's committee meeting firstly in August 2022 and still raised as a concern in April 2023.

Staff were not up to date with important training specific for their roles. All training modules offered to nursing staff had not been completed in line with the trust target of 91%. Tracheostomy e-learning was currently 75%, blood transfusion competency assessment and theory were reported at 68%, care of central venous access devices 77%, venous thromboembolism (VTE) 50% and blood culture collection 28%. This demonstrated that staff training was not prioritised across the department and could mean staff were not competent to carry out specific tasks correctly.

New staff did not always receive a full induction tailored to their role before they started work. There was a detailed induction protocol for both bank and agency staff to ensure they had the correct levels of skill to deliver safe care. We saw an induction and development programme which included ward-based competencies which staff should complete. However, we asked an agency worker if they had completed an induction and they confirmed they had not. They had been working at the hospital for several weeks and had not completed an induction. We also spoke with a student nurse who had not completed an induction specific to the ward. Without an induction to the ward, there is a risk staff working there may not be as familiar with the arrangements, access to equipment and other important information.

Managers did not fully support staff to develop through yearly, constructive appraisals of their work. We saw varied compliance with staff appraisals. Only 55% of nursing staff and 66% of clerical staff had an appraisal completed in the previous 12 months.

The chief medical officer held medical staff appraisal compliance. In the past year only 64% of doctors had received an appraisal.

Managers did not support nursing staff to develop through regular, constructive clinical supervision of their work. Apart from the formal clinical supervision of clinical nurse specialists. Supervision for ward nurses was ad hoc and was provided by the Practice Development Team.

The clinical educators supported the learning and development needs of staff. There was a practice development team who supported staff across the department. Staff knew how to contact them and felt they supported them with training and learning needs.

Staff had the opportunity to discuss training needs with their line manager and the practice development team and were generally supported to develop their skills and knowledge. Staff spoke of this being easier more recently as staffing levels had improved. We spoke with a staff member who was currently having additional training supported through their appraisal.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff reported often not being able to attend meetings on Padua ward due to the ward being busy. Meeting minutes were distributed via email after the meeting to allow staff to read what had been discussed.

Managers made sure some staff received any specialist training for their role. The NICU undertook scenario training and simulation training monthly. Due to the unavailability of resuscitation training they had recently included this in their scenario training. Staff reported these were valuable sessions and were always well attended.

Medical staff undertook Continuing Professional Development (CPD) training as part of their continued practice and felt that if they requested training, they would be encouraged to undertake this. Continuing Professional Development refers to the process of tracking and documenting their skills, knowledge and experience.

Services for children and young people

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression. The registered mental health nurse (RMN) would further assess patients and develop a care plan if staff had concerns.

There was embedded multidisciplinary working throughout children and young people's services. We witnessed effective communication between teams and witnessed two multidisciplinary team meetings during our inspection.

The South Thames Paediatric Network (STPN) is a Regional Network which has been in operation for approximately 10 years. The STPN met every month and discussed learning, new initiatives, concerns and staffing (amongst other things) across the patch. Staff reported a very positive learning environment and that changes across the area happened quickly as a result of this. A recent example was an STPN escalation policy which included the use of a single escalation rating system used across the area.

Staff were positive about the relationship between consultants and the wider team and said this had improved recently. Staff said this had been addressed through several trust initiatives. For example, in NICU the staff had the opportunity to talk to the freedom to speak up guardian who fed back to the department anonymously.

Speech and language therapists and dietitians could be contacted when required via telephone.

The multidisciplinary team agreed meal plans, which were reviewed daily to check dietary requirements of patients with eating disorders.

The care group had a positive relationship with Child and Adolescent Mental Health Services (CAMHS); this was largely because there was a registered mental health nurse employed who could communicate with CAMHS and an effective relationship had been formed as a result.

Seven-day services

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

Consultants led daily ward rounds twice daily on Padua and the NICU/SCBU, including weekends. Children and young people were reviewed by consultants depending on the care pathway.

There was 7-day access to x-ray, ultrasound, computed tomography (CT) scanning, magnetic resonance imaging (MRI) scanning and pathology. Consultants reviewed children twice daily, 7 days a week and emergency access to theatres was available out of hours.

Pharmacy support was available at all times via the telephone if out of hours.

Services for children and young people

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week. Children had access to play therapists and a registered mental health nurse Monday to Friday.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw children were empowered and supported to manage their own health. An example was giving children the opportunity to make their own drinks whilst on the wards. We saw leaflets around all departments encouraging healthy eating and weight management.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those over 16 who lacked the capacity to make decisions about their care.

There was a pathway for the management of patients detained under the Mental Health Act. All staff we asked could identify this to us. We spoke to several members of staff including consultants, nurses and junior doctors who understood their responsibilities in relation to paediatric mental health and capacity.

When children, young people or their families could not give consent, staff made decisions in their best interest, considering their wishes, culture and traditions. We heard an example where staff had recently had to alert the safeguarding team and held a multidisciplinary meeting which included the parents in relation to a child's capacity to decide, which showed a good understanding.

The process for consent was monitored and reviewed to ensure it met legal requirements. There were age-appropriate consent forms for under and over 16's and we witnessed all signatures were checked in the wards and in anaesthetic rooms prior to surgery. The check was completed between trained staff, parents and carers or the patient themselves depending on their age.

We saw young people were encouraged to involve their families or carers in decisions around consent. This was standard practice and was noted in the consent process. Staff made sure children, young people and their families consented to treatment based on all the information available. We reviewed the trusts consent policy which included the use of a specific form for patients who lack capacity.

Services for children and young people

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. We saw in guidelines and were assured from speaking with staff that they knew their responsibilities in relation to Gillick competencies and Fraser guidelines. Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust's target. The trust reported that Mental Capacity Act (MCA) training had been completed by 85% of staff within children's service.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. There have been no applications for Deprivation of Liberty Safeguards from Padua ward in the last 12 months.

Is the service caring?

Good 

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

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We interviewed 4 patients and their carers and most reported positively about the care they received within the division. The caring attitude of staff was evident throughout the division and we saw thank you cards and comment books which were positive about the care received.

Children, young people and their families said staff treated them well and with kindness. Throughout our inspection, on the ward, in outpatients and in the NICU and SCBU we observed patients and families being treated with care, compassion and understanding. The parents we spoke with praised medical and nursing staff for the way they communicated with them and we were repeatedly told staff were busy but kind.

Friends and family results for February 2023 showed 37 responses. Of these 89% were positive 8% were negative and 2% neutral.

The diabetes team had an active support and feedback groups, funded by the Paula Carr Diabetes charity. Recently they had a feedback session to gain valuable insight into the children and young people who access the service. This included asking children how the service may be improved. The trust had recently funded a day trip to a local zoo.

Staff followed policy to keep care and treatment confidential. In the NICU parents were given noise cancelling headphones during ward rounds to ensure confidentiality whilst allowing parents to remain with their child.

Services for children and young people

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. The department used videos from parents explaining their experiences within the department so staff could see the positive and negative impact that the service was offering. We saw this was also presented at the monthly governance meeting.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. Staff we spoke with could describe the specific needs of children within the unit and how their needs were met.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Staff involved patients and those close to them in decisions about their care and treatment. All patients, parents and carers we interviewed reported being fully aware of everything that was going to happen. We witnessed staff checking information was understood and asking if patients had any further questions to ask. Staff demonstrated an understanding of how both parents and children were affected emotionally by the need to spend time in hospital, and they ensured support was available to reassure parents and calm patients.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. We witnessed staff supporting a distressed child and their parents and moving them into a calmer area.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The play therapy team was based on the ward to work with patients around anxiety and distress and helped to prepare them for procedures. They were available every day and feedback we saw was unanimously positive.

Staff understood the emotional and social impact a child or young person's care, treatment or condition had on their, and their families, wellbeing. Parents who had children in the NICU could choose which bedding and blankets their children had. This gave them an element of control and empowered them to feel part of their child's care at a difficult time. The blankets and sheets were often donated by parents who had attended the department previously or from local charities.

Palliative care pathways were established by either tertiary hospitals or specialist community teams. We saw evidence these were well communicated and completed with family and key members of staff. On review we found they were comprehensive and ensured all care needs were met as required.

The trust Care after Death Policy for the Acute Setting - Adults, Infants, Children and Young People policy, dated October 2021 included information for the urgent release of the deceased outside out working hours for those patients whose religion requires internment within 24 hours.

Care after death boxes had been updated and included signposting to documents that would be useful in the event of a death of a child.

Services for children and young people

All families were allocated a bereavement key worker who was experienced in caring for and communicating with distressed families. Key workers acted as a named contact for the family and to provide emotional support signpost them to professionals that can assist and guide them through many aspects of bereavement care, including any trust and external investigations.

Parents of multiple births could use a purple butterfly symbol. This aimed to alert health care professionals that their surviving baby/child was part of a multiple birth. A poster explaining the scheme was displayed in all areas where the purple butterfly card is offered to parents. This allowed staff to recognise quickly that a family have suffered the loss of a baby or child.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. On wards, we observed staff going down to the child's level when speaking to them to discuss what the procedure was, what they were going to do before doing it, and asking the child for permission. Conversations were kept at a low level; we noted staff did not use medical terminology when explaining procedures to parents and saw staff took time to play with patients and interact with parents.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. Parents told us staff kept them informed of their child's progress in a way that they could understand, and staff supported them throughout, sharing information clearly and discussing their care plans. We saw evidence in patient records the medical staff had discussed the care plan with parents.

Parents told us they felt included and could ask questions if they did not understand something. Parents also told us staff took the time to ensure that where appropriate, their child also understood the need for treatment and felt included in their care plan.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported children, young people and their families to make advanced decisions about their care. They supported children, young people and their families to make informed decisions about their care. Children accessing the oncology service were supported by the main tertiary provider, t via a service called Young Lives versus Cancer they provided holistic support to children and their families. The community team manage the assessments and signpost accordingly.

Patients gave positive feedback about the service. Consultants and nurses gave parents regular updates on their child, especially after they had been away for a few hours to rest. Parents commented this was much appreciated and reduced the stress they were feeling about missing important information.

Is the service responsive?

Requires Improvement 

Services for children and young people

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

Service delivery to meet the needs of 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.

Managers planned and organised services so they met the changing needs of the local population.

Facilities and premises were appropriate for the services being delivered. Steps had been taken to ensure service provision, environment and atmosphere were young people friendly.

There were separate bays for adolescents within the children's wards with separation of females and males. This included the toilet and bathroom facilities. There were bays for younger children. This separation helped ensure children would feel more at ease and surrounded by their peer group.

There was a separate waiting area for children in the outpatient setting. This had books and toys to keep younger children occupied.

Parents accommodation was available in the NICU. This was provided using needs-based criteria and considered the children's health and distance the parents would have to travel. There was a kitchen available in both areas and shower facilities. Parents who stayed could get reduced parking and meal vouchers to support them. One parent could stay at the bedside of children on the ward.

Patients discharged from the ward were offered open access for 48 hours after discharge. However, this was open access to advice on the telephone. If staff felt the child needed to come into the hospital they would be seen in accident and emergency.

In the NICU parents were given a pack containing relevant information leaflets and details of how to reach the community team. Until recently there was an outreach team to support parents and their babies after discharge. This service received very positive feedback from both staff and parents.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities. The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. Patients had access to differing communication aids which were available through the play therapists. Patient requirements were recorded on admission to the hospital.

Managers ensured children, young people and their families who did not attend appointments were contacted. Consultants were informed of missed appointments and would follow up with a letter initially.

The service relieved pressure on other departments when they could treat children and young people in a day, for example with oncology patients.

Services for children and young people

The Paediatric Oncology Shared Care Unit (POSCU) was based on two inpatients sites. These sites were the QEQM Hospital, and the William Harvey Hospital. The POSCU therefore worked as two hospital-based teams, with inpatient and outpatient facilities for children and families located as conveniently as possible to the child's home. It is also supported by a team of community children's nursing team who provided specialist nursing care, community services and palliative care to children and families from both sites.

Meeting people's individual needs

The service did not always consider children's, young people's individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Although we saw children and young people who had mental health needs were mostly well managed within the department, some children needed one to one care which was provided by an agency support worker. Trust guidance states "The nurse in charge should ensure that an individual member of staff does not undertake a continuous period of enhanced observation for longer than four hours. If enhanced observation is needed for longer than four hours the member of staff should have regular breaks.".

On inspection one agency worker had been delivering one-to-one care for 12-hour shifts for 3 weeks. On the day of inspection, they had a half an hour break for lunch and said this was the same every day unless they needed to toilet.

The same guidance states there are 3 specific modules of training that need to be completed before an agency support worker could undertake this supervision as documented in the enhanced observation for agency workers policy. The agency worker we spoke with had no additional training. Without specific training there is a risk the agency worker would not have the knowledge to safely care for the child.

There was a 'Restrictive Physical Intervention and the Clinical Holding of Children and Young People' policy, dated June 2021. Staff did not receive specific restraint training. The trust had a service level agreement with a provider for security staff in which it stated all security staff were required to be trained in safe restraint and de-escalation techniques. Security staff were only to restrain patients under direct supervision of clinical staff. The practice development team provided the training for nursing staff on clinical holding only. Currently only 41% of staff had completed the training meaning more than half the staff were not up to date with this important skill.

There was no facility to provide education to children who were on the ward. The service did not have a classroom or educator employed by the trust. Although this was not the hospitals obligation to provide education, we would expect they would have a liaison or links with a peripatetic teacher to ensure the needs of children were assessed and the local authority were contacted if needed to provide support.

The Mental Health Act 1983: Code of Practice states all children and young people should receive the same access to educational provision as their peers. The ward had extended stay patients. One had been there for over a month. They had received no education for the entire period this could lead to children being unable to sit exams and restrict their future education.

The local County Council do not have peripatetic teachers; they rely on the children's school or a referral into the Kent Health Education Needs Service. The department have laptops and an iPad which the children can use to facilitate schoolwork or to link with virtual classrooms if needed.

Services for children and young people

Wards were designed to meet the needs of children, young people and their families. We saw there was a cubicle available if a patient required an isolated environment.

Staff used transition plans to support young people moving on to adult services. However, there was no specific transition lead. Staff reported working well with consultants to ensure a smooth transition, and there was an up-to-date policy on this which we reviewed. However, with no lead in place this could lead to inconsistent practice and lack of oversight.

There were no paediatric physiotherapists employed by the trust. The adult team would assist if appropriate. We were told about Cystic Fibrosis patients who had physiotherapists from a different NHS hospital attend to them on the ward after it was agreed they were needed. This could mean children were not always getting paediatric targeted physiotherapy to help their recovery in a timely manner.

