East Kent Hospitals University NHS Foundation Trust

Inspection report

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

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

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

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

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

Summary of findings

Background to the trust

The trust became an NHS foundation trust in 2009. It has five hospitals serving the local population of around 695,000 people throughout across Dover, Canterbury, Thanet, Shepway and Ashford.

The trust has 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. 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.

The trust has had four Care Quality Commission (CQC) inspections since 2014. Following the 2014 inspection, the commission put the trust into special measures. The commission recommended the trust stayed in special measures following an inspection in 2015.

The 2016 inspection tested the necessity for continued application of special measures. Following this inspection and a quality summit, the trust came out of special measures in March 2017. However, it received four requirement notices. These included: good governance (records), safe care and treatment (staffing levels), premises and equipment (maintenance) and good governance (audit programme).

NHS Improvement (NHSI) put the trust in financial special measures in March 2017 because it was forecast to be in significant financial deficit and was not meeting its control total (the trusts year end target against its budget). The trust was still in financial special measures at the time of the inspection.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement 

What this trust does

The trust operates from five sites. It has three 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 peoples care), surgery, critical care, gynaecology, services for children and young people, end of life care, and diagnostics.

It also operates two community hospitals, the Buckland Hospital in Dover and the Royal Victoria Hospital in Folkestone.

The trust also provide 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.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

Summary of findings

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

What we inspected and why

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

We inspected four core services and the 'well led' aspect of the trust in May and June 2018. These core services were across three hospitals including William Harvey Hospital, Queen Elizabeth the Queen Mother Hospital and Kent and Canterbury Hospital and included Emergency and Urgent Care, Surgery, Maternity and End of Life Care.

We plan our inspections based on all the information we have about services, including whether they appear to be getting better or worse.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at trust level. Our findings are in the section headed 'Is this organisation well-led?. We inspected the well-led key question on 12 and 13 June 2018.

Prior to this, we gathered information and data from the trust, NHS improvement, and stakeholders (community organisations with an interest in healthcare provided by the trust). We held focus groups for different staff prior to the core service and well led inspections.

Our last inspection of the trust was in September 2016. The report was published in December 2016, we rated the trust as 'Requires improvement' overall with 'requires improvement' ratings for safe, effective, responsive and well led. We rated the trust 'good' for caring. We considered all the information we held about the trust when deciding which core services to inspect and based our inspection plan on the areas considered to be the highest risk.

What we found

Overall trust

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

We rated safe, effective, responsive and well-led as requires improvement, and caring as good. We rated ten of the trust's 11 services as requires improvement and one as good.

Are services safe?

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

- Training compliance for medical staff was worse than the trust target of 85%, in the services we inspected.
- Training compliance in all core services we inspected had not achieved target for staff compliance in safeguarding children level three and safeguarding adult's level two.
- During the night the children's areas of the Queen Elizabeth the Queen Mother Hospital and William Harvey Hospital emergency departments were closed. This meant children shared waiting areas with adults. There was no audio or visual separation between children and adult patients. There were no facilities available for the distraction of the distressed child in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 43.
- There was a risk staff may not have recognised or responded appropriately to signs of deteriorating health or medical emergencies due to inconsistent practice in taking observations.

Summary of findings

- The arrangements for storing medicines did not always keep people safe. During our inspection, we saw opportunities for unauthorised people to access a variety of medicines.
- Daily fridge temperature monitoring across the core services we inspected was inconsistent. Staff did not always take fridge temperatures. When they did take fridge temperatures, they were sometimes taken incorrectly and when temperatures were outside of the expected range, staff did not always escalate concerns in line with guidance. Some staff we spoke to, who were responsible for checking the temperatures, did not understand how to take the temperature correctly, why they were taking fridge temperatures or the impact of temperatures that were out of range. This meant the trust did not have assurance medicines were stored in line with manufacturer's guidelines and would therefore be effective.
- The trust had not updated sepsis guidelines to reflect separate assessment by age group. Sepsis is a life-threatening blood infection. Although staff told us changes were in progress, we did not see any documents to evidence this.
- Some areas we reviewed during the inspection were visibly unclean.
- Equipment and the environment were sometimes old and dated. Staff in the surgery department had raised incident reports about broken equipment, but these incidents were closed and not always actioned. This meant staff used equipment which was faulty or unsuitable for its purpose.
- The trust was unable to provide us with results from hand hygiene audits when requested. This meant they were not assured staff cleaned their hands effectively and in line with national guidelines. Since our inspection we have seen evidence which demonstrated effective hand hygiene audits had been implemented, although the trust had not submitted the results previously.
- Staffing rates in some departments we inspected were below the planned staffing levels. We saw one department with unfunded beds, this meant the number of patients in the department had increased but funding to provide staff for those patients had not increased. In some instances, the hospital had not been able to recruit permanent staff or find bank or agency staff to fill in for uncovered shifts. This meant senior staff had to cover or there were not adequate numbers of staff to provide necessary care.
- Bank and locum staff provided a significant portion of nursing and health care assistant cover, this resulted in a large gap in skill mix as the day to day nursing care varied significantly.

However,

- Staff we spoke with understood their responsibilities to safeguarding both adults and children, despite low training compliance levels.
- There were processes and pathways to escalate and care for patients with suspected sepsis in a timely fashion. Staff managed suspected or confirmed cases of sepsis effectively using the 'Sepsis 6' care bundle. Audit findings showed improved compliance in relation to the screening and management of patients with sepsis.
- In some core services, we saw mandatory training had improved to meet the trust targets.

Staff understood their responsibilities to raise concerns and report incidents, even when the patient sustained low or no harm. The trust investigated serious incidents and staff complied with duty of candour requirements.

Are services effective?

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

- The trust performed some audits but they did not always perform scheduled audits. The trust did not always learn from audit outcomes or apply learning. This meant the trust was missing the opportunity to use audit information to implement meaningful change.

Summary of findings

- When staff identified learning from audit results and the organisation did not always implement changes or changes were sometimes delayed or stalled. We requested the action plans that had been created in response to the Royal College of Emergency Medicine audit results. The plans we received were incomplete. We did not see evidence in meeting minutes that action plans were shared or discussed. The plans did not always show they had a divisional sign off and although most actions had a completion date, it was unclear if these actions had been accomplished by their completion date. Many of the action plans were brief and limited. We did not see evidence that any of the actions were effective as audits were not repeated
- Audit results from national audits varied. Although there were areas where the trust performed similar to the national average, there were audits across the core services where the trust did not meet national standards.
- Staff still did not always receive timely and effective appraisals. Appraisal rates changed every month but generally the trust did not meet its target for appraisals. We reviewed the most recent staff survey which showed poor staff satisfaction regarding the effectiveness of their appraisals.

However,

- In the 2016/17 severe sepsis and septic shock audit, staff took 92% of patients' observations on arrival. This was better than the UK average of 69%.
- Staff we spoke with understood the importance of patients receiving sufficient nutrition and hydration. Dietitians within the hospital's clinical decision unit, supported patient nutrition and hydration. Staff could refer patients could if there were concerns about their weight and calorie intake.
- There were processes to make sure pain relief medicines were effective for patients.
- The trust supported national priorities to improve the population's health. Staff supported patients to manage their own health. We also saw information for patients on how to find emotional support and guidance.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff we spoke with could describe their responsibilities to ensure patients consented when they had the capacity to do so.
- In some individual departments, appraisal numbers had improved and met or exceeded the trust targets.

Are services caring?

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

- Staff provided emotional support to patients to minimise their distress and generally cared for patients with compassion.
- Across most core services, staff tried to ensure patients privacy and dignity for instance using discreet symbols to communicate personal or sensitive information about medical history, disabilities or end of life status.
- Staff involved patients and those close to them in decisions about their care and treatment. Medical staff provided clear information to their patients and families verbally and in writing across most of the core services.
- Staff spoke to patients, both adults and children, in a way that they could understand. Staff told us about how they worked to communicate clearly with patients who had communication difficulties.

However:

- There was no privacy and very little confidentiality for some patients waiting for and recovering from care.
- Feedback from patients regarding the care they received was mixed.

Summary of findings

- People's emotional, and social needs were not always addressed or reflected in their care, treatment and support.

Are services responsive?

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

- The trust remained under significant pressure to meet the needs of their patients. It did not have a clinical strategy, despite working with the Clinical Commissioning Groups (CCGs) and Sustainability and Transformation Partnership (STP) on this for some time. This meant the trust was not making some improvements or changes as they were waiting for the overall clinical strategy.
- The Royal College of Emergency Medicine standard recommends that the time patients should not wait more than one hour from the time of arrival to receiving treatment. The trust did not meet the standard for ten months over the 12-month period from February 2017 to January 2018.
- The Department of Health's standard for emergency departments states 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. The trust did not meet the standard from February 2017 to January 2018.Performance ranged between 70% and 80%.
- Flow through the emergency department was delayed due to low availability of beds in other departments. When patients were waiting for inpatient beds they were often waiting in the clinical decision unit or in the over flow corridor area. Although the department could discharge to ambulatory care, the unit was often too full to do so.
- Across the surgery services Referral to Treatment Times (RTT) for admitted pathways were worse than the England average.
- The hospital was not always responsive to the needs of children. A significant number of children could not access the area of the emergency departments, and nurses with paediatric competencies did not always treat patients in either the surgery or emergency departments. This was not in line with national guidance.
- There was little evidence of the learning applied to practice within the service from complaints.

However,

- The trust held bed meetings twice daily which ensured capacity was planned and discussed.
- The trust used technology to support patient access to care and treatment. There were screens in the waiting areas displaying estimated wait times and patients could access this information before they arrived on the trust website or through a mobile app.
- Staff took account of patients' individual needs. The service took action to meet the needs of different patient groups so they could access the service on an equal basis to others. This included the needs of patients living with dementia, patients with learning disabilities, bariatric patients (those with a high body mass index) and patients unable to speak English.

Are services well-led?

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

- The trust had not sufficiently embedded systems and processes to support the leadership to be able to drive improvement at the time of the inspection.

Summary of findings

- A focus of transformation was the new clinical strategy. The trust had been working on the clinical strategy with the Clinical Commissioning Groups (CCGs) and Sustainability and Transformation Partnership (STP) to develop the plans in line with regional needs for several years. This strategy had not yet been agreed. As a result, the board had suspended some decisions, which would affect governance and running of the trust until the strategy was in place. This impacted on many aspects of running the trust including investment, staffing and culture.
- The 2017 staff survey highlighted issues of concern. Board members recognised the need to focus on and improve the culture of the organisation and was developing processes to support staff and promote their positive well-being.
- The trust did not have effective structures, processes and systems of accountability to support the leadership's delivery of the strategy and high quality, sustainable services.
- The trust did not have a system or process to ensure it learned from mistakes, shared that learning or implemented changed based on it. For instance, lessons from incidents were not always identified. When it was identified, it was not always used to inform change or change was not fully implemented.
- Proactive risk identification and management was limited. Processes were not always adhered to and much risk management was reactive, risks were not always anticipated and it was not always clear that risks were escalated to the board.
- The trusts did not always use information and data effectively to monitor and improve the quality of care.
- Mandatory training numbers were low across core services and staff did not always feel they had time to complete mandatory and non-mandatory training.
- Staff provided a mixed picture about the visibility of the senior leadership team across the trust. Some staff members felt senior leadership was visible and approachable others said they would not know the senior leadership team if they saw them.
- Staff reported they did not always feel engaged and listened too. Some staff members told us they received too many e-mails and did not have time to read them. Some reflected they were disengaged and did not read communications, while others reported that they did not feedback to senior leadership because they did not feel they had been listened to historically.

However,

- We found the senior leadership team had the capability and integrity to ensure strategy could be delivered and address risks to performance.
- The trust was on a 'transformation journey'. It aimed to build on the improvements, which had raised the trust out of special measures in 2017. The trust had a transformation board, which was to oversee the transformation of the trust from ward to board.
- The transformation board was directly accountable to the Board of Directors and was on the agenda of each board meeting.
- The trust had six priorities for its transformation. These were: Getting to Good, Higher Standards for Patients, Healthy finances, A great place to work, Delivering our Future, Right Skills Right Time Right Place.
- These six work streams were used to develop change in the trust and were used in the board notes to justify and explain changes as well as being the structure used to communicate with staff and the public about change. The Trust included sustainability in its strategic and operational planning. The Sustainable Development Unit (SDU) and the regional network supported this.
- The trust had seen some improvements to culture since being put into quality special measures.

Summary of findings

- The organisation had processes to manage current and future performance. There were systems and processes to assess, prevent, deter, manage and mitigate risk, although they were not always used effectively.
- The trust managed data so that it was safe. It used an information management system developed as part of an NHS and private collaboration.
- The communications and engagement strategy focused on engagement with public and patients, staff, governors, members, partner organisations and other stakeholders. There was a cooperative relationship between the engagement and communications team and the board. The engagement and communications team supported trust strategies, for instance the Council of Governors membership engagement strategy, Quality Strategy, People Strategy, Research and innovation strategy and the Trust's charity.
- The trust was proactive in encouraging some kinds of learning and development. For instance, it had an active research department and encouraged quality improvement.

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Ratings tables

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

Outstanding practice

The trust demonstrated outstanding practice around communications. Communications were viewed as an essential tool to support the quality and transformation agenda and there was a symbiotic relationship between the engagement and communications team and quality group. The Director of communications was directly involved in many communications and senior staff explained that communication and engagement priorities, approach and plan were the basis of all trust communications.

The team had developed a Communications and Engagement Strategy 2016-2020 that supported other trust strategies, for instance the Council of Governors membership engagement strategy, Quality Strategy, People Strategy, Research and innovation strategy and the Trust's charity. The Communications and engagement strategy focused on engagement with public and patients, staff, governors, members, partner organisations and other stakeholders.

Areas for improvement

We found areas which need to be improved including five breaches of legal requirements that the trust must put right.

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

Action we have taken

We have issued requirement notices to the trust. The Requirement Notices related to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe Care and Treatment; Regulations 2014: Regulation 13 Safeguarding; Regulation 15 Premises and Equipment; Regulation 17 Governance; Regulation 18 Staffing.

We have asked the provider to supply an action plan in respect of the action that were identified that did not constitute a breach of regulations but which the trust should address.

Summary of findings

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust, feedback from other stakeholders and the public through our regular inspection.

Outstanding practice

The trust used technology to improve the patient experience. For instance, patients could use the trust's mobile phone applications to learn about wait times in emergency departments, access information about pregnancy and the maternity department and get support and guidance about the journey for a surgery patient from pre- to post-operative period.

It was notable that the maternity department had made great strides to drive learning, improve patient outcomes and inspire innovation. The team had a collaborate and multidisciplinary approach between clinical leaders and the team in the Maternity faculty. Its innovative training approach included human factors training and a simulation suite.

The intravenous access team took blood samples and inserted cannulas under ultrasound guidance. this was a better patient experience as it minimised the number attempts that were made.

Equipment in the resuscitation area was very well organised with colour coded drawers and clearly labelled equipment in glass fronted cabinets. The cabinets made it easy to see when a piece of equipment was missing. This meant staff could quickly find the correct equipment they needed to treat a deteriorating patient.

The surgery department had developed a tool to allow surgical ward clerks to carry out post-discharge telephone calls to patients to ease nurses' workloads. We saw a "post discharge telephone support form" completed by the ward clerks to document these calls. The form included set questions with clear "red/amber/green" ratings for different responses. There were clear criteria for escalating any areas of concern to the nursing team, including the need for immediate escalation of any "red flags".

Areas for improvement

Musts:

- The trust MUST take action to ensure all staff providing direct care and treatment to children and young people and vulnerable adults receive safeguarding level three training in line with national intercollegiate guidance and trust policy.
- The trust MUST take action to ensure staff are monitoring fridge temperatures correctly and are escalating any medicine fridge temperatures that are out-of-range and understand how to do this.
- The trust MUST ensure that consent to care and treatment is always sought in line with legislation and guidance in relation to records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR).
- The trust MUST develop robust quality measurement programme to ensure it can accurately monitor the quality of care, patients' outcomes, benchmark performance against National Institute for Health and Care Excellence Clinical Guidelines and other care standards in the maternity department at William Harvey Hospital.
- The trust MUST ensure it improves quality monitoring process and acts promptly where poor standards are identified to protect patients from receiving harmful care in the maternity department at William Harvey Hospital.

Summary of findings

- The service MUST ensure doctors are up to date with mandatory training including child safeguarding training in the emergency department.
- The trust MUST take action to maintain the premises and equipment in main theatres at Queen Elizabeth the Queen Mother Hospital and ensure all facilities and equipment are safe and fit for purpose.
- The trust MUST ensure they take action to ensure recovery areas are staffed by at least one registered children's nurse during children's operating lists in line with the Royal College of Nursing standards.
- The trust MUST take action to ensure sufficient levels of nurse staffing on all surgical wards.
- The trust MUST ensure staff in main theatres consistently complete all controlled drug register entries in line with national medicines management standards, including documenting witness signatures.
- The trust MUST improve referral to treatment times for surgical patients on 18-week pathways.
- The trust MUST implement systems to ensure existing board members continue to meet the criteria for fit and proper persons during the entire period they are on the board.