That lack of physiotherapy care is on the trust risk register. Children with Cystic Fibrosis were not receiving adequate physiotherapy care (airway clearance) during inpatient stays, causing increased length of stay and a negative effect on long term health outcomes. This risk continues, there has been no change or improvement from the therapy department. The children's ward staff were reminded regularly to complete incident forms to raise concerns when children with Cystic Fibrosis needs had not been met.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. We were told about many recent reasonable adjustments the division had made, examples included appointments arranged at times that were quiet for anxious patients and providing easy read or pictures for patients for communication.

The service had information leaflets available in languages spoken by the children, young people, their families and local community. Staff could access translators via the telephone and did not use family members to translate. Additional needs were identified on the initial risk assessment.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences.

Ward rounds took place twice a day. This included the night staff on the ward handing over any cases where there were concerns about the condition of children and young people in the late evening and any admissions. Daily handovers were attended by a wide range of disciplines, including play specialists who planned focused play sessions depending on the needs of the child and were on the wards daily.

We were told that the RMNs were a valuable resource and integral to the smooth running of the service. The division had one registered mental health nurse who managed the care of patients who needed extra support with mental health. There was a clear pathway of management and staff fully understood this. Child and Adolescent Mental Health Services were available daily to assess and support individualising specific pathways of care. The hospital crisis team were available 24 hours a day and usually responded within 4 hours or sooner in an emergency.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Services for children and young people

Managers and staff worked to make sure children and young people did not stay longer than they needed to. People could access the service when they needed it. Waiting times from treatment were in line with guidance and arrangements to admit, treat and discharge patients, were in line with good practice.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. Referral to treatment (RTT) performance is measured across the whole of the child health care group and was not reported for the William Harvey Hospital in isolation. The RTT performance included all services within the care group, acute and community, where a referral was received into a consultant lead service. The current RTT performance had improved from a low of 88%in August 2022 to 98.7% in April 2023. The national performance target is 95% which showed the department was delivering care slightly above national targets.

The NICU maintained a stabilisation space for patients at all times and therefore did not close. The NICU had an operational plan in place to stabilise and transfer any further admissions 66 times in the past 12 months, of these 57 times were due to capacity issues and the other 9 times staffing was the reason. The neonatal team had a manager on call at all times to support this operational escalation.

The service moved children and young people only when there was a clear medical reason or in their best interest. These were monitored monthly, for example we saw there were discharges to other NHS/non-NHS providers from across the CYP 3 times in January 2023.

Managers and staff started planning each child and young person's discharge as early as possible. The service aimed to discharge within 2.5 days. However, on average this target was only met for 2 months from May 2022 to April 2023. Staff told us this was due to the number of long-stay children, particularly those with eating disorders and disordered eating. Recently this accounted for 25% of beds on the children’s ward. The department did not have an audit specifically related to delayed discharge.

Managers monitored the number of children and young people whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The ward had a scheme called “the Golden Discharge” where patients who were expected to be discharged the following day, were identified on the ward handover sheet, which both doctors and nurses used. The aim of identifying these children was that the electronic discharge notification, medicines and discharge paperwork, were completed overnight, so the child’s discharge could be arranged the following morning.

Staff supported children, young people and their families when they were referred or transferred between services. Oncology medical staff were flexible in their working and would provide care at home if appropriate. For example, a child was seen at home after becoming unwell from a medicine they were taking and the oncologist visited them at home to avoid a hospital visit.

Managers monitored patient transfers and followed national standards. Children were admitted to wards through accident and emergency or GP referral. The division had an area used as a children’s assessment unit (CAU) at the time of inspection. However, the division had plans to relocate the CAU unit to the accident and emergency department. This unit would be staffed separately and provide a better flow for patients through the division.

Children were held on a separate paediatric surgical list so there was no need to prioritise over any adults as they had a separate pathway. Surgery waiting times were dependent on the urgency of the surgery, for example those in urgent need could be operated on immediately.

Services for children and young people

Children who had urgent mental health needs were seen promptly by either the registered mental health nurse in the department or in accident and emergency. There were good links with local GP, and they could call the paediatric registrar (who held a bleep) for telephone advice or could directly contact the consultant in charge.

If a child presented with unscheduled care needs, parents and carers were provided with both verbal and written safety information. A discharge summary was also sent to GP's and any other relevant healthcare professional.

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 service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. We saw information on how to raise a complaint was easily available to patients. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. There had been 12 formal complaints to the children's services since June 2022. The trust aims to respond to these within 45 days. Of the 12 formal complaints 50% had been responded to within 45 days.

Managers investigated complaints and identified themes. These were discussed in several meetings and committees and response times monitored.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. The quality lead assigned complaints to relevant staff members for follow up, and regular updates were fed into meetings.

Managers shared feedback from complaints with staff and learning was used to improve the service. Daily huddles and weekly newsletters contained information on learning from complaints.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. Leaders did not always understand and manage the priorities and issues the service faced. They were visible and approachable in the service for staff. They did not always support staff to develop their skills and take on more senior roles.

Services for children and young people

Children and young people's (CYP) services reported into the child healthcare division, led by a triumvirate with a mixture of medical, nursing and operational senior leaders. This included the head of nursing, operations director and clinical director (currently a vacancy for this position). Each contributed different skills to enable them to lead the service. The division was responsible for a wide portfolio of services, At the time of inspection, the CYP care group was responsible for acute paediatrics, NICU/SCBU and community child health.

Leaders were not always aware of the risks, issues and challenges in the service. Although there was access to the board through a series of meetings and committees some issues within the service had not been given adequate importance. Over the course of inspection and from information we received before and after our site visit, we found several members of staff felt they were not listened to. They had raised issues and potential improvements several times before they felt heard. We saw this evidenced in meeting minutes, where the same issues were raised through several meetings with no specific action to make any changes or specific recommendations followed up. Examples included issues with the integration of IT systems and follow up on quality improvement projects. Also, staff training particularly around resuscitation training and APLS/EPLS training.

New members of the leadership team had started to bring about changes and staff were optimistic about the future of the division. During this inspection we saw the trust had managers at all levels with the right skills and abilities to run a service.

Some staff, but not all, felt leaders were visible and approachable. During our inspection we observed managers and leaders were visible in clinical areas and observed them undertaking clinical activities to support staff and patients. Junior medical and middle grade medical staff described their seniors to be approachable, available and supportive. However, we did receive some reports of staff feeling unable to approach certain members of the leadership team and choosing to report to different staff members who they felt were more approachable. Others felt leaders did not fully understand the pressures staff were under and they did not always feel listened to.

Some senior staff we spoke with understood the challenges and could identify what changes were needed to address them. An example of this was the planned move of the children's assessment unit to the accident and emergency department to help with the flow and staffing throughout the division.

Staff did not always understand the decisions made about the department. Recently an outreach service offered by the NICU and SCBU was stopped. Staff felt this was a valuable and important service, which supported both parents and the department. Some staff were unclear why the service had been stopped. We were told this had meant staff left the service as they felt the needs of patients were not being considered and staff had not been involved in the decision to stop the outreach programme.

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. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. We did not see evidence how the strategy was monitored for progress.

It was not clear how leaders at all levels were held to account for the delivery of the strategy. The strategy was aligned to local plans in the wider health and social care economy to meet the needs of the local population. The trust had a group model approach with other acute hospitals in the area. The strategy outlined plans to develop a group model for CYP services including the development of shared paediatric pathways across hospitals. The service worked with the local integrated care board in developing community and acute paediatric pathways with community services including children and adolescent mental health services.

Services for children and young people

The Children's Care Group was realigned in 2021, with the leadership structure comprising of clinician's professionally supported by operational management teams with the sole purpose of focusing on children's health.

The vision of the department was "To provide a holistic service that puts our infants, children and young people at the heart of what we do."

The trust had 'We care' values developed using feedback from staff, patients and stakeholders with the aim to deliver "great healthcare from great people."

Staff were mostly aware of the trust vision and the departmental strategy and felt they could have their say and voice their opinion through team meetings and line managers.

Staff received information through the trusts newsletter and said that daily huddles were also used to give updates. There was a 'Golden Hearts' scheme which allowed staff to nominate colleagues who had made a big difference and who lived the trust's values.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most staff felt respected, supported and valued. Most staff described being under significant pressure, particularly at the time just before our inspection, when the service experienced unprecedented demand, and during the summer when staffing vacancies were particularly high.

Medical staff we spoke to told us they felt supported and valued. Some nursing staff did not always feel their feedback was respected or listened to, resulting in them feeling demotivated. For example, some staff felt there was unfairness in how shifts were allocated and did not always feel managers recognised their personal circumstances when planning the rota.

Staff were focused on the needs of patients receiving care and were passionate about their role in caring and treating children and young people. Whilst most staff commented on the pressures in their role, they described positive team working with colleagues of different professions. We observed respectful conversations take place between medical and nursing staff, demonstrating a collaborative approach to patient care and treatment.

A variety of tools were used across the child health care group to promote a positive culture. These included learning slides from incidents, complaints and RCA's which were circulated in governance slides to all staff.

The trust had a values and behaviours leaflet which had information on care group training sessions. These included sessions on using the Situation, Behaviour, Impact, Change or Continue (SBIC) tool. The SBIC tool was used to give feedback about behaviours and was a model for challenging poor behaviours.

The service had long service awards, employees that have worked for 25 years of continuous service with East Kent Hospitals will receive a gift voucher and those who have an aggregated NHS Service for 20, 25, 30 and 40 years will receive a milestone long service badge.

The department sent out weekly 'The Week That Was' emails for all staff. We reviewed 3 of these, in May 2023 the email highlighted staffing recruitment, praised staff during a particularly busy shift and gave staff advanced warning of closing specific areas withing the hospital for building works.

Staff could nominate colleagues for an Encouraging Praise in Colleagues (EPiC) award. A consultant recently nominated the whole team on Padua ward for supporting them through tough and busy shifts.

Governance

Governance processes were not always effective within the service. The department worked well 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.

Some areas of governance were not effective. Although there were several meetings and committees to discuss issues and performance, these were not always addressed in a timely manner. The service had failed to address the extremely low rates of training for medical and nursing staff in key safety areas and there was no plan to address this. The same issue with availability of training had been reported several months prior to inspection and had still not been managed. The lack of specific and lifesaving skills may have been affecting the ability of staff to recognise and escalate concerns, specifically around deteriorating children and babies. On reviewing data given to us after inspection we saw opportunities had been missed to escalate deteriorating children on occasions and despite this being highlighted in the investigations there had still been no progress against developing and training staff in key skills, in line with trust targets.

The service was not monitoring surgical site infections (SSI). Currently the Trust's SSI service covers the mandatory requirement of reporting infection related to hip and knee joint replacements and Neck of Femur Fracture. Although this is not a requirement in children's surgery it could mean the service is missing themes and trends. They were unable to provide us information on how many children may have had SSI after operations.

Monthly meetings were held in the divisions which fed back to the trust quality and safety committee. Meetings were also held weekly between management across the division which ensured oversight and allowed for feedback and to review incidents and complaints.

There was a monthly governance presentation which showed data on a variety of indicators such as staffing, paediatric specific safety, medicines optimisation, incidents and complaints. There were several ways for staff to receive and give feedback both to the leadership team and back down to frontline staff. There were monthly meetings for infection prevention and control, audits and national guidelines and the children's committee meeting.

Following the national review of paediatric critical care and paediatric surgery the South Thames Paediatric Network (STPN) was set up in September 2018. The STPN board has representation from each region South London, Kent, Surrey and Sussex and was formed of Operational Delivery Networks (ODNs). The aim of the network was to ensure all children in the region had equal access to excellent care and that the workforce was supported to meet future demands. The trust was represented on the STPN Board and the STPN Governance forum.

We saw standardised practice was shared across the network including the Safe Transfer of Paediatric Patients (STOPP) tool, preassessment and sedation guidelines. The guidelines were adapted to ensure they were appropriate for CYP and shared across the network. This was a good example of best practice and shared learning.

Services for children and young people

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified any relevant risks and issues and identified actions to reduce their impact but often these were not progressed in a timely manner.

The top risk on the departments risk register were children with Cystic Fibrosis receiving adequate physiotherapy care, registrars not being UK trained and staff vacancies within the registrar's rota at the QEQM hospital. Cystic fibrosis is an inherited condition which causes sticky mucus to build up in the lungs and digestive system. Children with Cystic Fibrosis are not receiving adequate physiotherapy care (airway clearance) during inpatient stays. This could lead to increased length of stay and a negative effect on long term health outcomes for children with cystic fibrosis. There was currently no onsite physiotherapist employed to work at the trust. This had been on the risk register since December 2022 (6 months) and had not been progressed, despite the rating of high risk. To mitigate the service suggested they used the play therapist/ leaders on the ward encourage children to take part in active sessions during their admission. Ward staff should contact the on-call physiotherapy team and refer the inpatient to them as normal procedure. Young people or their parents/carers were expected to complete physiotherapy sessions during inpatient stays.

Physiotherapy services within the trust were noted to be inadequate on the risk register, this required prioritising of workload within the trust. It was felt that children's health was not being prioritised in relation to this.

Although we saw risks were discussed and raised through several meetings, there was no plan in place to address some specific issues within the department. For example, there was a risk register entry which highlighted the lack of pharmacy support in the NICU. We saw several medicines management issues noted in meeting minutes and learning from incident feedback. This included missed and wrong doses, incorrect drug chart completion and prescribing errors on the drug chart. In January 2023 examples included administering of Docusate liquid which was prescribed in millimetres and without a strength and intravenous Gentamicin given to baby 24 hours early. Gentamicin is used to treat certain serious infections caused by bacteria such as meningitis and Docusate is used to prevent and treat constipation.

Although we saw good governance around reporting and sharing medicines errors, lack of pharmacy support had been on the risk register since October 2022. Neonates had pharmacy provision at all times but not a dedicated neonatal pharmacist. This showed a lack of urgency to address this risk, especially considering the number and frequency of medication management issues.

The department had an embedded mortality and morbidity review process. Two mortality meetings took place following every neonatal death. The first used the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) national perinatal mortality review tool. The neonatal team, the obstetric and midwifery team and bereavement nurses/midwives attended alongside an external medical and nursing reviewer. Three reports we reviewed evidenced learning and action points. Parental views were captured and presented by the bereavement key worker to ensure that the voice of the family was heard. The bereavement key worker then supported the return of the report to the family.