Shoulds:

- The trust should ensure it provides appropriate refrigerated milk storage for mothers wishing to breastfeed.
- The trust should consider providing appropriate breastfeeding facilities for mothers.
- The Trust should ensure it addresses the poor condition of the estate in the maternity department in a timely manner.
- The trust should take action to improve attendance at surgical divisional clinical governance meetings.
- The trust should take action to improve referral to treatment times (RTT) for admitted pathways for surgery.
- The trust should take action to ensure the trust values are embedded across all staff groups.
- Continue to review and take action to ensure that surgical areas are fit for purpose.
- Ensure that medicines are regularly checked and out of date medicines are removed from the fridges.
- Improve theatre utilisation for better use of staff resources and increased efficiency.
- Ensure regular staff meetings take place to improve staff engagement and the sharing and learning from incidents.
- Take action to ensure trust values are embedded across all staff groups.
- Take action to make sure that records for patients on the 'care of the dying patient and their family plan' are consistently completed.
- Make sure that lessons are learned and improvements made when things go wrong.
- Make sure that staff responsible for training other staff have the skills, knowledge and experience to do so and that all ward staff receive training in the delivery of effective care, support and treatment for patients at the end of life.
- Review the palliative care service with a view to providing a seven day face to face service.
- Make sure there is a framework and focus for identifying patients with an uncertain recovery who were at risk of dying, together with a framework for advance care planning.
- Make sure that capacity risks within the mortuary are comprehensively assessed and mitigated to ensure that the storage of the deceased is in line with the Human Tissue Authority published guidance and that people's dignity is respected during care after death.

Summary of findings

- Ensure that discussions about preferred place of care are consistently held in advance of the last days of life and that the achievement of discharge to the preferred place of care is monitored.
- Ensure that a trust wide end of life care strategy and action plans are in place.
- Ensure that processes for managing risks, issues and performance are effective. Risks should be identified and recorded on the risk register and adequately mitigated.
- Make sure that governance structures and processes are supported by structured action planning and prioritising.
- Ensure that improvement plans are sufficiently detailed, structured and timely.
- Take action to ensure that anticipatory prescribing for medicines is in line with trust guidance.

Is this organisation well-led?

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

- The senior leadership team had the capability, skills and integrity to ensure strategy could be delivered and to address risks to performance. There had been several changes to leadership since the last inspection and most interim posts were now filled permanently. However, there were still challenges delivering the boards objectives. Leadership development was limited and some systems and processes to support leadership and governance were not sufficiently embedded to drive improvement at the time of the inspection.
- The board focused on clinical leadership, but clinical leaders did not always have the capacity or systems to provide comprehensive clinical leadership. At board level, clinical leaders had large portfolios and did not always have adequate support. At departmental level some managers and leaders spent a significant portion of their time working in a clinical capacity which did not allow time to complete governance and leadership duties.
- A focus of transformation was the new clinical strategy. The trust had been working on the clinical strategy with the Clinical Commissioning Groups (CCGs) and Sustainability and Transformation Partnership (STP), to develop the plans in line with regional needs for several years. The trust was not able to unilaterally progress any one plan due to delays in consultation regarding the provision of health services across the system. The new clinical strategy was expected to be foundational for many of decisions about the trust in the future and would affect the trust's governance and leadership. As a result, the board had suspended some decisions which would affect governance and running of the trust until the strategy was in place. This impacted many aspects of running the trust including investment, staffing and culture.
- The 2017 staff survey highlighted issues of concern reflecting all staff did not feel they were listened to, supported or would recommend working for the trust. Board members recognised the need to focus on and improve the culture of the organisation and were developing processes to support staff and promote their positive well-being. The challenges raised by the staff survey highlighted the impact this had on the organisation and patient care. In response, the board implemented the staff engagement action plan 2018. However, at the time of inspection it was too early to measure whether the plan had had any impact.
- The trust did not have a system or practice to ensure it learned from mistakes, shared that learning or implemented changed based on it. For instance, lessons from incidents were only sometimes identified and then learning was identified, it was not always used to inform change or change was not fully implemented.

Summary of findings

- The trust did not always proactively identify and manage risks which could increase patients at risk of harm. We saw processes were not always adhered to and much risk management was reactive, some risks were not anticipated and high-level risks were not always escalated to the board.
- Information and data was not always used effectively to monitor and improve the quality of care.
- Mandatory training numbers, including safeguarding training rates, were low across core services and staff did not always feel they had time to pursue mandatory and non-mandatory training.

However,

- The trust was on a 'transformation journey' which aimed to build on the improvements which had raised the trust out of special measures in 2017. The trust had a transformation board which was to oversee the transformation of the trust from ward to board. The transformation board was directly accountable to the board of directors. Board papers and minutes reflected that a section of each board meeting was set aside, to deliver updates and reports regarding this programme.
- The trust had six priorities for its transformation. These were: getting to good, higher standards for patients, healthy finances, a great place to work, delivering our future, right skills right time right place.
- These six workstreams were used to develop change in the trust and were used in the board notes to justify and explain changes as well as being the structure used to communicate with staff and the public about change. The trust included sustainability in its strategic and operational planning. This has been supported by the sustainable development unit and the regional network.
- The trust had seen some improvements to culture since being put into quality special measures. Some staff felt positive about the future, supported and involved in the change process, but this was variable across the trust.
- The trust managed data so that it was safe, accessible and, in some instances functional. It used an information management system developed as part of an NHS and private collaboration. While the data was available, it was not necessarily used effectively to monitor and drive improvement.
- Communications were viewed as an essential tool to support the quality and transformation agenda and there was a symbiotic relationship between the engagement and communications team and quality group. The director of communications was directly involved in many communications and senior staff explained that communication and engagement priorities, approach and plan were the basis of all trust communications. T
- The team had developed a communications and engagement strategy 2016-2020 that supported other trust strategies, for instance the council of governors membership engagement strategy, quality strategy, people strategy, research and innovation strategy and the trust's charity. The communications and engagement strategy focused on engagement with public and patients, staff, governors, members, partner organisations and other stakeholders.

Ratings tables

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

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018

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

Ratings for William Harvey Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018
Medical care (including older people's care)	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Requires improvement Dec 2016	Good Dec 2016	Requires improvement Dec 2016
Surgery	Good →← Aug 2018	Good ↑ Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Good ↑ Aug 2018
Critical care	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
Maternity	Requires improvement →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Good ↑ Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018
Services for children and young people	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Requires improvement Dec 2016	Requires improvement Dec 2016
End of life care	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018
Outpatients and diagnostic imaging	Good Dec 2016	Not rated	Good Dec 2016	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016
Overall*	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018

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

Ratings for Kent and Canterbury Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Dec 2016	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Requires improvement Dec 2016
Surgery	Requires improvement →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement →← Aug 2018
Critical care	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
Services for children and young people	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
End of life care	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018
Outpatients and diagnostic imaging	Good Dec 2016	Not rated	Good Dec 2016	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016
Minor injuries unit	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall*	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018

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

Ratings for Queen Elizabeth the Queen Mother Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↓ Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018
Medical care (including older people's care)	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
Surgery	Requires improvement →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement →← Aug 2018
Critical care	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
Maternity	Requires improvement →← May 2018	Good →← May 2018	Good →← May 2018	Requires improvement →← May 2018	Requires improvement →← May 2018	Requires improvement →← May 2018
Services for children and young people	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Requires improvement Dec 2016	Requires improvement Dec 2016
End of life care	Requires improvement →← May 2018	Requires improvement →← May 2018	Good →← May 2018	Requires improvement →← May 2018	Requires improvement →← May 2018	Requires improvement →← May 2018
Outpatients and diagnostic imaging	Good Dec 2016	Not rated	Good Dec 2016	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016
Overall*	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018

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

Queen Elizabeth The Queen Mother Hospital

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Margate
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Key facts and figures

Queen Elizabeth the Queen Mother Hospital was originally built in the 1930s although most services have been relocated to the newer main hospital building. This is an acute hospital located in Margate, Kent. It serves the community of East Kent providing an extensive range of inpatient, outpatient and elective and emergency services. It has a postgraduate teaching centre that works in coordination with the local university.

Summary of services at Queen Elizabeth The Queen Mother Hospital

Requires improvement 

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

We rated safe, effective, responsive and well-led as requires improvement, and caring as good. We rated four of four core services as requires improvement.

Urgent and emergency services

Requires improvement 

Key facts and figures

East Kent University Hospitals NHS Foundation Trust (EKHUFT) delivers a range of urgent and emergency services through three hospitals in the region.

The urgent and emergency care department at Queen Elizabeth The Queen Mother hospital provides emergency care to people living in Margate and Thanet in Kent and serves a mixed population.

The emergency department at Queen Elizabeth The Queen Mother hospital has a four-bed resuscitation bay, 10 major cubicles, a mental health assessment room, seven minor injury assessment bays, plaster room and clinical procedure room. There is an observation area which has four bays. There is a separate area for children which has a waiting area and three designated child treatment cubicles, there is also a designated child resuscitation bay in the resuscitation area. There is an x-ray facility in the emergency department.

The hospital does have an inpatients paediatric ward but does not have paediatric intensive care support. Children requiring intensive care are transferred to a specialist paediatric unit. Children under the age of six months after registering in the emergency department are sent directly to the paediatric ward. The department has a newly built procedure room which was used to undertake minor procedures.

Patients who go to the hospital with minor injuries or illnesses register with reception before a triage nurse assesses them. Urgent and emergency services were last inspected in 2016 when overall, we rated it as requires improvement. We rated safe and caring as good as, responsive, effective and well-led as requires improvement.

Our inspection was unannounced and we inspected all five key questions. We spoke to 11 patients and carers and over 30 staff from different disciplines, including support and administration staff, nurses, doctors, managers and ambulance staff. We observed daily practice and viewed 30 sets of records. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

Summary of this service

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

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it. Mandatory training compliance amongst doctors was low, the module with the least compliance (40%) was infection control level one, the modules with the highest (60%) compliance was moving and handling level one and health and safety. The overall mandatory training compliance for medical staff at Queen Elizabeth The Queen Mother hospital was 50%. This was significantly lower than the trust target of 85%.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, child safeguarding training compliance was low amongst both doctors and nurses but particularly low amongst doctors and significantly lower than the trust target of 85%. Only 27% of doctors had up to date level three child safeguarding training and 20% had were up to date with level two safeguarding training. This meant doctors caring for children may not have the necessary skills and knowledge to identify a child at risk. Staff gave us examples of how to recognise and report abuse.

Staff working in the triage area of the department did not have direct access to handwashing facilities. This meant staff had to leave the triage area to wash their hands.

Decontamination products for example, sanitising hand alcohol gel was not stored securely and in line with the control of substances hazardous to health guidelines. During our inspection we identified that the cupboard which contained the hand gel was unlocked.

We reviewed the cleaning log of the toys and play equipment in the Children's department which showed that the toys were not cleaned every day. This meant there was no assurance that the equipment was being cleaned and could pose a risk of infection.

The environment in the emergency department did not always enhance patient safety.

The major treatment area and children's treatment area, were too small for the numbers of patients and staff who used them. This meant staff had to constantly move patients from one space to another and that moving patients around the department was a slow and difficult process.

There was inconsistent checking of emergency equipment on the resuscitation trolleys in both the adult department and Children's department. In addition, there was inconsistent checking of emergency equipment in the resuscitation bays. This meant there was no assurance that emergency equipment was available and fit for use.

The Children's waiting area was not visible from the Children's treatment area. This meant children could not be observed or supervised by staff in this area.

A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From February 2017 to February 2018 the trust reported 2,395 "black breaches", with December 2017 having the highest number just over 350.

The department was using the National Early Warning Score system for the monitoring of vital signs in adult patients to highlight early signs of deterioration of a patient's conditions. We identified two occasions when patients had a National Early Warning Score that required action to be taken, but there was no documentation in the patients electronic or paper record which outlined what action had been taken. This meant it was not possible to know if any action had been taken and the patients could be at risk of deterioration.

Staff told us that the department did not always feel safe. During busy times patients in the majors area were "doubled up" with one patient in front of the other, the patient in front was in the corridor and there was no access to suction or oxygen. Staff told us that they were unsure if the patient in the bay deteriorated if they could access the patient.

There was insufficient medical cover to provide consultant presence in the department for 16 hours a day, as recommended by Royal College of Emergency Medicine. Cover was only provided for 14 hours a day. This was consistent with our findings at the last inspection.

Patient safety checklist and risk assessments such as tissue viability assessments were not always completed. This meant the risks were not understood.

Staff cared for patients with compassion. However, there was no privacy and very little confidentiality for patients waiting on trolleys. Staff did not use privacy screens.

Doctors told us that abdominal (tummy) and chest x-rays were not reviewed and reported on by a radiologist or radiographer.

The service did not always have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There were insufficient registered children's nurses in post to ensure that the children's emergency department had at least one registered children's nurse

on duty per shift in line with national guidelines for safer staffing for children in emergency departments. Between the hours of 07:30am and 10pm there was a children's nurse within the children's department, outside of these hours adult nurses cared for children. Since our inspection the trust have provided assurance that there was now competent staff supporting children in the department at night.

There was a vacancy rate of 67% amongst the consultants, this meant locums were used to support the service.

Risks were not adequately assessed and understood. The risk register only contained two risks and didn't reflect areas of concern that we identified during our inspection.

Shared learning and feedback to staff from incidents was limited. This meant lessons learnt were not shared and changes communicated effectively.

We observed the service provided care and treatment based on national guidance and evidence of its effectiveness. However, there was limited oversight which checked to make sure staff followed guidance. In addition, Clinical guidelines had not been updated which meant they might not reflect the current best practice guidelines.

Although the service participated in national audits, local audits undertaken were limited. Audit results varied. Although there were areas where the department performed similar to the national average, results generally did not meet national standards, except for the Royal College of Emergency Medicine Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16. Performance in the Royal College of Emergency Medicine Audit: Severe sepsis and septic shock 2016/17 was also varied.

Two of the four consultants working in the department was on the General Medical Council Specialist Register and had completed and passed their specialist medical training in emergency medicine.

The trust's urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average from January 2017 to December 2017.

The environment was not sufficient to meet the needs of patients and placed patients at an increased risk of harm.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for ten months over the 12-month period from February 2017 to January 2018.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

The trust did not meet the standard from February 2017 to January 2018.Performance ranged between 70% and 80%.

A lack of flow through inpatient areas resulted in the department being regularly overcrowded.

Governance processes needed embedding and were not effective. There was no formal structure to departmental meetings or minutes produced. Meetings were often cancelled due to the busyness of the department and staff being required to work clinically.

Managers we spoke with were clear about the challenges the department faced and they were committed to improving the patients' journey and experience. However, we were not assured that there was a systematic approach to improving the quality of services and safeguarding high standards of care.

Staff told us during the winter they did not have time to give patients the care they required as they were so busy.

However:

Mandatory training compliance amongst nurses had improved since our last inspection, compliance for five of the six modules was better than the trust target of 85%.

Staff adhered to the infection control policy and used personal protective equipment such as gloves and aprons correctly when delivering care. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained.

The Children's area was secured by swipe-cards to prevent people inappropriately entering areas where children were seen. It had a separate waiting area so that there was audio and visual separation of adults from children.

The mental health room used for conducting mental health assessments was compliant with the Quality Standards for Liaison Psychiatry Services Fifth Edition 2017. For example, the room had no cables, heavy weight furniture and no ligature points. However, directly opposite the mental health room was an unlocked office which contained items which a patient could use to inflict harm on themselves.

The median time from arrival to initial assessment was better than the overall England median in all the months over the 13-month period from February 2017 to January 2018.

In January 2018 the median time to initial assessment was two minutes compared to the England average of nine minutes.

The department was using a Paediatric National Early Warning Score system for the monitoring of vital signs in children to highlight early signs of deterioration in the child's condition. We reviewed two Paediatric National Early Warning Score system forms and found they both been completed correctly and, where necessary, escalated to a senior decision maker.

Suspected or confirmed cases of sepsis (a life-threatening infection of the blood) were managed effectively using the Sepsis 6 care bundle. Sepsis 6 is a nationally recognised six-step care bundle that should be implemented within one hour. Our review of patient records and audit findings showed effective management of patients with sepsis.

De-briefs were regularly undertaken for staff to provide support after involvement in distressing situations. Staff gave an example of when a child died a consultant undertook a de-brief with the staff involved including ambulance staff who had also treated the child.

The emergency department provided care and treatment that was based on national guidance. This included National Institute for Health and Care Excellence and the Royal College of Emergency Medicine standards.

Unplanned re-attendance rate to the department within seven days was generally better than the national standard of 5% and generally better than the England average.

Eighty-eight percent of staff had received an appraisal which was better than the trust target of 85%.

We observed staff asked patients what name they wished to be called during their visit to the department and checked if patients were warm enough. Staff displayed an understanding and non-judgmental attitude towards patients.

The department had acknowledged the mental health needs of the local population and had access to mental health services 24 hours a day, seven days a week via the mental health liaison team.

There was an electronic application that patients and visitors could download which provided information about wait times for the department and neighbouring services such as the minor injury unit.

Despite widespread frustration there was a positive culture in the department which was centred on the needs and experience of patients. We observed relationships amongst staff in the department were cooperative, supportive and appreciative.

Urgent and emergency services

Is the service safe?

Requires improvement 

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

The trust could not be fully assured that staff were cleaning their hands effectively and in line with national guidelines. Audit findings supplied to us showed the number of staff observed during the audits varied between one staff member and ten members of staff. For example, in the audit carried out in March 2018 only one staff member was observed, this only provided limited assurances that staff were cleaning their hands effectively and in line with national guidelines. Since our inspection we have seen evidence which demonstrates effective hand hygiene audits are being undertaken.

We observed staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. However, there was a lack of audits to provide assurance that the service controlled the risk of infection.

The service did not have suitable premises and equipment and did not ensure that equipment was available and fit for use.

The adult resuscitation trolley did not have a tamper evident seal. This meant it was not obvious to staff if the trolley had been opened and may have been used and equipment not replaced.

The toilets within the urgent and emergency care department all contained pull cords which could be used as a ligature point if a patient wanted to inflict harm on themselves. We informed the matron of this issue who said they would arrange for the cords to be replaced.

There were no assurances that emergency equipment was available and fit for use. Daily safety checks on emergency equipment and resuscitation equipment were inconsistent.