The second neonatal mortality meeting was held by the unit team and shared with the Kent, Surrey and Sussex (South East) Neonatal Operational Delivery Network and Kent and Medway Child Death Review Team.

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.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. There had been issues with the integration of some IT systems and there had been frustration raised to inspectors during inspection. Some staff felt there was not enough support after new systems had been introduced and issues were not being addressed to fit in with the specific needs for paediatric services.

Records were managed securely. We saw computer screens were shielded from public view behind nurse stations. Any notice boards checked did not contain patient identifiable information.

Separate rooms were available in all areas for staff meetings and handovers ensuring patients confidentiality was maintained.

We spoke to staff throughout the division who could explain and demonstrate how to access information through the trust's comprehensive intranet pages. This was accessible to all staff including agency staff who were given a login as part of their induction. This ensured staff could access up to date policies, guidance and training opportunities. They could also access safeguarding information and contact details for internal and external professionals if needed.

We saw test results and x-rays were also available online for instant review by consultants. The online system allowed staff to access real time monitors, blood gas machine results, and laboratory results. This enabled information sharing between staff and other centres and national databases.

Engagement

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

In response to patient feedback and with the maternity improvement project, the head of midwifery and neonatal matron worked with bereaved families to develop a maternity and neonatal bereavement service. The aim of the service was to ensure that all bereaved families had access to a health care professional to offer them dedicated support and guidance following pregnancy loss, stillbirth or neonatal death. This was developed using the guiding principles of the national bereavement care pathway. This included supporting previously bereaved parents through their subsequent pregnancy.

Families were involved in the development of the service and the submission of the business case, formulation of job descriptions, interviewing prospective team members, developing guidelines and pathways, guiding staff education days and supporting opportunities for memory making.

There was a series of newsletters and messages of the week delivered to all staff. All staff were emailed the ‘Week That Was’ which delivered positive feedback, learning points and updates.

The triumvirate held ‘Your Voice’ sessions via teams, these were open to all staff within the care group who could ask questions, raise concerns and gain feedback from the leadership team.

A patient experience committee met monthly and produced quarterly reports for the service. These formed part of the monthly governance presentation

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Services for children and young people

The service implemented a new technology trial for finding veins in CYP following a complaint from a child and parent related to taking bloods. The new technology increased first attempt success and reduced escalation calls. It also helped catheters last for the duration of therapy. The equipment had been purchased by charity funding and would be in use within 3 months.

The trust had an active and dedicated diabetes team who had been involved in improving diabetes care for CYP both regionally and nationally. This included leading regional projects, such as unifying guidance on hypoglycaemia treatment and work on the AIM stream for education (AIM streams are elements of the national CYP diabetes network delivery plan for 2020-2025). The team participated in the development of a document to ensure equity of specialist support within educational settings for CYP with diabetes, published in May 2023.

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 but did not ensure everyone completed it.

Staff across all roles did not always receive and keep up-to-date with their mandatory training. The trust target for attendance at mandatory training was 91%. On average 75% of staff had attended mandatory training.

Only 26% of medical and dental staff had attended adult basic life support training. The trust could not be assured that medical and dental staff had the most up-to-date training when attending an adult patient who needed basic life support.

The mandatory training was comprehensive and met the needs of patients and staff. The mandatory training was aligned to the key skills in health and met the needs of patients and staff. The trust offered clinical staff training on learning disabilities, autism and dementia and on recognising and responding to patients with mental health needs. Records showed that 85% of nursing staff had completed the training, but only 50% of medical staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers used an electronic dashboard to monitor staff compliance with mandatory training. Individual teams discussed mandatory training at their monthly meetings and staff were emailed 90 days before the training expired to book onto the training. The ward managers assistant was responsible for maintaining the electronic dashboard.

Medicine had set up a method of monitoring and escalation for leaders to follow in their area, the figures indicate the process was not as effective as it could be.

Following our inspection we issued a warning notice, which included concerns around the completion of mandatory training, such as basic life support training, safeguarding adults level 2 and safeguarding children level 2 training. The trust has supplied us with more information that showed improvement in the mandatory training figures.

Safeguarding

Most staff understood how to protect patients 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 staff received training specific for their role on how to recognise and report abuse. The trust target for attending safeguarding training was 91%. At the time of inspection 76% of nurses had attended level 2 adults safeguarding training and 62% of nurses had attended level 3 adult safeguarding training. All nurses had completed level 1 childrens

safeguarding training and 76% of nurses had completed level 2 childrens safeguarding training. Most staff we spoke with during the inspection could tell us what a safeguarding concern was. All staff we spoke with knew the process of reporting a safeguarding and showed us the documentation involved and the trust intranet site with safeguarding information.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had a good knowledge of what constituted harassment and discrimination. They understood protected characteristics. Staff told us that patients were treated equally regardless of gender, race, religion or any other protected characteristic. We reviewed the documentation for 2 patients with protected characteristics and found them both to be fully completed. The protected characteristics defined by the Equality Act are: age, sex, race (including ethnicity and nationality), disability, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity and marriage or civil partnership.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Most staff described the types of abuse adults and children could be at risk of; for example, physical, emotional, financial and including female genital mutilation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Ward areas displayed boards which had information on what to do if staff had a safeguarding concern. In addition, we were shown the local intranet page which had information on what abuse was and the process to follow if staff suspected abuse had occurred. Staff had access to an up-to-date guidance policy, via the internal intranet, called Safeguarding Vulnerable Adults. They also had access to a policy for Safeguarding Vulnerable Children.

Cleanliness, infection control and hygiene

The service did not always prevent infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. Not all equipment or premises were visibly clean.

The hospital had an infection, prevention and control team who had primary responsibility for providing advice and expertise in all aspects of infection prevention and control. There was an antimicrobial stewardship group which included a representative from the pharmacy team.

Not all ward areas were clean or had suitable furnishings which were clean and well-maintained. In the acute medical unit, the flooring and furnishings had multiple repairs with duct tape. The toilets and washing areas for patients were dirty and we observed unflushed waste and soiled pads left on top of general waste bins. We checked the area after 2 hours and found nothing had been cleared up. Each ward area had allocated domestic staff who had a cleaning regime to follow during their shift.

Showers were either being used as storerooms or were not in use. The medical assessment units were clean, and the furnishings were in a good state of repair.

Flooring on Cambridge K Ward was old and worn. Staff told us this flooring had asbestos underneath and could not be replaced. Cambridge L Ward was very cluttered and untidy which made accessing emergency equipment difficult. On Cambridge L Ward we observed 3 trays of cold food left over from lunch stacked by a clinical hand washing sink in 1 of the patient bays. Kennington and Cambridge K Wards were clean and tidy with no clutter in the corridors.

Medical care (including older people's care)

Ward managers collected electronic data on the fundamentals of care which included infection prevention and control. Concerns were escalated to the matrons and heads of nursing and action plans to address any issues were developed and monitored. Staff had access to policies and procedures, via the internal intranet, called National Infection Prevention and Control Manual for England. This policy was up-to-date and was reviewed as needed.

The service monitored the number of patients who had hospital acquired infections such as Meticillin-resistant Staphylococcus aureus (MRSA), c-difficile, pseudomonas aeruginosa, meticillin-susceptible staphylococcus aureus (MSSA), e-coli and klebsiella. A hospital-acquired infection is an infection that is acquired in a hospital or other healthcare facility. Records showed low rates of the following infections in the 12 months before the inspection; 3 cases of c-difficile, 2 cases of pseudomonas aeruginosa, 2 cases of MSSA, 1 case of e-coli and 1 case of klebsiella. There had not been any MRSA in the period. Records showed that all cases of these infections had been investigated by a root cause analysis investigation. An action plan was developed and implemented to prevent a reoccurrence of the infection.

Cleaning records were up-to-date and demonstrated that cleaning was performed regularly. All areas except the Acute Medical Unit were visibly clean. Cleanliness of the clinical areas was audited by the head of nursing for that area. Records showed all areas of infection prevention and control were covered as part of the audit. Action plans had been developed to drive improvements and progress was monitored in monthly review meetings.

Monthly audits were used to monitor staff compliance with hand hygiene, hand decontamination and the use of personal protective equipment. All wards had scored between 93 and 100% in the 3 months before the inspection.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). PPE, including surgical facemasks, nitrile gloves and plastic aprons, were available in all areas we inspected. On the acute medical unit patients with infectious illnesses were cared for in private rooms. We observed doors that should have remained closed to prevent the spread of infection, were left open. We saw staff walk in and out of the rooms without changing PPE or washing their hands. This posed a risk of infection being transmitted to staff and other patients. The cleaning staff also cleaned the rooms with the same mop as non-infectious areas and did not change PPE when entering and exiting the single rooms. This was reported to the nurse in charge on the day of the inspection.

Clinical handwashing sinks and alcohol hand gel were available in all areas we visited. On the day of inspection some staff did not clean their hands in accordance with the World Health Organisation 5 moments of hand hygiene. The 5 moments of hand hygiene instruct clinical staff to wash or decontaminate their hands before and after patient contact, after exposure to bodily fluids, before a clean or aseptic procedure and after contact with the patients' surroundings. There were hand hygiene stations outside ward areas and at regular intervals inside the ward areas. Each hand hygiene station displayed instructions for washing hands, the 5 moments of hand hygiene, alcohol gel and soap and a clinical sink. Staff on the Acute Medical Unit and Cambridge L Ward and Cambridge 2 Ward were observed wearing the same pair of nitrile gloves with multiple patients. This risked spreading infection between patients. This was reported to the nurse in charge on the day of the inspection.

Cambridge K Ward and other areas in the hospital where systemic anti-cancer therapies were administered was the exception and we saw all staff follow correct hand hygiene practices. All patients had been issued a pack of disposable hand hygiene wipes. The packs were accessible to patients on their table next to the bed.

Staff did not always clean equipment after patient contact or label equipment to show when it was last cleaned. Although the staff had access to 'I am clean' stickers,' not all areas we visited were using them. Staff could not be sure

the equipment had been cleaned before using it with a patient. Staff did not always clean equipment such as blood pressure machines in between individual patient use. There was a risk of cross-contamination when sharing equipment, which had not been cleaned. We observed the 'I am clean' stickers in use on Kennington Ward and Cambridge K Ward and observed staff decontaminating equipment in between patient use.

Endoscopes, used for diagnostic procedures were noted to be cleaned and decontaminated in line with national guidance: the Health Technical Memorandum on decontamination.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not manage clinical waste well.

Patients could reach call bells, but staff did not always respond quickly when called. We observed that patients were left with call bells within reach but were often waiting more than 20 minutes for staff to respond. This could be distressing for patients if they needed the toilet.

The design of the environment followed national guidance. All areas had been designed to meet DH Health Building Notes 04-01. Each bed area had piped oxygen, which was compliant with the health and safety executive directive oxygen in the workplace. Fire exits were clearly marked, and some fire extinguishers had relevant checks completed. However, on the day of inspection we saw 1 fire extinguisher that should have been checked in 2019. We could not find evidence of internal fire extinguisher safety checks as the hospital relied on the contractor to check the fire equipment. In addition, on Richard Stevens Ward we found a boarded patient obstructing a fire exit. This was brought to the attention of the nurse in charge who ensured the patient bed was moved and the fire exit unobstructed.

All wards had a locked entry door system; visitors needed to be admitted by staff after pressing an entry buzzer. Visitors told us there was no delay in being admitted to the wards. During the inspection we found chlorine tablets in unlocked cupboards in the sluice areas of all wards. The sluice doors were not locked and could be accessed by those without the authority to do so. These tablets are controlled by Control of Substances Hazardous to Health Regulations (2002) and should be stored in a locked cupboard to prevent harm to the public. Staff told us they were not used and were not sure why they were still on the ward.

Staff did not always carry out daily safety checks of specialist equipment. On the acute medical unit emergency equipment checks were missing 5 out of 14 checks for the 2 weeks before inspection for both emergency trolleys. Although the trolley had a security tag in place to show all drawers were locked, we were able to open a drawer that should have been locked to stop unauthorised access to drugs and equipment in the emergency equipment trolley without removing the security tag.

The service had enough suitable equipment to help them to safely care for patients. Staff told us there was no issue getting the equipment they needed to safely care for patients.

Staff did not dispose of clinical waste safely. In all areas we visited, waste was not separated correctly. We found infectious waste in the general waste bins and in recycling waste bins, which could result in waste being disposed of in unsafe ways. Waste was collected regularly from ward areas and stored in a locked bin store while awaiting disposal.

In areas where systemic anti-cancer therapies were administered all clinical waste was disposed of correctly. Staff were aware of what action to take in the event of a cytotoxic spillage. Staff had access to a guidance policy, via the internal intranet, called Systemic Anti-Cancer Pathway Therapy Care Pathway. This policy was up-to-date and was due to be reviewed in October 2024.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. We reviewed 10 patient records and found the scores were completed correctly. When a concerning score had been calculated the patient would be escalated for medical review. During the day the wards had medical doctors to review patient and out of hours the wards were supported by an outreach team who specialised in caring for deteriorating patients. The outreach team could monitor NEWS2 scores remotely and did not need to be alerted to review the patient.

The trust educated staff on caring for deteriorating patients and patients who may have sepsis as part of the General and Specialist Medicine' Fundamentals of Care course. It was also included in the induction of new clinical staff. Seventy five percent of clinical staff had received training in care for septic or deteriorating patients. Staff had access to an up-to-date guidance policy, via the internal intranet, called Management of the Deteriorating Adult Patient. Senior nurses audited the care pathways of patients suspected of having sepsis and patients whose NEWS2 scores indicated their condition was deteriorating to check all actions had been taken correctly by the clinical team looking after them. Records showed that the correct actions had been taken but not always documented on the electronic system.

Staff completed risk assessments for each patient on admission to the hospital using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with any specific risk issues. The patient record included a range of risk assessments which included – falls, pressure areas, sepsis, nutrition and venous thromboembolism (VTE). Staff knew about and dealt with any specific risk issues. We reviewed 10 records during the inspection and found them to be completed correctly. The hospital had implemented a sepsis care bundle which educated staff on the risks of sepsis in patients. Sepsis is a life-threatening reaction to an infection.

Patients at risk of falls, wandering or had challenging behaviours had a one-to-one nurse with them most of the time. The hospital booked agency or bank staff in addition to the planned staffing numbers so care was not compromised for the rest of the ward. Cambridge K Ward had a high number of patients needing constant supervision and had liaised closely with the nursing agencies to provide them with a bespoke service that met their needs.