The service only collected a limited amount of safety information for example infection control audits. Safety information that was collected for example actual staffing against planned staffing was not displayed and therefore shared with staff patients and visitors.

The overall mandatory training compliance for medical staff at Queen Elizabeth The Queen Mother hospital was 50% which was worse than the trust target of 85%.

Empty and full oxygen cylinders were stored together and not secured to the wall. This meant an empty cylinder could be attached in error and free-standing cylinders could fall over and injure someone or be stolen. Following the inspection, the trust told us they had taken action to rectify this with the use of new storage racks and the segregation of full and empty cylinders.

The service prescribed, gave, and recorded medicines well. Patients received the right medication at the right dose at the right time. However, the service did not monitor that medicines were always stored correctly.

The trust lacked assurance that medicines were always stored in line with manufacturers guidelines. Daily fridge temperature monitoring within the resuscitation area was inconsistent so the trust could not be assured medicines would be effective in an emergency.

The department was using the National Early Warning Score system for the monitoring of vital signs in adult patients to highlight early signs of deterioration of a patient's conditions. We reviewed five sets of notes and identified two occasions when patients had a National Early Warning Score that required action to be taken, but there was no documentation in the patients electronic or paper record which outlined what action had been taken. This meant we could not identify whether any action had been taken and the patients could be at risk of deterioration.

Urgent and emergency services

Doctors told us that abdominal (tummy) and chest x-rays were not reviewed and reported on by a radiologist or radiographer. The doctors had to interpret these x-rays without the specialist training that a radiologist or radiographer had. This meant they might not notice something that someone with specialist training would which could lead to delayed treatment.

There was not a ratified standard operating procedure on what patients could be cared for within the observation area. This meant unwell patients could be cared for in this area without the resources to meet their needs.

Medical cover was provided in the unit14 hours a day. This did not meet the Royal College of Emergency Medicine recommendation that medical cover be provided 16 hours per day. This was consistent with our findings at the last inspection.

During busy times patients were “doubled up” in the majors area, this meant there was no oxygen or suction immediately available for some patients and restricted access to patients.

There were insufficient registered children’s nurses in post to ensure that the children’s emergency department had at least one registered children’s nurse on duty per shift in line with national guidelines for safer staffing for children in emergency departments. Between the hours of 07:30am and 10pm there was a children’s nurse within the children’s department, outside of these hours adult nurses cared for children. Since our inspection the trust have provided assurance that there was now competent staff supporting children in the department at night.

Medical locums were used to support the service due to the 67% consultant vacancy rate.

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date. However, the electronic patient systems used by the department and the mental health service were different and did not interact together. This meant accessing information could be challenging.

The management of patient safety incidents needed improving. Staff recognised incidents and reported them appropriately. Managers investigated incidents however lessons learned were not always shared with the whole team or the wider service. For example, we were told that lessons learned were shared at handover but we could only find one example of this in the handover folder. However, we reviewed root cause analysis reports and saw when things went wrong, staff apologised and gave patients honest information and suitable support.

However:

Mandatory training compliance amongst nurses had improved since our last inspection, compliance for five of the six modules was better than the trust target of 85%.

From March 2017 to February 2018, the trust reported no incidents classified as never events for urgent and emergency care.

Staff adhered to the infection control policy and used personal protective equipment such as gloves and aprons correctly when delivering care. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained.

Suspected or confirmed cases of sepsis (a life-threatening infection of the blood) were managed effectively using the Sepsis 6 care bundle. Audit findings showed improved compliance in relation to the screening and management of patients with sepsis.

Is the service effective?

Requires improvement 

Urgent and emergency services

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

We observed the service provided care and treatment based on national guidance and evidence of its effectiveness. However, there was limited oversight which checked to make sure staff followed guidance. In addition, clinical guidelines had not been updated which meant they might not reflect the current best practice guidelines.

Although the service participated in national audits, local audits undertaken were limited and results were not compared with those of other services to learn from them. For example, no records audits were undertaken. This meant the service could not be assured of compliance within these areas.

There was a lack of facilities for preparing food and drink for patients, this meant only a limited menu was available.

Audit results from national audits varied. Although there were areas where the department performed similar to the national average, results generally did not meet national standards, except for the Royal College of Emergency Medicine Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16. Performance in the Royal College of Emergency Medicine Audit: Severe sepsis and septic shock 2016/17 was also varied.

Two of the four consultants working in the department was on the General Medical Council Specialist Register and had completed and passed their specialist medical training in emergency medicine. The Specialist Register is a list of doctors who are eligible to take up appointment in any fixed term, honorary or substantive consultant post in the NHS excluding foundation trusts. East Kent NHS trust is a foundation trust.

Adult nurses cared for children between 10pm and 07:30am without having the skills, knowledge and training to do so. Since our inspection the trust have provided assurance that there was now competent staff supporting children in the department at night.

There was insufficient medical cover to provide consultant presence in the department for 16 hours a day, as recommended by Royal College of Emergency Medicine. Cover was only provided for 14 hours a day. This was consistent with our findings at the last inspection.

Nurses caring for patients in the resuscitation department did not have a Trauma Immediate Life Support training. This meant nurses might not have the necessary skills and knowledge to care for trauma patients. There was a plan to ensure all nurses had received this training by November 2018.

Staff told us that there was no support and a lack of engagement from specialist teams for example the specialist medical team. Staff felt specialist teams did not review patients in a timely manner which meant patients had to wait unnecessarily in the department.

In the 2016/17 Moderate and Acute Severe Asthma report, Queen Elizabeth The Queen Mother Hospital failed to meet any of the standards.

In the 2016/17 Consultant sign-off audit, Queen Elizabeth The Queen Mother Hospital failed to meet any of the standards.

In the 2016/17 Severe sepsis and septic shock audit, Queen Elizabeth The Queen Mother hospital was in the lower UK quartile for three standards.

In the 2015/16 Vital signs in children audit, Queen Elizabeth The Queen Mother Hospital failed to meet any of the standards.

In the 2015/16 Procedural sedation in adults audit, Queen Elizabeth The Queen Mother Hospital failed to meet any of the audit standards.

However:

Sepsis screening and management reflected best practice and audit results showed improving compliance.

Urgent and emergency services

From February 2017 and September 2017, the trust's unplanned re-attendance rate to the department within seven days was generally better than the national standard of 5% and generally better than the England average.

Eighty-eight percent of staff had received an appraisal which was better than the trust target of 85%.

In the 2016/17 Severe sepsis and septic shock audit, Queen Elizabeth The Queen Mother Hospital was in the upper UK quartile for three standards.

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit, Queen Elizabeth The Queen Mother Hospital failed to meet one of the audit standards.

The service generally made sure staff were competent for their roles. Managers appraised staff's work performance however supervision meetings with them to provide support and monitor the effectiveness of the service were limited. For example, the emergency nurse practitioners did not have regular supervision to ensure they were competent to fulfil their role.

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

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 who lacked the capacity to make decisions about their care.

Is the service caring?

Good  

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

Staff provided emotional support to patients to minimise their distress. Staff cared for patients with compassion.

Staff involved patients and those close to them in decisions about their care and treatment.

We observed staff asked patients what name they wished to be called during their stay in the department and checked if patients were warm enough. Staff displayed an understanding and non-judgmental attitude towards patients.

We observed that staff spoke to children in a way that they could understand and tried to make things fun and used toys as a distraction.

However:

There was no privacy and very little confidentiality for patients waiting on trolleys. Staff did not use privacy screens.

We observed staff taking blood and inserting cannulas (a thin tube inserted into a vein or body cavity to administer medication, drain off fluid, or insert a surgical instrument) without the use of screens.

Feedback from patients regarding the care they received was mixed.

The trust's urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average from January 2017 to December 2017.

Is the service responsive?

Requires improvement  

Urgent and emergency services

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

The service did not always take into account patients' individual needs.

The environment was not sufficient to meet the needs of patients and placed patients at an increased risk of harm.

The children's department was not responsive to the needs of children. The treatment area was not big enough to accommodate patients who needed treatment.

We observed there was not enough room and resources to cope with the number of patients attending the department. Patients were frequently doubled up in the majors waiting area and there was insufficient room in the Children's treatment area.

A lack of flow through the inpatient areas resulted in the department being regularly overcrowded

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for ten months over the 12-month period from February 2017 to January 2018.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

The trust did not meet the standard from February 2017 to January 2018.Performance ranged between 70% and 80%.

From February 2017 to January 2018 the monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was worse than the England average.

People could not always access the service when they needed it. We observed there was not enough room and resources to cope with the number of patients attending the department. Patients were frequently doubled up in the majors waiting area and there was insufficient room in the Children's treatment area.

A lack of flow throught inpatient areas resulted in the department being reguarly overcrowded.

However:

The department had acknowledged the mental health needs of the local population and had access to mental health services 24 hours a day seven days a week via the mental health liaison team.

There was a box within the department, which contained resources such as candles and a teddy to help provide emotional support to parents who had lost a child.

The department had worked with the mental health provider to improve services for people with mental health needs who presented to the emergency department.

From February 2017 to January 2018. East Kent Hospitals University NHS Foundation Trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted started the reporting period better than the England average but has decreased since October 2017 to worse than the England average with January 2018 showing signs of improvement.

There was an electronic application (phone app) that patients and visitors could download which provided information about wait times for the department and neighbouring services such as the minor injury unit.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Urgent and emergency services

Is the service well-led?

Requires improvement 

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

There was no shared vision and strategy between the trust's senior leadership team and staff working on the frontline. Staff felt operational activity was always prioritised and did not feel the department had the resources or capacity to improve. Staff felt they 'firefighting' just to get through every shift and cared for patients the best they could.

Some concerns highlighted in the previous report had been addressed, for example an improvement in mandatory training compliance amongst nurses.

The risks and operational challenges were not fully understood by the senior leadership team.

There was minimal oversight and visibility of the senior trust's leadership team within the department. Medical and nursing clinical leadership needs to be strengthened.

Leaders within the department were working hard but dealing with operational challenges within the service hindered improvements and maintaining effective governance processes.

Managers across the trust did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff told us that senior managers did not have a realistic view of what happened operationally within the department or the challenges they faced.

Managers we spoke with were clear about the challenges the department faced and they were committed to improving the patients' journey and experience. However, we were not assured that there was a systematic approach to improving the quality of services and safeguarding high standards of care.

Local clinical leaders were responsible for all governance, quality and risk management in the department. They were supported by divisional managers; however, it was evident from the lack of set meeting agendas and meeting minutes, information provided and what staff told us on inspection, that local clinical leaders did not always have capacity within their roles to focus on governance and performance to a sufficient level.

Although we saw early signs of improvement we remain concerned about governance processes.

Risks were not adequately assessed and understood. The department's risk register only contained two risks and didn't reflect areas of concern that we identified during our inspection.

Monitoring the quality and performance management of the department was not always a priority. For example, one of the clinical leaders told us that over the winter the division was not always able to support the root cause analysis or governance meetings so they were cancelled.

Staff told us that it had become normalised practice to "double up" patients in the majors area when the department was overcrowded. Staff did express safety concerns to us about this practice. This meant that the leadership team were aware that patients were "doubled up" but had accepted it as normal and had not taken any action despite staff raising concerns.

Many staff expressed a sense of despondency and resignation about the long delays for assessment and treatment.

Reception staff described a poor relationship between themselves the management team and the nurses. There was a vacancy rate of 50% amongst reception staff at the time of our inspection, the team described a lack of support from management.

There was a disconnect and break down of relationship between reception staff and clinical staff which had a negative impact on staff morale.

There was a disconnect between the trust's senior leadership team and frontline staff. Staff and managers told us that the trust's senior leadership team made changes without discussing them with the staff and they were just implemented.

Staff described an over reliance on emails as a way of communicating with staff. Staff said especially over the winter months they did not have time to access their emails and read them. This meant staff were not kept informed of changes.

However:

Staff were positive about changes that had been made since the matron had been appointed a year ago who acknowledged there was still a lot of work to be done and that they were at the beginning of their journey.

Despite widespread frustration there was a positive culture in the department which was centred on the needs and experience of patients. We observed relationships amongst staff in the department were cooperative, supportive and appreciative.

Outstanding practice

The intravenous access team took blood samples and inserted cannulas under ultrasound guidance. This was a better patient experience as it minimised the number attempts that were made.

Areas for improvement

The service MUST ensure doctors are up to date with mandatory training including child safeguarding training.

The service MUST ensure consultant presence in the department for 16 hours a day, as recommended by Royal College of Emergency Medicine.

The service MUST ensure risks are fully understood, assessed and reflected on the departmental risk register.

The service MUST ensure adult nurses caring for children have the skills and knowledge required.

The service MUST ensure daily safety checks of emergency equipment are undertaken.

The service MUST ensure daily monitoring of fridge temperature temperatures.

The service MUST ensure the controlled drug ordering book is stored securely.

The service MUST ensure governance processes are strengthened and embedded.

The service MUST ensure that patients in the majors area are risk assessed and there is adequate access to patients in an emergency.

The service MUST ensure National Early Warning scores are calculated correctly, escalated and documented.

The service MUST ensure patients undergo risk assessments to ensure the risks are understood and mitigated.

The service MUST ensure patient safety checklists are fully completed.

The service MUST ensure substances subject to Control of Substances Hazardous to Health regulations are kept securely.

The service MUST ensure the safety of children is maintained whilst in the waiting room which is not in view of staff.

Urgent and emergency services

The service MUST ensure the dignity and respect of patients is maintained whilst in the majors area.

The service MUST ensure that there are forums and processes which allow shared learning from incidents.

The service MUST ensure that that performance is monitored and local audits monitor standards of care within the department.

The service should ensure there is an effective process which ensure toys are cleaned consistently.

The service should review handwashing facilities in the triage area.

The service should review arrangements for the reporting of x-rays.

The service should review the paediatric nursing establishment.

The service should ensure clinical guidelines are up to date and reflect current best practice.

Surgery

Requires improvement ➔➔

Key facts and figures

Surgery is provided at the three main hospital sites. There are 18 surgical wards across the trust and 303 inpatient beds.

(Source: Routine Provider Information Request (RPIR) – "Sites-Acute" tab)

The trust had 53,563 surgical admissions from November 2016 and October 2017. Emergency admissions accounted for 15,456 (29%), 29,881 (56%) were day case, and the remaining 8,266 (15%) were elective.

(Source: Hospital Episode Statistics)

Queen Elizabeth the Queen Mother Hospital had 90 surgical beds across four wards: Bishopstone Ward, Sea Bathing Ward, Cheerful Sparrows (male) and Cheerful Sparrows (female) Ward. There was also a Day Surgery Unit, which was open Monday to Wednesday from 7am to 8pm, Thursday to Friday from 7am to 10pm, and occasionally at weekends. The hospital mainly covered trauma and orthopaedics, and general surgery specialties.

The hospital has a dedicated emergency theatre, as well as a surgical emergency assessment unit with two trolleys where patients with surgical emergencies could be referred from their GP for urgent assessment. The surgical emergency assessment unit was open Monday to Friday, 11am to 7pm.

During our inspection, we spoke with 40 members of staff, including nurses, doctors, physiotherapists and ward clerks. We spoke with four patients and reviewed three sets of patient records. We also reviewed a variety of performance data, meeting minutes and staff competency records.

Summary of this service

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

- The service had not taken sufficient action to maintain the premises and equipment in main theatres. Leaders were aware of safety concerns regarding lack of maintenance of some of the premises and equipment in main theatres but had failed to address this.
- Nursing staff in day surgery theatres did not have had a sufficient level of safeguarding children training in line with national intercollegiate guidance.
- Medical and dental staff failed to meet the trust's mandatory training target of 85% between January and December 2017 for any of the six required modules. Nursing staff also did not meet the 85% target for information governance training.
- Nurse staffing in the main surgery recovery areas did not meet the Royal College of Nursing standards during paediatric operating lists. This was because there was not at least one registered children's nurse on duty in the recovery area during children's operating lists.
- The service sometimes had insufficient nursing staff on the surgical wards to meet patients' needs. Nurse staffing shortages did not feature on the risk register. This meant the service might not have had sufficient oversight of this risk.
- The service did not have assurances staff always stored refrigerated medicines within the manufacturer's recommended range to maintain their function and safety.

Surgery

- Referral to treatment times (RTT) for admitted pathways for surgery were worse than the England average. In December 2017, 57% of patients were treated within 18 weeks, which was worse than the England average of 72%.
- Governance meetings were not given sufficient priority. Clinical governance meetings did not regularly take place, and there was poor attendance from staff.
- The trust values did not appear to have been embedded amongst staff. Most staff we asked were unable to tell us the trust values, despite them being included in staff appraisals.

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with staff to continuously improve patient safety.
- When things went wrong, staff apologised and gave patients honest information and suitable support. This was in line with the duty of candour regulation under the Health and Social Care Act (Regulated Activities Regulations) 2014.
- Staff kept records of patients' care and treatment in line with Nursing and Midwifery Council and General Medical Council guidance and standards. Records were clear, up-to-date and available to all staff providing care.
- The service used safety monitoring results well. Staff collected safety thermometer information, such as rates of falls, pressure ulcers and catheter-acquired urinary tract infections and shared it with staff, patients and visitors.
- The service carried out assessments of risks to patients and took action to lessen risks such as falls and pressure ulcers. We saw evidence of regular observations of patients using an early warning system and action taken to escalate any deterioration.
- The service provided care and treatment based on national guidance and best practice. The service carried out audits to check staff followed internal policies and guidance.
- Patients had good outcomes following surgery. Results from national audits showed the service performed well, with patient outcomes about the same as other NHS acute hospitals nationally.
- The service made sure staff were competent for their roles. Managers appraised staff performance, and we saw evidence of meaningful appraisals. Competency records we reviewed provided assurances staff had the skills they needed to do their jobs.
- Staff of different kinds worked together as a team to benefit patients. We saw positive examples of multidisciplinary working between different staff groups, including doctors, nurses and therapists.
- Staff obtained patient consent in line with national guidance and legislation. Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.
- Staff took account of patients' individual needs. The service took action to meet the needs of different patient groups so they could access the service on an equal basis to others.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results. The service shared learning from complaints with relevant staff to help drive continuous improvement.