The acute oncology team worked with the wards and emergency department to educate staff about the risk of patients having a systemic anti-cancer treatment such as chemotherapy developing neutropenic sepsis. Neutropenic sepsis is a life-threatening condition which needs antibiotic treatment started within an hour of presenting at the hospital. Patients at risk were given an alert card to show staff in the emergency department and a prefilled prescription for antibiotics. Posters displayed by the acute oncology team gave information to clinicians on how to treat the condition and who to call for support. In the 4 months before the inspection 3 out of the 4 months 100% of patients attending with neutropenic sepsis where given antibiotics within an hour of arriving at hospital. Staff also had access to a guidance policy, via the internal intranet, called Neutropenic Sepsis Management Guidelines. This policy was published in February 2023 but did not have a date for review. It is good practice for a guideline to have a review date to ensure that it contains the most recent guidelines for staff to refer to.

Medical care (including older people's care)

The hospital had a range of local safety standards for invasive procedures as a reference for staff. Radiology staff used a World Health Organisation safety checklist before each procedure; use of the checklist was audited and in the last 3 months, compliance with the checklist showed poor completion rates. The compliance was March 64%, April 41% and May 86%. There was an action plan in place to improve compliance rates.

The hospital had a risk assessment to use when the inpatient wards were used as escalation areas. The risk assessment had a list of actions to take to keep patients safe. On Richard Stevens Ward we saw a boarded patient whose bed was blocking a fire exit. Boarded patients were being cared for in the corridor and did not have an allocated bed space. On Kennington Ward a boarded patient was being examined by a doctor in the corridor without any privacy screens in place. These observations showed the risk assessments were not effective in ensuring patients were safe.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. The local mental health trust provided a mental health liaison service which could be accessed via a pager 24 hours a day. Staff told us the mental health liaison team were always responsive when called. We observed the interaction between the mental health liaison team and ward staff and saw the team working for the benefit of the patient. Staff also had access to guidance policies, via the internal intranet, called de-escalation and rapid tranquilization of adults in acute hospital settings and all age clinical restraint, restrictive and safe holding policies. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The trained nurses completed the enhanced care needs assessment tool which produced a red, amber or green score according to the patients' needs and the staff followed the appropriate actions for the level of need identified. Staff told us the tool was reassessed when the patient behaviour changed or when a patient changed wards. Staff had access to a guidance policy, via the internal intranet, called Provision of Enhanced Care and Supervision for Adult Patients. This policy was up-to-date and was due to be reviewed in June 2026. Staff also had access to a guidance policy, via the internal intranet, called Ligature Risk Assessment Policy. Staff we spoke with were knowledgeable in the care of patients thought to be at risk of self-harm or suicide and knew how to get specialist help when needed.

Staff shared key information to keep patients safe when handing over their care to others. Staff used a handover sheet to record key information when handing over care to other staff. When moving wards, an electronic handover was given to the receiving ward. The electronic patient notes were available in real time to all staff. For complex patients there would be a call between wards to discuss the issues.

Shift changes and handovers included all necessary key information to keep patients safe. Each area had a safety huddle twice a day. All staff on duty attended the huddle and were updated on all key information. We observed several huddles during the inspection and saw there was a standard agenda. This covered for example: staff wellbeing and staff numbers; patient infection status (covid), and incidents or events for learning. They also discussed patients with high risk of falls; frail skin; nutritional needs; those with a high NEWS score and patients under deprivation of liberty safeguards (DoLS). Additional information discussed included; audits and surveys to be completed; end of life patients; patients for discharge, any new patients and any issues with facilities and estates.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients 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.

Medical care (including older people's care)

The service did not always have enough nursing and support staff to keep patients safe. On the day of inspection, the acute medical unit had 8 trained nurses and 5 clinical support workers on duty. The unit should have been staffed to 11 trained nurses and 7 clinical support workers. Staff told us this often happened and staff were worried the care they did give did not keep patients safe from avoidable harm or provide the right care and treatment. The low numbers were related to staff sickness and the vacancy rate on the ward.

Each cancer tumour site had a clinical nurse specialist and a pathway coordinator to care for cancer patients.

Managers 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 ward manager could adjust staffing levels daily according to the needs of patients. Staff told us the hospital used a nationally recognised tool to monitor staffing levels every shift. Staff would be deployed to other areas with low staffing numbers to maintain a safe staffing level. This could be frustrating for well-staffed areas as staff based there were continually moved away from that ward. Staff told us this affected team morale. This left the well-staff area short of staff for the rest of the shift. There was no evidence of actual patient harm due to the reduced numbers of staff.

Staff had access to a guidance policy, via the internal intranet, called Nursing and Midwifery Safe Staffing Policy. This policy was up-to-date and was due to be reviewed in August 2024.

The number of nurses and healthcare assistants did not always match the planned numbers. Staff told us they often worked in different areas to increase staffing levels to a safe amount. Staff understood the reason why but felt unsettled by having to change areas of work without much notice.

In some areas the service had low turnover rates. For example, the Cambridge M1 Ward had a turnover rate of 2.57%. However, Cambridge K Ward had a turnover rate of 14.7% and Richard Stevens Ward had a turnover rate of 10.42%. Staff we spoke to told us the team they worked with, and job satisfaction were the main reasons for not leaving.

The service had low sickness rates. Most medical wards had a sickness rate of 4% or under. The Medical Day Unit was an exception and had a sickness rate of 17.91%.

The service had high rates of bank and agency nurses used on the wards. In the 12 months before the inspection records showed the service had used 434,514 hours of bank staff and 225,210 hours of agency staff. Most bank staff were employed to provide one-to-one care of patients with addition needs.

Managers limited bank and agency staff to staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. During the inspection staff could describe how they orientated a temporary member of staff to ensure patients were kept safe. Staffing issues were discussed monthly at the trust board meeting and actions were agreed to make any necessary changes. Agency staff on duty told us there had been a full induction and they were orientated to the ward area at the start of the shift. There was no paper record to confirm this had happened. Managers told us they tried to block book agency staff to provide some continuity for the patients and teams.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients 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.

Medical care (including older people's care)

The service had enough medical staff to keep patients safe. The service always had a consultant on call during evenings and weekends. The acute medical unit had 6 consultants and 2 locum consultants. There were no consultants in the hospital overnight and the unit operated an on-call system. All on call consultants could reach the unit within 30 minutes of being called. The consultants on call could sleep on site if needed.

The medical staff matched the planned number. Records showed that medical rotas were filled as planned. Managers could access 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 low vacancy, turnover and sickness rates for medical staff. Doctors told us they generally had enough staff. Records showed that the service had low vacancy, turnover and sickness rates for junior doctors and a recruitment campaign was in place to recruit medical consultants.

The service had a high use of bank and locum staff. Records showed that in the 12 months before inspection the medical staff had used 40211.01 hours of bank staff and 67027.5 agency staff.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Medical staff told us that rotas were reviewed regularly during each shift and staff moved to areas of need.

Records

Staff kept records of patients' care and treatment. Records were clear and easily available to all staff providing care but were not always stored securely or up to date.

Patient notes were not always accurate, but all staff could access them easily. During the inspection we reviewed a selection of 10 notes and found records were clear. However, they were not up to date as the staff often documented care retrospectively. For example, there was a patient with an ungradable pressure ulcer who needed turning every 2 hours. There had not been a documented turn for 5 hours. When this was discussed with the nurse, we were told the turn had been done but not yet documented.

When patients transferred to a new team, there were no delays in staff accessing their records. Patient notes were electronic and could be accessed from any terminal in the hospital. Nursing notes were kept in paper format.

Records were not always stored securely. In the acute medical unit 7 out of 8 computers on wheels (COW) were unlocked and left unattended. In addition, we saw an unattended trolley of confidential patient records near the nurse's station. Because of this, there was a risk of unauthorised access to confidential medical information. On the wards the COWs were locked when not in use and we did not find any unattended notes.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff could not always follow systems and processes when safely prescribing, administering, recording, and storing medicines. For example, appropriate medicines storage was not always available on escalation wards and clinical pharmacy support was limited.

Some staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. However, staff told us they were concerned that escalation wards did not receive clinical pharmacy support.

Medical care (including older people's care)

Staff could not always store and manage all medicines and prescribing documents in line with the provider's policy. Whilst medicines were stored and managed safely on the general medical wards, appropriate medicines storage and computers on wheels (COWs) with medicines storage were not consistently available on escalation wards. Medicines, when needed, were obtained from surrounding wards. We saw medical gas equipment on escalation wards was not always managed safely, for example piped medical air was accessible and planned preventive maintenance for medical gas regulators was overdue.

The weekend before the inspection across the hospital most adult medicines charts had been transcribed from paper medicines charts to the computer e-prescribing and medicines administration (EPMA) system. Therefore, we did not review the prescribing and administration of medicines on the EPMA system. Staff felt it was too early to comment on the effectiveness of the new system.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents but did not always report 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 patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents but did not always report near misses in line with trust policy. Staff of all grades said they were encouraged to report incidents and near misses and the electronic system was accessible and easy to use. The shifts were often too busy to report the more minor incidents and staff told us they tended to report only the more serious incidents. The service had an incident reporting policy staff could refer to as a reference for updated guidance on reporting incidents. During the inspection we reviewed the documentation of 5 incidents and found them to have been reported, investigated and learning shared correctly.

Staff reported serious incidents clearly and in line with trust policy. Staff we spoke with could describe the reporting procedure for the trust and told us how they reported incidents of all grades via the electronic reporting system.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Senior staff could describe duty of candour and when it should be used with patients and families. The investigation reports checked that duty of candour had been carried out correctly.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback from their managers about the incidents they reported.

There was evidence that changes had been made as a result of feedback. Records showed that learning from reported incidents was shared widely within the service. This was via staff meetings, safety huddles and newsletters. For example, when it was identified a patient's skin integrity had deteriorated due to not being repositioned frequently enough the specialist tissue viability nursing team provided teaching to ward staff and monitored practice to prevent the same happening to other patients.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw a completed investigation which focused on areas of good practice, care delivery problems, service delivery problems, root causes, concerns raised by family, immediate safety actions and a final risk rating. The findings had been shared with the staff and the family of the patient who had died.

Medical care (including older people's care)

Managers debriefed and supported staff after any serious incident. It was evident the wellbeing of the staff involved in incidents was considered and they were supported throughout the investigation process.

Is the service effective?

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff used a patient clinical pathway record to plan, give and evaluate care and treatment. The document referenced National Institute for Health and Care Excellence (NICE) guidance for each plan of care. NICE and trust guidelines were available on the trust intranet. Staff said guidance was easy to access, comprehensive and clear to follow. They showed us how they accessed the guidance.

The trust had a policy for the Implementation of NICE Guidance and Quality Standards. This policy had been reviewed, a draft completed and circulated to relevant stakeholder groups for comment. This policy was planned to be presented at an upcoming Clinical Effectiveness and Audit Committee approval.

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. The service adjusted for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw patients regularly being offered hot drinks and snacks. Fresh water was freely available and kept topped up by staff. Patients were offered 3 hot meals a day and there were 2 planned rounds in addition offering snacks such as biscuits or cake. Patients were supported to eat and drink if needed. Patients were generally positive about the quality and quantity of the food provided.

On the wards we observed information boards about nutrition and hydration which the staff could refer to for advice. The wards had a daily food safety huddle with the catering staff to update them on the nutritional needs of each patient.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Patient records in relation to nutrition were complete and up to date with dietitian reviews if needed. Nutrition and fluid care plans were followed with fluid balances totalled and acted upon appropriately.

Medical care (including older people's care)

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.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

The hospital had a specialist pain team who supported the ward areas to manage patients' pain as needed. Staff told us this team were very responsive to requests for support. Patients told us any pain they experienced was well managed and staff responded promptly if they needed pain relief.

Staff monitored the pain level of patients and recorded the information. Pain scores were recorded in most patient notes. Staff used pictorial aids to assess the pain of patients who could not communicate verbally. During the inspection we saw evidence of the use of a person-centred pain tool for people less able to verbalise. Facial and body language cues were observed as well as asking for input from the patient's family to assess pain.

Staff had access to a guidance policy, via the internal intranet, called Pain Management Guidelines for Non-Specialist Clinicians. This policy was up-to-date and was due to be reviewed in August 2024.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Records showed that the service submitted data to the Gastroenterology National Audits, Health Care of the Elderly National Audits, Renal National Audit, Cardiology National Audit, Diabetes National Audits and Neurology National Audits.

Outcomes for patients were generally positive, consistent and met expectations, such as national standards. Records from the previous audit cycle 2021 – 2022 showed patient outcomes matched national standards in each of the audit groups. Although data had been submitted for the current audit cycle the results had not yet been published. The stroke service improved in the 2022 Sentinel Stroke National Audit Programme (SSNAP). The service was rated A (the highest rating).

Managers and staff used the results to improve patients' outcomes. Records showed the results of the previous year's audit cycle results had been used as part of an action plan to improve patient outcomes. Action plans had been monitored and actions achieved as planned.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Each area collected audit data on a large range of metrics which were used to drive improvements over time. Managers held monthly meetings to discuss the results of the audit data with their teams. This was an opportunity to recognise good performance and create action plans to improve areas as needed. Staff took pride in positive local audit results.

Managers shared and made sure staff understood information from the audits. Records showed audit meetings occurred regularly and performance was discussed with those who attended. Minutes of the meetings were made available to those who could not attend in person. In addition, real time teaching was provided in areas needing improvement and posters were displayed to act as aide memoires to staff to prompt improvement.

The endoscopy service was accredited by the Joint Advisory Group on gastrointestinal endoscopy.

Competent staff

The service made sure staff were competent for their roles. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

Staff were not always experienced, qualified or had the right skills and knowledge to meet the needs of patients. Staff told us the skill mix was junior with many nurses still completing their induction training. We were told not all staff were trained in how to manage patients who present with challenging behaviour, such as verbal or physical aggression.

Managers gave all new staff a full induction tailored to their role before they started work. All staff completed an induction before starting work. Staff told us they remained supernumerary while completing a competency document which ensured they had the knowledge needed to work within the service.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Appraisals were conducted twice a year. We were told ward managers monitored when appraisals were due. The appraisal process also included compliance with mandatory training and nursing registrations. The monthly workforce performance report for April 2023 identified several wards where appraisal compliance was low. Records showed that 68% of doctors had received an appraisal in the 12 months before the inspection. Records showed that between 25% and 100% other staff such as nurses and allied health professionals had had an appraisal in the 12 months before the inspection. For example, only 25% of site coordinators had an appraisal and in the Frailty Assessment Unit 100% of staff had an appraisal in the last 12 months.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told is that team meetings were recorded, and the minutes shared electronically with the team. We saw copies of the meeting records were also on notice boards in the staff break areas.

Managers did not always identify any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. New nurses were assigned a mentor and had 3 months of protected time. This meant they were not included in the staffing numbers, which allowed them to focus on learning without the pressure of time constraints. Experienced nurses said they felt supported by their ward managers and were given opportunities to develop their skills and knowledge, such as, taking on link nurse roles. A link nurse is a nurse who is responsible for providing support and education to other nurses in a particular area of practice, for example, tissue viability. This gave more experienced nurses development opportunities while providing junior staff with the support they needed to learn.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us this happened during appraisal but also more informally during the working day. Most areas had posters denoting the special interests of staff such as dementia care or pressure sore prevention.

Managers made sure staff received any specialist training for their role. Staff told us their managers encouraged them to gain specialist knowledge needed for their roles and training sessions were provided in ward areas in improve staff knowledge on topics such as end of life care or nutrition of the patient.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us action plans could be used to manage poor performance, including the possibility of transferring staff to less acute areas.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings (MDM) to discuss patients and improve their care. Throughout the inspection we saw multidisciplinary team working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within medicine and felt part of the team. We noted that social workers did not routinely attend MDM's and a referral needed to be made after the meeting if the input of a social worker was needed. This meant that there was a delay to completing the patient discussion if the input of a social worker was needed.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was an electronic system to review patients to other health care discipline. Staff told us this system worked well and other health care disciplines reviewed and made care plans for their patients. The acute oncology team and palliative care team had worked hard to develop relationships with all ward areas including the emergency department. They proactively visited all areas daily to offer specialist support to patients needed their input.

Allied health professionals (AHP) worked closely with the ward teams and attended patient board rounds.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The hospital had a mental health liaison service which was provided by the local mental health NHS trust. During the inspection we reviewed medical notes which showed patients had been referred to and reviewed by the mental health liaison team.

Patients had their care pathway reviewed by relevant consultants.

Seven-day services

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

Consultants led daily ward rounds on all wards but did not always do a ward round at weekends. Patients were reviewed by consultants depending on the care pathway. Staff told us and records showed that on weekdays patients on the wards were reviewed by a consultant every day. Their care plan was reviewed and updated. Staff told us they did not always have a consultant ward round at the weekend but had support from junior doctors if needed. Patients on the acute medical unit were reviewed by a consultant every 12 hours, 7 days a week, unless they were medically ready for discharge. Patients who were medically ready for discharge would only be reviewed by a doctor if they became unwell.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week. The trust provided diagnostic radiology such as scans or x-rays at the trust 7 days a week. Patients needing an intervention for conditions such as a spinal cord compression would be re-directed to a neighbouring NHS trust for treatment. Staff told us this system worked well for patients. Physiotherapy and occupational therapy were available 7 days a week. The acute oncology service was available in the trust 7 days a week with telephone support when not on site.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. The service had relevant information promoting healthy lifestyles and support on wards. We saw posters and information leaflets throughout the service for patients and relatives to promote a healthy lifestyle. For example, we saw a poster about living well with cancer.

Cancer patients were offered a wellbeing recovery programme after treatment which included exercise, diet and access to a clinical psychologist. The aim was to support patients to return to a normal life after their treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

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. They used measures that limited patients' liberty appropriately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records in all but one of the notes we reviewed.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff could clearly describe the correct process for establishing the capacity of patients to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, considering the patients' wishes, culture and traditions. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were completed correctly.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. We observed staff seeking verbal consent before taking patient observations or a blood test. Consent for procedures was written and a record of consent was documented in the patient notes.

Not all staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff attendance at training in mental health conditions, learning disability, autism and dementia had a compliance rate of 74%. This included the Mental Capacity Act and DoLS.

Records showed managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could describe and knew how to the access policy and get accurate advice on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff we spoke with could describe the policies and show us where to access them on the intranet. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. We saw ward boards with information about the Mental Capacity Act and Deprivation of Liberty Safeguards for staff to refer to.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Staff had access to a current guidance document called Mental Capacity and Deprivation of Liberty Standards. Assessment forms were available to record complex and non-complex decision-making forms. Staff told us if they had concerns about a patient's capacity, they would refer them to the medical team for an assessment. Staff were knowledgeable about DoLS and used this legislation appropriately.

Medical care (including older people's care)

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Compassionate care

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

Staff were discreet but not always responsive when caring for patients. When able staff took time to interact with patients and those close to them, they did so in a respectful and considerate way. On the acute medical unit patients had to wait a significant amount of time for staff to respond to call bells. Patients were understanding and told us the staff were so busy they tried to avoid using the call bells unless absolutely needed. In other areas staff were able to answer call bells promptly to meet patient needs.

We observed some staff introducing themselves and their role to patients and being incredibly kind to patients.

Curtains were pulled around the bed areas to provide privacy when needed unless the patients were discharged on the ward corridors. Although we were told there were privacy screens available, we observed a patient on Kennington Ward being examined in the corridor with no privacy screens in place.

However, staff told us it was sometimes difficult to protect patients' privacy and dignity when they were boarded in the ward corridor. Staff informed us patients who were boarded, were sometimes examined by doctors in corridors and had to eat their meals or use a commode in the corridor where staff and relatives were walking by.

None of the staff had been trained as chaperones but the trust had plans to train chaperones and provide a competency framework.

Patients generally said staff treated them well and with kindness. Patients thought the staff were kind and took time to understand and meet their needs. Cambridge K Ward had developed a checklist which the nurse in charge of the shift used to find out how patients were feeling and if there were any issues. This checklist was monitored for themes and trends of any recurring issues they could improve upon.

Other comments from patients included: 'staff are outstanding and really friendly', 'I wish the staff had more time for me; I know it's not their fault there is just too much work' and 'I would only press my call buzzer if I was desperate, they are so busy'.

We met several patients who were being boarded in ward corridors as there were no bed spaces left in the ward. Patients were very unhappy as there was no call bell, locker or table for their belongings. The hospital had provided privacy screens, but we observed a boarded patient being examined in the corridor by a doctor with no screens in place. One patient had waited in the corridor in the emergency department for 48 hours for a ward bed and could not believe he was on another corridor in a ward after being moved from the emergency department.

Medical care (including older people's care)

Staff did not always follow the hospital policy to keep patient care and treatment confidential. Boarded patients did not have privacy and information could not be kept confidential as the corridor had a constant stream of staff and visitors. However, in other areas, efforts were made to keep patient care and treatment confidential by pulling curtains round bed areas while care was being delivered by staff.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed holistic assessments of patients which included their physical and mental health. These needs were discussed in a non-judgemental way at ward and board rounds.

Staff always understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We observed close and compassionate interactions between staff and patients in all areas. This extended to staff discussions about care and discharge; for example, patients' individual circumstances were discussed and considered when planning care.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients told us staff had clearly explained their care and treatment and we saw good communication between staff and patients in most areas. In the acute medical unit patients told us staff were too busy to talk to them and they did not feel comfortable speaking about emotional concerns with the staff.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. There were Clinical Nurse Specialists for each cancer tumour group. They had received advanced communication skills training. Patients told us the staff were caring and empathetic when delivering bad news or having difficult communications.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. All staff we spoke to clearly understood patient needs in relation to social and emotional wellbeing. Records shows patients emotional and social needs had been assessed fully and care planned considering any issues that had been identified.

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 told us staff had clearly explained their care and treatment and we saw clear communication between staff and patients.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff had access to translation services, communication aides and used them with patients as needed. The hospital had a learning disability and dementia team who supported staff to communicate fully with their patients.

Medical care (including older people's care)

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave mixed feedback about the service. Ward areas undertook monthly audits to assess patient feedback about the service. The results were generally positive, but patients had concerns about the amount of notice given when discharging them, lots of noise disturbing their sleep and being able to understand the answer doctors gave them when they asked a question. Most areas displayed posters inviting patients and their families to give feedback on their care.

Staff supported patients to make advanced decisions about their care. The trust had an end-of-life team who specialised in palliative and end of life care. This team supported both patients and staff to make advanced decisions about care. There were good relationships between this team, the local hospice and community services which aided realising the decisions patients had made.

Staff supported patients to make informed decisions about their care. All areas had leaflets explaining procedures and medical conditions which informed patients about their care. Staff had access to specialist teams who supported patients. For example, cancer, diabetes, stroke and mental health specialist teams visited the wards regularly.

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.

Managers planned and organised services, so they met the changing needs of the local population. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were all aware of the dementia liaison team and their contact details and reported a good collaboration with them. Wards had information boards about dementia for staff to use as an information resource.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There were 102 reported breaches in the past 12 months. The trust had documented all the details for the breach and reported no harm had occurred as a result.

Facilities and premises were not always appropriate for the services being delivered. The hospital had implemented a policy of 'boarding patients' this meant patients are on a ward without a dedicated bed space, call bell, locker or curtains. Staff told us this was meant to be for patients going home and would be for a maximum of 12 hours, but patients spent several days as boarded patients. We observed boarded patients blocking fire exits and access to emergency equipment. The senior leaders were informed of this on the day of the inspection.

Staff told us there was a shortage of porters in the hospital. Ward nurses often had to take patients to other departments in the hospital for planned investigations. This was a great concern for staff as they were already low in numbers on each shift.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The local mental health trust provided a mental health liaison service which could be accessed via a pager 24 hours a day. Staff were aware of the mental health liaison team and knew how to contact them for support. Staff told us they had a good relationship with the mental health liaison team, who were very responsive.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted. Administrators supported the team by contacting patients who missed their appointments, and leaders asked patients why they missed their appointments to see if they could improve their services to better support patients. For example, patients provided feedback that transportation assistance was an issue, so the trust provided transportation assistance for outpatients to attend their appointments.

The service tried to relieve pressure on other departments when they could treat patients in a day. For example, SDEC (Same Day Emergency Care) and Ambulatory care which provided a same day service to patients; however, these areas were incredibly busy, and patients had significant waits to be treated. Often patients who needed investigations such as an ultrasound ended up admitted to an overnight area and waited more than 72 hours for the investigation.

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.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Medical staff explored mental health with patients and sought to understand patients' individual needs outside of their immediate physical health condition.

Cambridge K Ward provided regular activities for the patients and their families. For example, they offered pamper sessions, chair exercises and massage. We were told of a patient and his son who played skittles in the corridor as an activity.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. During the inspection we observed a number of handover meetings and found the staff discussed the psychological and emotional needs of patients and those important to them. Referrals to support those identified as having enhanced needs were made.

Environments were designed to meet the needs of patients living with dementia. Staff had access to "this is me" or "about me" patient passports which provided information about patients living with dementia, who were not able to communicate their preferences verbally. Staff wrote some patient details on a whiteboard behind each patient's bed. This included the patient's preferred name and most of the time, staff used the preferred name.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff on medical care wards worked closely with the learning disabilities, mental health and dementia liaison teams. Staff all knew contact details for these teams and reported good working relationships with them. Staff were able to give us examples of supporting patients in need of additional support.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us the policy could be found on the intranet, and the service had access to information in large print, easy read, and braille format. This allowed staff to provide information and communicate with patients in a way that was accessible and understandable.

The service had information leaflets available in languages spoken by the patients and local community. Staff told us they could obtain leaflets in multiple languages for patients and their families as needed.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they could book face to face interpreters and a telephone language line as needed. They did not use family or friends to translate confidential information but found them helpful when building up a relationship with the patient.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff gave us examples of supporting patients with specific dietary requirements. We looked at the menus used, which were varied and included suitable alternatives for a range of religious or cultural needs.

Staff had access to communication aids to help patients become partners in their care and treatment. Reception areas had hearing loops to communicate with patients and their carers or family. Staff had access to an equipment library to support patients with learning disabilities, and patients who communicated in ways other than speaking. Staff showed us the materials and explained how they used them. Staff gave other examples of supporting patients with communication difficulties.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The referral system was through the online electronic record used throughout the hospital, so it was quick and easy to refer patients.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Managers and staff worked to make sure patients did not stay longer than they needed to. The hospital employed a team of site coordinators, who managed flow of patients through the hospital. The site coordinators met regularly with key staff in the hospital to monitor the patient flow from patients in the emergency department, planned admissions and patients ready for discharge. Extra meetings were planned when the hospital became very busy.

Managers monitored that patient moves between wards/services were kept to a minimum. Staff used a symbol on the Patient Transfer List (PTL) board for patients who had reached a high number of bed moves. This symbol is used to remind staff not to move these patients unless necessary.

The service moved patients only when there was a clear medical reason or in their best interest. However, there was no documented inclusion or exclusion criteria to aid decision making when deciding which patients could be moved. Staff told us the decision was made using their clinical judgement. This meant more the decision made to move patients were not consistent.

Staff tried not to move patients between wards at night. Records showed that 332 patients were moved between 10pm and 6am in the last 12 months. This is not best practice as it can be confusing for patients and their relatives and disturbs their sleep. This data was reviewed regularly by the hospital leadership team.

Managers and staff started planning each patient's discharge as early as possible. On admission nursing staff calculated the estimated day of discharge for each patient. This was monitored via patient tracking lists at board rounds and site coordinator meetings. Many patients remained in hospital when medically ready for discharge because they were waiting for packages of care in the community to start.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. Managers told us there was a weekly 'delayed discharge meeting'. There were no records or documented minutes following this meeting. It was therefore unclear how effective this meeting was in bringing down rates of delayed discharges.

Managers monitored patient transfers but did not always follow national standards. This led to some patients being inappropriately transferred to unsuitable ward areas or in unsuitable spaces within the ward area. Nursing staff told us site coordinators would pressure them to transfer patients to different areas in the middle of the night, even when the patient was not appropriate for night transfer, for example, patients with dementia.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Due to pressures on capacity and bed availability, patients were sometimes cared for on a ward that did not specialise in their condition. Staff told us these patients would be looked after by the medical team on the ward they are on, and if they required a specialist review, the specialist team would be informed.

Managers worked to minimise the number of medical patients on non-medical wards. Ward managers told us they tried to keep medical patients within their speciality. If patients had to be moved to a non-medical ward, flow teams would be informed and try and place them back to the correct ward. However, this did mean patients sometimes had multiple bed moves during their stay before getting to the correct speciality for their needs.

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 service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they knew how to make a complaint or who to speak to if they had a concern. Staff understood the policy on complaints and knew how to handle them. Staff were able to explain the complaints process, and give examples of when a complaint was received, how it was handled and the outcome.