Surgery

- Managers across the trust promoted a positive culture that supported and valued staff. Staff generally spoke positively of the culture and described positive working relationships with colleagues and managers.
- The service took action to actively engage with staff and seek their views through focus groups and open forums.
- The service had a strong focus on training and developing its own staff. The service had recently introduced an "improvement journey" programme to support nurses recently promoted from band five staff nurses to band six junior sisters/charge nurses. The service hoped this would help fill some of the nursing vacancies by helping improve staff retention.
- The service had some recent areas of innovation. This included a tool for ward clerk post-discharge telephone calls and a smartphone application for orthopaedic patients called "my journey". The application, which was due to be rolled out two weeks after our visit, supported patients on their journey from pre to post-operative. The application reminded patients of their medications and exercises to support them as they prepared for, and recovered from, surgery.

Is the service safe?

Requires improvement 

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

- The service did not always look after premises and equipment well. The service had not taken sufficient action to maintain the premises and equipment in main theatres. We had concerns around the safety of some equipment and the fabric of the building in main theatres. This included chipped paintwork and doorframes, and operating lights that failed to stay in position while surgeons operated on patients. We saw staff had persistently raised these concerns, both with the estates department and by completing electronic incident reports. However, the trust had failed to address them in a timely way.
- After raising our concerns regarding main theatres, particularly the broken operating lights, the trust took immediate action to address this risk. We received written assurance from the Chief Executive on 1 June 2018 confirming the theatre lights had been repaired and replacements ordered to replace others as the trust continued to review the remaining theatre lights. We saw that the trust added our concerns regarding the operating lights to the surgical divisional risk register on 18 May 2018 and took immediate action to repair or replace the broken lights. The risk register showed the trust had replaced or repaired the faulty operating lights and audited all remaining operating lights to identify any further lights for repair or replacement. The trust completed this audit on 20 June 2018 and obtained assurances all operating lights were safe and fit for purpose.
- The service did not always provide mandatory training in key skills to all staff and made sure everyone completed it. Nursing staff in day surgery theatres did not have had a sufficient level of safeguarding children training in line with national intercollegiate guidance. The trust only required day surgery theatre staff to complete level two safeguarding children training. However, the national intercollegiate guidance, "Safeguarding Children and Young People: roles and competences for health care staff" (2014) recommends, "All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns should have level three training". Staffing rotas provided by the trust confirmed day surgery theatre staff covering paediatric operating lists did not have up-to-date level three safeguarding children training. This was not in line with the intercollegiate guidance.

Surgery

- Medical and dental staff failed to meet the 85% trust target for safeguarding adults level two and safeguarding children level two between January and December 2017. Nursing staff also failed to meet the target for these modules, as well as failing to meet the target for safeguarding children level three training. Only 32% of required nursing staff completed safeguarding children level three training between January and December 2017. This was much worse than the target of 85%.
- Nurse staffing in the main theatre recovery areas, where children recovered following surgery on paediatric operating lists, did not meet the Royal College of Nursing standards as set out in their 2013 guidance, "Defining staffing levels for children and young people's services- Royal College of Nursing standards for clinical professionals and service managers". This was because registered adult nurses, rather than paediatric nurses, staffed this area. However, the Royal College of Nursing guidance states, "At all times there should be a minimum of one registered children's nurse on duty in recovery areas".
- Following concerns around a lack of registered children's nurses in theatre recovery areas, the trust provided a written statement confirming that in main theatre recovery areas, all nurses and operating department practitioners were adult-trained but they had "cared for and managed children for many years without incident". Although theatre recovery staff had paediatric competencies, such as paediatric equipment competencies and paediatric immediate life support training to mitigate this risk, the lack of a dedicated registered children's nurse did not meet the Royal College of Nursing guidance. In the day surgery recovery area, the trust used a dedicated registered children's nurse for paediatric operating lists to meet the Royal College of Nursing standards.
- Medical and dental staff failed to meet the trust's mandatory training target of 85% between January and December 2017 for any of the six required modules. Information governance had the worst completion rate, with only 54% of medical and dental staff completing this module between January and December 2017. Nursing staff also did not meet the 85% target for information governance training, and had a 75% completion rate for this module.
- The service did not always have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The service had insufficient nursing staff on the Cheerful Sparrows (female) Ward to meet patients' needs. There were three "unfunded" beds on Cheerful Sparrows (female) Ward, with no additional staff to cover these beds. We saw incident reports that demonstrated the impact of low staffing levels on Cheerful Sparrows (Female) Ward, such as patients having to wait for pain relief and intravenous fluids.
- The service did not always prescribe, give, record and store medicines well. The service did not have assurances staff always stored refrigerated medicines within the manufacturer's recommended range to maintain their function and safety. On Cheerful Sparrows (female) Ward, staff had consistently recorded fridge temperatures outside of the manufacturer's recommended range and not taken action to notify pharmacy. We raised our concerns about the medicines fridge on Cheerful Sparrows (female) Ward with staff, who escalated this issue to the estates department. The estates department subsequently condemned the fridge and ward staff shared the medicines fridge on the adjacent Cheerful Sparrows (male) Ward while waiting for a replacement.
- Controlled drugs registers in main theatres did not always have all entries signed and witnessed by two members of staff. This was not in line with the Controlled Drugs (Supervision of management and use) Regulations 2013. We raised our concerns with theatre staff, and observed staff receive feedback at the team briefing the following morning. We saw staff receive a reminder of the importance of complete and accurate documentation in the controlled drugs registers. This demonstrated the service took prompt action to address our concerns.

However:

Surgery

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with staff to continuously improve patient safety. When things went wrong, staff apologised and gave patients honest information and suitable support. This was in line with duty of candour under the Health and Social Care Act (Regulated Activities Regulations) 2014.
- Staff kept appropriate records of patients' care and treatment. Staff kept records of patients' care and treatment in line with Nursing and Midwifery Council and General Medical Council guidance and standards. Records were clear, up-to-date and available to all staff providing care.
- The service used safety monitoring results well. Staff collected safety thermometer information, such as rates of falls, pressure ulcers and catheter-acquired urinary tract infections and shared it with staff, patients and visitors. We saw "safety crosses" displayed on the surgical wards providing assurances around the rates of harm-free care.
- The service carried out assessments of risks to patients and took action to lessen risks such as falls and pressure ulcers. We saw evidence of regular observations of patients using an early warning system and action taken to escalate any deterioration. Records we reviewed demonstrated staff completed early warning charts and calculated scores correctly, as well as escalating patients for urgent medical review in line with the associated guidance. Early warning charts included prompts to screen for possible sepsis, which the trust audited each month for every ward to provide ongoing assurances around sepsis screening.
- Theatre staff completed all required steps of the World Health Organisation (WHO) Surgical Safety Checklist to ensure patients received the correct operation. Staff were fully engaged in the carrying out the checks and the checklist appeared embedded into the theatre team's routine practice. Audit results showed a high level of compliance with the checklist (between 97.9% and 100% in the period March 2017 to April 2018), which was consistent with our observations.
- The service controlled infection risk well. Staff Staff kept themselves, equipment and the premises clean to prevent infections. All clinical areas we visited were visibly clean and tidy. Staff used control measures to prevent the spread of infection. For example, all staff we met were "bare below the elbows" in line with best practice.

Is the service effective?

Good  

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

- The service provided care and treatment based on national guidance and best practice. The service carried out audits to check staff followed internal policies and guidance. This included World Health Organisation Surgical Safety Checklist and sepsis screening audits. Audits provided assurances around staff compliance and helped identify areas for improvement.
- Patients had good outcomes following surgery. The service participated in a range of national audits, including the national bowel cancer audit, the national emergency laparotomy audit, and patient reported outcome measures (PROMS). The results showed the service performed well, with patient outcomes comparable to other NHS acute hospitals nationally.
- The service made sure staff were competent for their roles. Managers appraised staff performance, and we saw evidence of meaningful appraisals. Competency records we reviewed provided assurances staff had the skills they needed to do their jobs.

Surgery

- 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 followed the Royal College of Surgeons' guidance on fasting before surgery. The service began auditing pre-surgery fluid intake in March 2018, and results showed the service achieved 100% compliance with the standard of clear fluids two hours before surgery in March and April 2018.
- The service was pro-active in preventing post-operative pain. Records demonstrated staff regularly assessed and recorded patients' pain and responded accordingly. Patients we spoke with told us staff promptly offered pain relief when they reported pain.
- Staff of different kinds worked together as a team to benefit patients. We saw positive examples of multidisciplinary working between different staff groups, including doctors, nurses and therapists. Patient records we reviewed demonstrated multidisciplinary involvement in patient care.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care. We saw evidence of best interests' decision-making for patients who lacked capacity in accordance with the Mental Capacity Act 2005. We also saw evidence the service obtained patient consent for surgery in line with General Medical Council guidance.