The service clearly displayed information about how to raise a concern in patient areas. We saw posters detailing the complaints process on all ward areas. There were patient feedback leaflets on all the wards. The trust responded to complaints within set timescales and followed their internal policies as well as the national guidance. Staff told us how the duty of candour was met, including recording of the process and the involvement of patients and families.

Staff understood the policy on complaints and knew how to handle them. Staff told us they had access to a guidance policy on patient complaints. Managers told us they would attempt to resolve the complaint if possible. Complainants were signposted to the formal complaints process as needed. The service had 9 stage 1 complaints being investigated and 6 stage 2 complaints being investigated.

Managers investigated complaints and identified themes. Feedback from complaints was shared with staff in daily safety huddles, on ward rounds and in team meetings. Serious incidents which were at the origin of complaints were discussed with staff and escalated. Staff gave examples of using patient feedback to improve daily practice. For example, staff told us of a complaint leading to changes in visitors' restrictions to better support end of life patients.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The service had a team of investigators to investigate complaints and provide feedback for staff and patients.

Managers shared feedback from complaints with staff and learning was used to improve the service. The team meetings and staff huddles were used to share feedback and learning from complaints. Records showed this was minuted and shared with staff who were off duty.

Staff could give examples of how they used patient feedback to improve daily practice. The results of the monthly patient feedback assessments were shared and discussed at ward level. Ward managers used the themes and trends identified from the results as a focus for improvement. For example, reducing ward noise at night to promote a good sleep environment for patients.

Is the service well-led?

Requires Improvement 

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

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. Some staff felt there were groups of leaders who were unapproachable.

The senior leadership team, although newly formed, had a rich background in operational leadership in other NHS trusts and within East Kent University NHS Foundation Trust itself. The medical clinical lead and operations manager split their time between William Harvey Hospital, Canterbury Hospital and Queen Elizabeth the Queen Mother Hospital in Margate. There were 2 lead nurses; 1 was responsible for William Harvey Hospital and the other responsible for Queen Elizabeth the Queen Mother Hospital and Canterbury Hospital.

The leadership team believed in a flat hierarchy and told us they made all efforts to link in with staff of all grades when in the hospital. They attended site safety huddles, the emergency department and bed meetings to develop relationships with key staff across the hospital. The soft intelligence gathered through interactions with staff across the hospital was very beneficial to their leadership roles.

Medical care (including older people's care)

Cambridge K Ward had previously had a high turnover of staff and a high staff sickness record. This was improved by a new ward manager who had a strong focus on staff wellbeing. The ward subsequently received silver accreditation and became a desirable place for staff to work. This in turn has improved the experience of patients and their families.

Most staff spoke positively about the visibility of senior leaders. Several staff described the support they had received to develop into more senior roles in their area of work. The department had developed a ward leadership programme, which provided education and support to those nurses appointed as ward managers. However, some staff described a 'clique' of leaders at matron level who were not approachable, who they avoided.

Vision and Strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

General speciality medicine was in a period of re-structure at the time of inspection and had not yet developed a formal vision or strategy for the future. The senior leadership team were in the early stages of involving key stake holders in workshops to create a vision and strategy that reflected the department. The leaderships team identified service improvement in endoscopy and 'getting the patient pathway right' and reducing unnecessary patient admissions as key priorities for the developing strategy. The patient voice would be strong in any strategy developed and would be gathered using patient feedback.

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 patients, their families and staff could raise concerns without fear.

The leadership describe a culture of all staff being able to bring 'their real selves to work'. Getting to know one another as people and not just colleagues. The hospital had recently recruited a cohort of internationally trained nurses. The hospital has arranged food festival days to try food from the nurses' home countries and set up an information resource for the nurses to give them information about local hairdressers, banks and churches.

There was a strong emphasis on equality and diversity with the medical department. The department was committed to the trust value of 'committing to creating a diverse and inclusive environment where all our staff, patients, carers and service users are treated with dignity and respect.' Senior staff were well represented from staff from all ethnic backgrounds and staff told us their ethnicity was not a barrier to career progression. This contrasts with the trust wide Workforce Race Equality Standard data.

The hospital had several initiatives in place to support staff well-being. These included a Freedom to Speak Up Guardian, health and well-being teams and "connectors". Connectors were members of staff who could support international nurses who may not be familiar with some processes in this country, such as setting up a bank account. Leaders also told us they tried to have their lunch with staff at all levels, as they believe this helps to build better relationships; "If you sit down and eat with staff, your working relationship is better".

Overall, the service had a positive culture where staff felt valued and respected. They were focused on providing the best possible care for patients, and they were supported by their colleagues and managers.

Medical care (including older people's care)

Patients we spoke to knew who to speak with if they had any concerns about their care. We saw posters which displayed information about what to do if patients or visitors had a concern. The trust had a Patient Advice and Liaison Service (PALS) which could be contacted by email or telephone.

The last staff survey in 2022 the medical department scored well in 6 out of the 7 promised made to staff by the hospital. The promises were statements the staff could agree or disagree with. For example, 'we are compassionate and inclusive' and 'we are safe and healthy'.

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.

There were clear governance structures at trust board level with good representation from all disciplines. Medicine governance group meetings directly fed into the trust board governance meetings so we could see performance data being discussed at all levels of management.

There was a clear governance structure within the medical department. Monthly meetings took place at all levels to discuss key risk and performance issues. Meeting minutes showed them to run to a set agenda and clearly recorded. Actions could be tracked, and minutes showed they had been completed. However, during the inspection, it was clear that although leaders were assured by the recorded performance, we found in practice the standards of safe care were not met. For example, checks on safety equipment, fire extinguishers, data protection and infection prevention and control measures.

The trust board received routine reports on performance and risk metrics. The report showed the trust's performance against each of the performance and risk metric and the actions taken to improve and sustain performance. We were told the service needed to improve on reporting near misses and establish a culture of reporting potential harms. The trust told us they held governance meetings to focus on near miss incidents and aim to ensure staff learn from them as well as incidents with harm.

The cancer steering group met monthly and fed into a quarterly cancer board. Cancer performance was discussed at this meeting and actions were used to drive improvement within the trust.

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.

Risks were recorded at ward, department and trust level. The top risk identified within the medical department was patient flow within the hospital and boarded patients. Boarded patients are patients who are cared for in the corridor area of the ward as there are no bed spaces available. This was also a concern for the staff caring for the patient as the area lacked privacy, a call bell and sometimes blocked access to fire exits and emergency equipment. The leadership told us this was unavoidable due the number of patients requiring admission from the emergency department.

Throughout the medical department, clinical and non-clinical managers worked well together to identify risks and make improvements. Matrons and ward managers had a good understanding of the issues within their clinical areas.

Leaders at all levels could clearly describe the risks in their area of work and the mitigation in place to reduce the risks. The risk register was updated regularly, with risks added to the register relating to patient care, safety performance and current issues. Monitoring of risks and actions were allocated to named staff who recorded regular updates with the mitigations to reduce the risk.

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 but not always secure. Data or notifications were consistently submitted to external organisations as required.

The department collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The trust's website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and members of the public a range of information about the safety and governance of the hospital.

Each area we visited had several computer terminals and computers on wheels to allow staff to access electronic patient records and test results. All staff had individual log on passwords. In several areas, the terminals were not locked when not in use and private information about patients was on display and could be accessed by those without the authority to do so. We also found handover sheets left unattended in ward areas. These sheets had printed confidential information about the current patients on the wards.

Engagement

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

The medical department involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including Healthwatch, feedback from the Friends and Family Test and inpatient surveys. Several of the wards had social media pages which the public could view to see the good practice going on in these areas.

Oncology services organised ward-based patient groups ran in conjunction with charitable organisations. Patients and their families were given access to support groups and information resources to help them understand and adjust to their treatment.

The management team said any good ideas put forward by staff were discussed at weekly ward and monthly team meetings. Useful suggestions and good ideas were passed on to the clinical and quality boards. Staff felt informed and involved with the day-to-day running of the service.

Staff advised us there were regular staff meetings and that managers arranged these for different times and days to ensure all staff were able to attend regularly.

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.

Medical care (including older people's care)

The medical wards demonstrated several actions they had taken to improve the service they provided. On Richards Stevens Ward there was an enhanced enablement project where staff worked together across the multidisciplinary team to encourage patients to mobilise at any earlier point in their admission. This pilot, if successful, will be extended to other medical wards.

Patients were encouraged to wear their own clothes to promote a sense of normality. The wards had raised funds to purchase clothes for patients without a family nearby to ensure all patients had day clothes to wear.

There had been a focus on multidisciplinary working to ensure the patient was offered a bed on the most appropriate ward for their medical illness. When discussing the patient tracking list discussions focused on pre-empting which patient was most suitable for predicted beds for example if a bed became available on a respiratory speciality ward it should be allocated to a patient with a respiratory problem. This meant the patient was on the ward of that speciality team and would receive high quality, speciality care and spend less time in hospital.

Urgent and emergency services

Inspected but not rated

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients 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. However, the service had not met the trusts target rate for safeguarding training.

The trust had a People at Risk, Safeguarding Vulnerable Adults policy which was comprehensive and reflected current guidance but was out of date (review date December 2020). This provided staff with guidance on how to identify abuse and the processes to follow if they needed to raise a safeguarding concern. There was a quick reference guide for staff which gave details of how to make safeguarding referrals. The Safeguarding Children policy for the trust was in date and reflected current legislation and guidance and covered other elements of safeguarding such as female genital mutilation and child sexual exploitation.

Safeguarding was part of the staff induction and mandatory training. The trust set a target of 91% for completion of safeguarding training. Staff we spoke with said they had received safeguarding training at a level appropriate to their role. However, mandatory training data, broken down by role, showed the training targets were not being met. Medical staff were 69% compliant for both adult and child safeguarding training level 2. Nursing staff were 76% and 79% compliant with adult and child safeguarding training level 2 respectively. This was not in line with the trust's own policies and the national standards for the protection of vulnerable adults and children.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff described how to make safeguarding referrals and who to contact if they had concerns about patients. Children identified as being at risk while in the emergency department (ED) were referred to the trust safeguarding team and to the local authority appropriately. There was a system to flag known concerns about children and families.

Staff followed safe procedures for children visiting the ward. Children and adults who left without being seen were reviewed and if necessary, followed up by a GP. We had concerns when children were referred to the Urgent Treatment Centre (UTC). The UTC was a GP led service co-located within the hospital site. Patients were transferred to the UTC, using an agreed criteria, to relieve pressure on the ED service. The physical distance between the two units meant there was opportunity for families to leave the hospital without concerns or risks being followed up or addressed.

Environment and equipment

Due to high demands on the service, and excessive capacity pressures, the premises did not always keep people safe. There was insufficient space to accommodate all the patients in the department and some rooms were unsuitable for the purpose they were being used.

The adult and children's ED were separate departments and purpose built. The general environment in the adult ED was light and spacious and all patient cubicles were fully enclosed single rooms. The design of the environment mainly

followed national guidance, but the size and layout of the department did not meet the needs of all the patients requiring access to the service. There were insufficient treatment and assessment areas to accommodate all the patients attending the department. This led to overcrowding, delays with handovers and providing care and treatment.

The children's ED was not an appropriate size had insufficient space to safely accommodate the numbers of children and infants seen. In contrast to the adult ED, the children's ED was cramped and not fit for purpose. Staff told us the children's ED was frequently crowded and there were not enough treatment rooms. We saw there was not enough space for any cots to be stored within the department. Staff could get cots from stores, but workloads and staffing issues meant they did not have time to get them. Staff told us infants were regularly assessed and treated on standard size trolleys. There were also no toilet facilities or a suitable room for breastfeeding within the children's ED.

At the time of the inspection a new children's ED was being built and it was hoped this would provide more appropriate facilities for both staff and patients.

Patients arriving by ambulance were taken directly to the Rapid Assessment Treatment (RAT) area. Ambulance staff handed-over the patient to the senior nurse who triaged every patient and carried out an initial clinical assessment.

All walk-in patients, including children and referrals from GPs, arrived at the front door and were greeted by 2 streaming nurses. The front door was staffed 24 hours per day, 7 days a week. Patient details were recorded using a nurse initial assessment sheet, including name, date of birth and main reason for attendance. The streaming nurse prioritised each patient initially based on an Emergency Index score as; Red, Amber, Yellow, Green or Blue. The streaming nurse also performed routine observations including temperature, heart and respiratory rate and oxygen saturation. The streaming nurse then used this information to determine the most appropriate pathway for each patient i.e. Urgent Treatment Centre, Same Day Emergency Care or the Emergency Department waiting room.

Once the walk-in patient had seen the streaming nurse, the patients were booked in at the main reception area by the reception staff. Reception staff were on duty day and night and booked patients onto the hospital system using information collected by the streaming nurse and printed the patient wristband, for identification purposes.

Due to the open layout of the reception area in the lobby by the front door to the ED, it was possible both the streaming nurse and reception staff conversations could be overhead by other patients and relatives waiting. Staff said they often spoke with patients in a mental health crisis or having a suspected miscarriage in this area. Staff told us they were concerned about the lack of privacy and dignity for patients in the reception area.

There were times when the availability of appropriate rooms to triage patients in was reduced, which impacted on meeting the desired timeframes for triaging. Due to crowding and lack of space, assessments for these patients were routinely carried out in the corridor in the RAT area without any privacy and dignity for the patient. It was possible personal medical details and other confidential information could be heard by others. Vulnerable patients were possibly at the greatest risk in these circumstances.

The RAT area consisted of 12 cubicles and each cubicle had oxygen, suction, monitors, call bells and clear doors. The nurse's workstation was central to the RAT area and had unobstructed views of all cubicles, this meant staff could observe the patients' condition.

On the day of the inspection there were 31 patients in the RAT area. Staff said this was not unusual and there were often far more patients in the department. The trust used escalation or overflow areas to review patients, these

included the area immediately adjacent to the ambulance bay (5 trolleys) and the corridor space in and around the RAT area. Overcrowding meant patients were on trolleys for extended periods of time, and there was limited or in some case no privacy and dignity. We saw patients being assessed by doctors without the use of screens. Trolleys needed to be moved to allow access for other patients to be moved around the department. We saw trolleys blocking fire doors. Patients told us they were unsure who had been allocated to care for them.

The trust also used a waiting room for the x-ray department as an escalation area, for example for patients waiting admission to the hospital for a bed. Patients frequently stayed there for excessive periods of time and overnight if necessary. At the beginning of the inspection day there were 4 beds in the area, by the end of the day this had increased to 5 beds. Staff said this area frequently had up to 6 beds. This space was not designed for beds and for patients to sleep in overnight. There were no doors to the area to separate it from the main hospital, and it lacked privacy and suitable facilities.

The trust had risk assessed this area and trained nursing staff were allocated to support patients who had been placed there. There were screens to separate the beds from the main hospital, but the area was still being used by patients booking in to have an x-ray. There was a constant stream of people attending the area throughout the time we were there. One patient described the poor state of the toilet facilities made available to patients, and how they had used a urine bottle while standing in the corner of the room.

The majors area had 9 cubicles, with a further 9 under construction. The resus area consisted of 9 cubicles. The cubicles within the new major's area had glass doors to support effective infection prevention and control. Staff magnetic alert labels on the whiteboard, to display patient information. The environment and corridor within the major's area were wide, bright, and clean. There was a nurses / doctor workstation located centrally with unobstructed views of each cubicle. One cubicle was dedicated for paediatric use and another was set up as a hybrid cubicle, that could be used for either adults or children. Additionally, 1 cubicle was designed with negative pressure and so was utilised as an isolation room for patients with potential infectious conditions.

Clinical waste was disposed of safely using separate designated waste bins for general and clinical waste and sharps buckets for sharp instruments were available throughout the department.

The ED had 2 separate mental health assessment rooms and a separate waiting room attached to them. The rooms had been designed in line with national guidance; for example, ligature risks had been minimised and safety concerns had been assessed. Each room had a strip alarm running around the perimeter of the room and CCTV in each area. The assessment rooms had 2 exits for additional safety.

The CCTV was constantly recording and had an observable screen in the main ED nursing station. One of the mental health assessment rooms had a door which did not close, meaning conversations in this room could be overheard in the waiting room. In 1 of the assessment rooms the lights were broken, meaning staff had to continuously push the switch otherwise the light would dim. Staff told us these defects had been reported but there had not been any action to resolve the issues.

Generally, there was enough suitable equipment in the emergency department to help staff safely care for patients. Staff had access to emergency resuscitation trolleys for adults and children and knew where the nearest one was in the emergency department. Daily safety checks of specialist equipment had been carried out on most days. However, staff told us there was a shortage of paediatric monitors in the children's ED, which affected their ability to safely monitor their patients. This had been reported and staff had had been advised this would be resolved when the new children's ED was opened.

Urgent and emergency services

Assessing and responding to patient risk

Staff completed initial risk assessments for each patient upon their arrival to the department. For patients in the department, staff did not always identify and quickly act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients attending the ED, either by ambulance or walk-in, were prioritised initially based on their Emergency Index Score as: red, amber, yellow, green, or blue and moved to the appropriate area for further assessment. With red being higher priority and blue being the lowest priority.

Lack of space in the department meant nurse assessments were frequently carried out in the corridor, often without any privacy and dignity for the patient. This also led to clinical observations not being able to be carried out effectively.

Both nursing and medical staff described their concerns regarding the overcrowding and impact this had on their ability to carry out effective assessments of patients.

The hospital used National Early Warning System (NEWS2) to record patients' observations. NEWS2 is a recognised tool used as a guide which looks at a patient's vital signs such as respiration rate, blood pressure, oxygen saturation level, pulse, and pain levels. Any changes in these parameters could indicate early deterioration and prompt actions would be indicated.

All children and young people were streamed at the front door upon arrival at the emergency department. They were then triaged within the children's emergency department. Staff used a Children's Emergency Department safety care plan when triaging children. This consisted of hourly observations, paediatric Sepsis 6 screening tool and a discharge checklist.

Patients taken through to paediatric ED were risk assessed and clinically observed using NEWS2 or the paediatric early warning score (PEWS) during their stay in the department to help staff identify unwell patients or signs of deterioration. All records we reviewed had accurately calculated PEWS scores. Where required, appropriate action was taken if the score was raised.

Although, staff told us they were not able to always carry out routine observations in the main ED as this took time and increased the backlog. Staff at the Urgent Treatment Centre, (UTC) told us that several inappropriate cases had been streamed to the UTC. Staff told us they had raised concerns and, following a recent incident, the service had introduced a change to the pathway relating to the referral criteria for paediatric patients to mitigate the risk.

Staff could describe the process for the management of sepsis. Clinical guidelines supported staff in managing sepsis. The guidelines were accessible from the trust intranet and the emergency department mobile app.

Staff shared key information to keep patients safe when handing over their care to others. This included sharing of key information during shift changes and handovers. Staff undertook board rounds every 2 hours in the ED, throughout the 24-hour period, to monitor the timeliness of patient identification and movement. Huddles were with the medical, nursing, and operational teams. Nursing staff in the department had a handover meeting between each shift which included an update on all patients and highlighted any specific concerns such as infection risks or safeguarding concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had 24-hour access to mental health liaison and specialist mental health support.

Staff at the hospital completed adult basic life support (BLS) or immediate life support (ILS) training depending on their role. Compliance training rates were low compared to the trust target of 85%. Nursing staff had achieved 72% for adult BLS and 57% for paediatric BLS. Medical staff had achieved 42% for adult BLS and 25% for paediatric BLS. After the inspection the trust outlined their plans to provide additional training and to prioritise staff across the ED.

Nurse staffing

There were nurse vacancies in the emergency department (ED) and on some days, not all services operated due to staffing shortages. The ED did not always have enough nursing staff with the right qualifications, skills, training, and experience which increased the risk of patients experiencing longer waits for care and treatment.

Not unlike other NHS trusts, recruitment of clinical staff was challenging. Managers regularly reviewed staffing levels, skill mix and moved staff to mitigate shortages**.** Nurse staffing in the ED had been established as 34 nurses across all shifts per day. However, we were told the department had contingencies to function with 28 nurses. This included reducing the number of nurses taking triage, and the number of nurses working in the children's department, which affected the level of service the ED provided.

Children's nurses told us the Childrens Assessment Unit was not always staffed and was occasionally closed as a result. We had no specific data to support this comment from staff, but they told us this led to increased pressure on the children's ED and longer waits for patients.

The children's ED staffing establishment was 9 per day shift, 4 of whom were required to be paediatric trained. Nurse leaders and nurses told us this was not always achievable and there were occasions when there was only 1 paediatric nurse on duty. We reviewed shift rota information provided by the service which showed shortfalls for the 3-month period, between February and April 2023. For example, data from 1 February to 28 February 2023 showed there were 9 occasions when there were not enough registered children's nurses working in the PED. On those 9 occasions, 45% were covered by adult nurses without full paediatric competencies.

This was not in line with the 'Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings' document titled, "Standards for Children and Young People in Emergency Care Settings" (2012) which recommends that EDs should have a minimum of 2 paediatric trained nurses per shift.

To mitigate the concern, adult trained nurses working in the paediatric ED had completed children's nursing competencies including recognition of the sick or injured child, paediatric life support skills, and the ability to initiate appropriate treatment.

Incidents relating to nurse staffing shortages had been reported across all areas of the ED. This included the paediatric ED, majors, and the ambulatory and ambulance assessment areas. The incidents demonstrated the extra delays patients experienced while waiting to access the service. There had been no serious harms reported as a direct result of staff shortages.

Nurse staffing was on the service risk register. There were some mitigations to cover staffing shortages, which included daily ED safety huddles and twice daily nurse staffing meetings across the trust. Nurses were moved across the emergency floor to where the risk was greatest.

New nurses to the ED attended a trust induction and a local induction and were given competency booklets along with a full programme of mandatory training. Bank and agency staff were used, if necessary, to keep patients safe. Agency staff used were generally regular staff who knew the department and were experienced ED nurses. New bank and agency staff underwent a local induction in the department.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not have enough emergency department (ED) or paediatric emergency medicine (PEM) consultants to meet the Royal College of Emergency Medicine (RCEM) or The Royal College of Paediatrics and Child Health (RCPCH) guidelines. The guidelines state there should be 12-hour consultant cover in the ED, 7 days a week.

The ED service had 10 whole time equivalent (WTE) consultants. However, service leads told us, based on the number of attendances, they required 16 WTE consultants to run an effective service.

There was 1 PEM consultant with 1 allocated session to paediatrics (x1 PA, equating to 4 hours) every 2 weeks. This level of cover was insufficient to safely support PEM consultant cover at the service.

Consultants told us they had raised concerns to senior management about maintaining a robust rota due to lack of consultants. They also stated they didn't have enough permanent consultants to be regularly involved in clinical governance meetings.

Service leads described how the service had 31 middle grade and junior doctors, all of whom were graded ST4 or above. The relatively high number of experienced junior doctors somewhat mitigated the consultant shortfall.

Junior doctors spoke highly of the support they received from the consultants and their regular teaching and training program.

Records

Staff kept records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. However, not all nursing care plans had been started or were up to date.

Staff could access patient records easily. The department used both paper and electronic patient records (EPR). Paper records included individualised plans of care; for example, falls prevention and nutrition. The EPR was used to register patients, monitor their movement through the department and request and review investigations.

Staff told us patient care plans were accessible and kept with the patients' records, and felt they had access to information needed. Staff were familiar with the main EPR system, which was where most of the notes were written, and they navigated it well. However, they also told us the system was not always straight forward to use if staff were not familiar with it.

We reviewed 14 patient records across a combination of electronic and paper records. Children's safeguarding referral documentation had been completed in all records we reviewed. Care plans for patients, including falls assessments, were generally well completed. However, these were not always started or updated for patients in the major's assessment area. Staff told us the crowded department often hindered their ability to either carry out assessments effectively or to complete them at all.

Records were stored securely. Paper records were stored in the central area in trolleys. These were not locked, to enable easy access, but were always monitored.

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. At the time of the inspection. the trust was in the process of introducing an electronic prescribing and medicines administration system (EPMA). This had not yet gone fully live at the hospital and we were unable to assess the impact of the change.

There was a paper-based system to prescribe and record the administration of medicines. Patients' notes were held alongside their medicine's administration records.

There were systems to ensure patients received their medicines when they were due, this included time sensitive medicines, and this was reviewed regularly. Pharmacy staff provided a 5-day service to the rapid assessment and treatment RATs area and a 7-day service to the acute medical unit (AMU). This included, medicines reconciliation, medicines administration and ordering medicines. Outside of these hours staff could contact pharmacy working on AMU or the on-call pharmacy service.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Antibiotic prescriptions were reviewed after 72 hours and recorded the indication, for example, sepsis. A staff member was specifically assigned to review patients pain needs and ensure they received the medicines they needed.

On the acute medical unit, pharmacy staff provided a regular clinical review of all medicines prescribed. Medicines were dispensed on the ward by pharmacy.

Staff stored and managed all medicines and prescribing documents in line with the trust's policy. Medicines areas and electronic records could only be accessed by authorised staff using swipe cards, keys pads and individual logs ins. Staff were not always locking computer terminals or removing their smart cards when the terminal was not in use which posed a risk of unauthorised people accessing patient information.

Medicines were stored in temperature-controlled areas to ensure they remained stable and effective to use. Staff knew what to do if temperatures went outside the recommended range.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The pharmacy had a system for monitoring and cascading medicines safety alerts to the ED department where appropriate.

The trust used an incident reporting system to record near misses and errors. These were analysed regularly, and learning was shared with staff across the trust. This included newsletters and bulletins from the pharmacy to highlight areas for improvement and ways to avoid repeating errors.

Urgent and emergency services

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Patients were receiving medicines to control behaviour. Pharmacy staff told us they challenged staff about using these medicines and used a system to check if the patient needed support other than medicines, for example, a drink or pain relief. The pharmacy department had produced guidance for staff and were actively working towards reducing the use of these medicines.

Incidents

Staff recognised and reported incidents, however not all near misses were reported. 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.

The hospital used an electronic system for reporting incidents. All staff could access the incident reporting system. Staff working in the ED told us they knew what constituted an incident and were encouraged to report incidents or near misses so that effective measures could be taken to minimise ongoing risk to people or the organisation. Staff said there was a no-blame culture and they felt confident to report incidents.

Some staff were not always reporting near misses, including those that have potential for harm. Nursing staff told us doctors had prescribed adult doses to children and felt they relied on nurses to pick this up. We were told these situations had not been reported as near misses, which was a missed opportunity for investigating and shared learning.

Service leads described how they considered each incident as a learning experience. The service had a proactive approach to reviewing incidents and making changes as a result. Whether that be additional staff training or a change of a working practice or procedure. Staff told us learning from serious incidents was immediate and feedback from investigation of incidents was via monthly emails, face to face and team meetings.

Agency staff told us they received feedback from incidents and were able to provide us information about a recent incident involving a child and what learning had come out of this.

Post-inspection we reviewed clinical governance meeting minutes and saw evidence incidents were discussed, investigations in to incidents reviewed, actions taken to reduce risk and reduce the likelihood of reoccurrence put in place and to see if there were any trends emerging.

Staff could explain duty of candour and understood their responsibility to be open and honest with patients and their relatives when something had gone wrong.

Is the service effective?

Inspected but not rated

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Urgent and emergency services

The trust participated in all relevant Royal College of Emergency Medicine (RCEM) audits and published reports were reviewed with local action taken. Some of these included IPC and pain in children audit. The hospital provided us with the paediatric pain audits from the previous quarter and stated this was moved off the audit programme and placed on a local watch due to compliance remaining good. An audit on the last quarter's performance was currently underway.

In addition to this, the trust participated in the Trauma Audit and Research network, (TARN) audit with data presented to the trauma board for discussion. We reviewed the meeting minutes for April 2023 and saw the agenda included topics such as work plan, data reports, frailty, training, and education.

The trust had previously participated in the National Society of Acute Medicine Benchmarking Audit (SAMBA) audits each year and local actions were taken. Actions were formulated from the 21-22 report but for the 22-23 cycle, due to clinical pressures meant they were unable to participate.

The ED had an ongoing programme of auditing, which took place daily, weekly and monthly; some of these included patient safety checklists, corridor care, falls risk assessment and medicines management.

The trust provided us with a local urgent and emergency local audit program for April 2023, which consisted of several projects run by leads. Out of the 26 projects, 10 of these had been completed with most of them on schedule. An example of this was the chest pain pilot. This had been designed to improve the pathway for those presenting with chest and epigastric pain, ensuring they were in the right place being seen by the right person.

The children's emergency department completed several audits across site. This included Paediatric Early Warning Score combined with blood pressure in children, pain in children, sepsis, and torsion in children. All audit results were sent to the senior management monthly for oversight. The paediatric sepsis audit results were low, at 40%. Nurse leaders described challenges completing the sepsis paperwork because of the lack of paediatric trained nurses. The nursing education team within the ED had developed a training package to help address the knowledge gap in this area. The department had plans to deliver the training across once the training package had been approved.

Competent staff

The service made sure staff were competent for their roles. Staff had supervision meetings to provide support and development. Data showed not all staff had received an annual appraisal of their work performance. Some competencies had not been written for staff to be assessed against.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. The trust made sure staff were competent for their roles. There were opportunities for staff to develop their clinical and other skills and there were programmes of leadership development. Staff competency was formally assessed in key areas. We noted there were no paediatric resuscitation competencies for staff to be assessed against. We were told revised competencies were being developed.

Information received from the trust showed that 100% of eligible ED nursing staff had completed their Emergency Department Complex streaming training. Of these staff, 86% were recorded as being assessed and signed as competent. Remaining staff were in the process of completing their training competencies.

Staff within the department were expected to complete a triage competency book. Information post inspection showed that all Children's ED nursing staff had completed their competency at initial assessment and triage.

The enhanced observation support workers completed additional training as part of their role and completed a development plan with the Liaison Psychiatry team, which included teaching and shadowing sessions.

Managers gave all new staff a full induction tailored to their role before they started work.

Although there were systems for manager to appraise staff's work performance, not all staff had a current appraisal. Information received post inspection showed that 84% of staff within the department had received their appraisal. The data was further broken down to different areas within the department and showed the lowest was with paediatric ED nursing staff, with 54% having received their appraisal. The low rate of compliance was attributed to staffing challenges within the children's ED.

We spoke with junior doctors who told us that they received regular supervision from the emergency department consultants as well as weekly teaching.

The emergency department employed security officers through a third party and the training matrix provided by the trust post inspection showed all staff were compliant with the training as required by the trust.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However, there was a lack of collaborative working with specialty services outside of the ED.

Staff in the ED held regular and effective multidisciplinary meetings to discuss patients and highlighted issues and outstanding tasks. The department held regular board rounds, which were led by the consultant in charge and senior nurse for the shift.

We observed good collaboration and communication between all grades and professions within the department itself. However, medical and nursing staff highlighted concerns and challenges when contacting specialty doctors, for example when a patient required a specialist review. They said sometimes specialty doctors did not respond to or pick up phone calls. ED doctors were unable to make the decision to admit a patient. Specialties needed to accept a patient and give the decision to admit. This created a power imbalance and was a patient safety issue, with ED doctors left with the burden of specialty patients in the ED due to ineffective communication.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We reviewed patients records and found these had been completed in a timely way. Staff we spoke with told us relationship with the liaison psychiatry team had improved and they had access to the team 24 hours a day, 7 days a week for advice.

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.

Staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff understood and could describe their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Urgent and emergency services

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. We saw in guidelines and were assured from speaking with staff that they knew their responsibilities in relation to Gillick competencies and Fraser guidelines. Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent.

Staff told us they had completed the Oliver McGowan training and were confident in their ability to support children, young people and adults with autism.

Staff in the ED could access the psychiatric liaison service for advice and guidance. This service was provided by an external provider. The psychiatric liaison team were based onsite in the hospital and provided a 24-hour, 7-day service.

Although the service aimed to provided mental health assessment within an hour for urgent referrals and 24 hours for routine referrals, staff told us there was always a long wait for Child and Adolescent Mental Health Service (CAMHS) and sectioned beds.

The hospital provided teaching sessions to staff to help refresh their knowledge on capacity considerations. Topics included principles of capacity, Mental Capacity Act, police powers and a refresher on DoLS.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Since our last inspection the department had built a new majors department. The service was in the process of completing a new paediatric ED department.

For patients self-presenting to ED, on entering the department the streaming desk was at the entrance which made it easy to find. The streaming nurse assessed patients depending on their clinical need and assigned them to different areas of the department.

For patients who arrived at the ED via ambulance there was a different entrance. This gave direct access into the major's area of the department. Ambulance crews told us they did not queue at the hospital. There was an informal arrangement that crews would offload patients within maximum of 45 minutes of arrival. This allowed ambulances to be assigned to their next job more quickly.

Staff were restricted in the way they could interact with patients in a discreet, respectful and friendly way. This was due to the increased volume of patients using the service, and overcrowding in some areas which meant conversations with some patients could be overheard by others and it was difficult to share confidential information privately.

Some areas of the ED provided mixed sex accommodation overnight. This was permitted and within national guidance on mixed sex rules in emergency care, but impacted for staff to always respect the individual personal, cultural, social and religious needs of each patient cared for in these areas.

For example, when the department was at capacity, some patients individual care needs were not met. Patients who had been in the department for many hours told us they struggled to get to the toilet or access facilities to wash. The overcrowding also led to nursing care reviews not always being completed in a timely way.

Not all patients were aware what they were waiting for in ED. Some patients told us they were not aware of the next stage of their hospital journey. This was particularly noticeable in patients who were told they were waiting for a bed to become available in the hospital, but they had no idea where or when this would be. This increased patient anxiety and inhibited their ability to communicate with family on what was happening. This also led to staff not being able to provide effective updates.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with poor mental health, learning disabilities and dementia.

Access and flow

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

The department was not meeting the national four-hour performance target which meant patients could not always access emergency services when needed or receive treatment within agreed timeframes and national targets.

The hospital did not have an effective handover process of patients who had been in the department for more than 24 hours. For example, on the day of the inspection, there were patients who had been in the department with a decision to admit (waiting for a bed) for more than 24 hours.

Patient flow in and out of the department was monitored throughout the day at the site huddle, quality and flow meetings and the cross-site calls. The status and escalations were recorded on 2 site reports daily at 7am and 7pm.

Overcrowding within the ED departments was included as part of the Operational Pressures Escalation level (OPEL) Plan. The OPEL status for the WHH was recorded centrally and was OPEL 4 for 40 days during the last 3 months.

The service had an escalation plan as part of the management and mitigation of overcrowding within the department. This included the use and management of non-clinical areas to house patients while waiting for treatment or a bed within the hospital. However, we saw there was an ineffective and inefficient implementation of the escalation plan.

Service leads described a lack of trust-wide ownership of the pressures faced by the ED. Overcrowding and delayed transfer of patients from the ED was attributed to a combination of factors. These included a lack of collaboration from the specialty teams towards the ED team. This affected efficient flow of patients into and out of the ED, which led to longer wait times for patients.

Delayed discharges of patients from the receiving wards, with most discharges occurring later in the day, restricted the ability for wards to accept patients from the ED. This meant patients could not be admitted from ED or the short stay units to the wards until beds were freed up.

Urgent and emergency services

During the inspection, we interviewed staff of all grades who described the lack of flow, and urgency to deal with flow issues, as a major concern. They described their concerns about examining patients in crowded areas and escalation areas. They told us a lack of privacy and ability to maintain people's dignity meant they were worried they could miss something clinically important because of inadequate examinations.

The department used a flow coordinator to help with the onward movement within the department using an electronic medical recording system. The flow co-ordinator managed patient's results and ordered diagnostic tests. They recorded escalation against the ED Escalation action card to the site team and/ or UEC senior team. This was then recorded on their shift log.

The trust had standard operating procedure and pathways for children and young people into the different specialist areas.

Is the service well-led?

Inspected but not rated

Leadership

Service leads 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. Despite low appraisal rates, they supported staff to develop their skills and take on more senior roles.

The Emergency department (ED) was managed by the urgent and emergency care group. The group was overseen by a clinical director who had been in post since September 2022. They held the responsibility for both the William Harvey (WHH) and Queen Elizabeth the Queen Mother (QEQM) hospitals.

The ED had a dedicated leadership team who were responsive to the needs of patients, developing staff and improving safety. At the local ED level, there was an ED head of nursing and the ED operational manager who were responsible for the running of the ED. The ED triumvirate had multiple meetings together and linked with the clinical leads onsite regularly.

The ED had 2 matrons,1 for adults and 1 for paediatrics, who were responsible for the nursing aspects of the ED at the time of our inspection. The paediatric matron worked 4 days a week and split their time between the 2 sites, 80% QEQM and 20% WHH. Despite the challenges with the children's ED at the WHH, it did not appear this working pattern had been reviewed or additional support provided.

The ED leadership team understood and could describe the challenges to quality and sustainability within the department and had plans in place to address them. They were aware of the challenges to meet ED targets and had plans to improve service delivery. They were working to create better patient facilities, patient flow and increase capacity. For example, through the on-going refurbishment of the department and facilities.

The leadership team felt the trust-wide leadership did not fully understand the pressures in the ED, for example relating to overcrowding. The use of escalation areas, or 'corridor care', to deal with over-crowding had been normalised and there was an apparent lack of urgency or drive from senior leadership to resolve issues within the ED.

The nurse in charge of the shift had responsibility for overseeing the running of the whole ED, including monitoring waiting times and moving staff around the ED to cope with demand and capacity. They escalated patient concerns to medical staff or senior managers when and if appropriate.

Senior staff in the ED were aware of the challenges they faced and felt the responsibility of delivering a safe service for all. The medical team and the nursing team worked well together and spoke highly of each other's abilities and support.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress. Staff spoke highly of the senior leadership and described them as approachable, knowledgeable, and supportive.

Culture

Staff felt respected, supported and valued by the local leadership and their peers. 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. Staff reported a disconnect with other services within the hospital.

Staff reported the team worked effectively together, with staff across all areas respecting each other and working together to provide the best possible care and treatment to patients. We observed positive and caring interactions between staff and their patients and their relatives.

We noted good collaboration and communication between ED staff of all grades and disciplines. Staff told us they felt supported, respected, and valued. We observed strong teamwork across the department. Most staff described being under significant pressure, particularly as the service was experiencing unprecedented demand.

Medical and nursing staff highlighted concerns in contacting specialty doctors, for example when a patient required a specialist review. They said sometimes doctors did not always respond to or pick up phone calls. ED doctors were unable to make the decision to admit a patient. Specialties needed to accept a patient and give the decision to admit. This created a power imbalance, with ED doctors left with the burden of specialty patients in the ED.

Junior doctors told us they were happy to work in the unit. They spoke highly of their regular teaching and training program.

The service promoted equality and diversity and had an equality, diversity and inclusion policy and process. All policies and guidance had an equality and diversity statement.

Staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and responsibility for everyone. However, they also told us they had concerns when the department was overcrowded, as this adversely affected their ability to provide the standard of care they wanted to give.

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. However, leaders reported challenges with accountabilities from department to board.

At the time of the inspection, the trust had vacant posts for the role of medical director and deputy medical director. Leaders at the local level described this as affected overall decision-making abilities and impacted accountability between services.

Clinical governance meetings were held monthly and were open to all staff who worked in ED. The meetings had a set agenda which included patient safety, patient experience, risks and clinical audit. An action plan was produced after every meeting and progress reviewed at the following meeting.

Senior ED staff told us information from ED governance meetings was shared to staff in various ways. For example, at staff meetings, during handovers and safety huddles. Information was escalated up to the trust board via the monthly divisional governance meeting.

However, the lines of accountability from the department to the board, through the trust's governance structure were not always clear. Due to a series of changes at executive level within the trust over the previous 12-24 months, leaders told us they felt no connection with the board and found it challenging to establish relationships with them.

The department held mortality and morbidity meetings to discuss patient deaths or adverse incidents affecting patients. These meetings gave an opportunity for the clinical team to review deaths as part of their professional learning and reflective practice in a safe space. Talking through patient case studies was seen as a way to improve quality of care given to patients and their families in the department.

There was a systematic corporate programme of clinical and internal audit to monitor quality, and operational processes in the department. This helped leaders understand and analyse performance issues and put measures in place to address them.

The Urgent Treatment Centre, (UTC) was led in collaboration with the trust and the GP Alliance. The centre was open 24 hours a day with a third party GP onsite. As part of the governance arrangements there were a variety of meetings to ensure there was oversight of the safety and effective process to maintain patient safety and review of practice and shared improvement and learning.

The UTC board met monthly as a group where they discussed risks, incidents, complaints, training, policies, and pathways. UTC governance was discussed at the site-based governance meetings monthly. The hospital was in the process of recruiting a UTC matron and told us reporting between the care group and UTC at the hospital would be strengthened once the post had been filled.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, some staff told us they had not always reported some incidents that would have been classed as near misses.

There were clear processes for identifying, recording, managing and mitigating risks in the department. Senior leaders in the ED described how these processes were not always followed by specialty teams within the trust. This led to capacity and staffing concerns, and a lack of flow through the ED. For example, it was difficult to establish who had clinical ownership of patients who were waiting in ED for a hospital admission. While the trust's position was patients in ED who had been accepted by speciality teams, were the responsibility of the speciality team, clinical directors had failed to enforce it.

The department operated a local risk register. This was reviewed at the clinical governance meeting and was a standing item on the agenda. New risks were added to the register and risks already on the register were monitored and managed. If the risk was determined to be a high, it would be added to the divisional risk register.

At the time of the inspection, the top 3 risks on the risk register included staffing, overcrowding and length of stay for mental health patients.

Risks remained for patients who were waiting a long time in the ED. The ED leadership team had committed to look for harms because of patients waiting in the department for 'a long time' and had instigated some plans to reduce the risks for these patients. However, for some areas of concern, the risks remained unmitigated. For example, not all patients who required a VTE assessment or nursing care plan had received one, and not all patients suspected of sepsis were treated within the appropriate timescales.

When the ED was full and over-capacity it was difficult to have thorough oversight of every patient. Opportunities existed for patients to deteriorate rapidly without being detected. For example, in majors, not all patients had their early warning scores reassessed in line with guidelines.

Hospital flow was recognised by the ED leadership team as a serious risk to the department's ability to provide safe care and treatment and achieve the performance standards required by both the royal colleges and NHS England. Senior clinical staff told us about the pressure they felt working in the department faced with the everyday overcrowding and capacity risks. These staff told us they did not always feel the trust leadership was aware of this pressure and had not tried to assure staff these risks belonged to the trust and the system and not to individual ED staff.

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.

The department used various IT systems to collect, analyse and share information within the department and the wider trust. Patients were tracked through their ED journey by an electronic computer system.

The department could monitor its performance on a live basis through an electronic patient dashboard. For example, monitoring the 4-hour targets, patient waits in the department, and the patient decision to admit status. The dashboard was monitored by staff in the department who could see the department's live activity and operational performance. The information was also shared at the trust's bed management meetings which occurred throughout the day to monitor and coordinate patient flow through the hospital.

There were arrangements to ensure information was used to monitor, manage and report on quality and performance. Monthly reports were produced and discussed at the relevant governance meetings.

The service collated and submitted data to a range of national audits. This allowed the comparison of data against national averages and standards to help facilitate continuous improvement. There were arrangements to ensure data or notifications were submitted to external bodies as required.