Is the service caring?

Good

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

- Staff cared for patients with compassion. Feedback from the NHS Friends and Family Test demonstrated most patients (between 93% and 98%) would recommend the service to their friends and family. Patients we spoke with confirmed staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress. We observed staff in theatres talking with patients in the anaesthetic room to lessen their anxiety. We saw a member of staff stay with a patient who had their operation under local anaesthetic throughout the procedure, explaining what was happening at each stage and providing support. The hospital had a chaplaincy service available to provide spiritual support to patients while they recovered from surgery.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients described how staff introduced themselves and put them at ease. Patients we spoke with on the wards described how nursing staff responded promptly when they rang their call bells for assistance.
- A member of staff we spoke with described how a consultant had given their own money to buy some new clothes for a homeless patient so they could be discharged with dignity. Staff also described how they had brought in some of their partners' old clothes for elderly patients on the wards that had no family nearby to bring clean clothes into the hospital for them.

Is the service responsive?

Requires improvement 

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

- People could not always access the service when they needed it. Referral to treatment times (RTT) for admitted pathways for surgery were worse than the England average. In December 2017, only 57% of patients were treated

within 18 weeks, which was worse than the England average of 72%. The trust was working to address this, for example by bringing patients' planned operations forward to fill cancelled theatre slots where it was safe to do so. However, more recent data for January to April 2018 showed referral to treatment rates had remained the same and not improved.

However:

- Staff took account of patients' individual needs. The service took action to meet the needs of different patient groups so they could access the service on an equal basis to others. This included the needs of patients living with dementia, patients with learning disabilities, bariatric patients (those with a high body mass index) and patients unable to speak English.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results. The service shared learning from complaints with relevant staff to help drive continuous improvement. Complaint responses we reviewed showed evidence of investigation, explanation and apology.
- The trust planned and provided services in a way that met the needs of local people. The service had a dedicated emergency theatre to allow priority access for those with the greatest need. The trust opened a new, two-bedded Surgical Emergency Assessment Unit in September 2017. Patient feedback about the unit was highly positive and it meant some patients could avoid waiting in the emergency department before admission for emergency surgery. In the day surgery unit, there was a separate four-bedded paediatric bay with an adjacent children's waiting area and bathroom. This ensured children were not sharing the same facilities as adult patients
- The percentage of cancelled operations at the hospital was better than the England average. The average length of stay for elective operations was as expected compared with the England average, but 1.2 days longer than the England average for non-elective surgery. Operating lists generally started on time. The percentage of operating lists in day surgery that started on time had improved since our last inspection in 2015 from 85% to 92.9%.

Is the service well-led?

Requires improvement 

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

- The trust had systems for identifying risks, planning to eliminate or reduce them, however, concerns were not always escalated sufficiently. Leaders were aware of safety concerns regarding lack of maintenance of some of the premises and equipment in main theatres but had failed to address this. The restriction on using private agency staff on the wards also meant there were often unfilled nursing shifts. This created a risk of not having enough staff to meet patients' needs.
- Areas of risk we identified, such as maintenance of the facilities and equipment in main theatres and nurse staffing shortages did not feature on the risk register at the time of our inspection. This meant the service might not have had sufficient oversight of these risks. However, we saw the trust took our concerns seriously and added the risk of faulty operating lights to the surgical divisional risk register on 18 May 2018. The trust subsequently took immediate action to repair or replace the broken lights.
- The service did not always use a systematic approach to continually improve the quality of its services and safeguard high standards of care. Clinical governance meetings were not given sufficient priority. Clinical governance meetings did not regularly take place, and there was poor attendance. We requested copies of the last three clinical governance

meeting minutes, and the most recent minutes the trust could supply were from 21 November 2017. This meant there had not been a surgical divisional governance meeting for six months before our visit. The minutes from 21 November 2017 showed poor attendance. Only six staff attended the meeting, with no clinical representation from most surgical specialties.

- The trust values were not embedded amongst all staff. Most staff we asked were unable to tell us the trust values, despite them being included in staff appraisals.

However:

- Managers across the trust promoted a positive culture that supported and valued staff. Staff generally spoke positively of the culture and described positive working relationships with colleagues and managers. Staff felt confident to raise concerns and report incidents and told us their managers encouraged them to do so. Staff described having an "open culture" and showed awareness of the need to be honest with patients when things went wrong.
- The service took action to actively engage with staff and seek their views. A theatre matron held staff focus groups and divisional directors held quarterly open forums for staff to share their views. The service also used a "claims, concerns and issues" exercise to capture staff feedback and senior managers gave an example of how they had used this to make immediate improvements for administrative staff.
- The service had a strong focus on training and developing its own staff. The service had recently introduced an "improvement journey" programme to support nurses recently promoted from band five staff nurses to band six junior sisters/charge nurses. The service hoped this would help fill some of the nursing vacancies by helping improve staff retention.
- The service had some recent areas of innovation. This included a tool for ward clerk post-discharge telephone calls and a smartphone application for orthopaedic patients called "my journey". The application, which was due to be rolled out two weeks after our visit, supported patients on their journey from pre- to post-operative. The application reminded patients of their medications and exercises to support them as they prepared for, and recovered from, surgery.

Outstanding practice

We identified the following areas of outstanding practice:

- At the time of our visit, the trust was in the final stages of developing a smartphone application called "my journey" for orthopaedic patients. The application, which was due to be rolled out two weeks after our visit, supported patients on their journey from pre- to post-operative. The application reminded patients of their medications and exercises to support them as they prepared for, and recovered from, surgery.
- The service had developed a tool to allow surgical ward clerks to carry out post-discharge telephone calls to patients to ease nurses' workloads. We saw a "post discharge telephone support form" completed by the ward clerks to document these calls. The form included set questions with clear "red/amber/green" ratings for different responses. There were clear criteria for escalating any areas of concern to the nursing team, including the need for immediate escalation of any "red flags". A senior matron described how this system was working well to identify any post-discharge concerns and relieve nursing staff to perform other tasks on the ward.
- We identified a consultant giving their own money to buy some new clothes for a homeless patient so they could be discharged with dignity as an area of outstanding practice. Staff also described how they had brought in some of their partners' old clothes for elderly patients on the wards that had no family nearby to bring clean clothes into the hospital for them.

Surgery

Areas for improvement

Action the service MUST take to improve:

- The trust must take action to maintain the premises and equipment in main theatres and ensure all facilities and equipment are safe and fit for purpose.
- The trust must take action to ensure all staff providing direct care and treatment to children and young people receive safeguarding level three training in line with national intercollegiate guidance.
- The trust must ensure they take action to ensure recovery areas are staffed by at least one registered children's nurse during children's operating lists in line with the Royal College of Nursing standards.
- The trust must take action to ensure sufficient levels of nurse staffing on the surgical wards.
- The trust must take action to ensure staff take prompt action to escalate any medicine fridge temperatures that are out-of-range and understand how to do this.
- The trust must ensure staff in main theatres consistently complete all controlled drug register entries in line with national medicines management standards, including documenting witness signatures.
- The trust must improve referral to treatment times for surgical patients on 18-week pathways.

Action the service SHOULD take to improve:

- The trust should take action to improve attendance at surgical divisional clinical governance meetings.
- The trust should take action to ensure the trust values are embedded across all staff groups.

Maternity

Requires improvement 

Key facts and figures

The trust has 50 maternity beds across two sites; Queen Elizabeth The Queen Mother Hospital and William Harvey Hospital.

The Queen Elizabeth The Queen Mother Hospital in Margate delivers approximately 2,800 births a year. It offers specialist obstetric care for women with complications and anaesthetists providing a 24-hour epidural service for women who prefer this for pain relief as well as for women who require anaesthesia for operative and assisted births. The Special Care Baby Unit takes babies born after 28 weeks. Those babies born unexpectedly earlier or who are very sick are transferred to William Harvey Hospital. In general, women with very high-risk pregnancies or likely to deliver before 28 weeks were transferred prior to delivery.

The hospital provides specialist obstetric care for pregnancy, childbirth and the post-partum period. The labour ward is consultant led and has an obstetric theatre. Obstetric relates to childbirth and the processes which go with it.

The midwifery led unit is next to the labour ward and is a midwife run unit. The unit supports birth in a less clinical environment. The unit has four multifunctional rooms, two with birthing pools, which is used for labour, delivery and postnatal care.

Kingsgate ward provides consultant led antenatal (before birth), labour and in patient postnatal (after birth) care for women with high risk pregnancies and those who chose consultant led care.

Next to the maternity unit is the fetal medicine and antenatal clinic which is open between 8am to 8pm. The clinic arranges all first trimester scans, books antenatal and postnatal appointments as well as running a range of midwifery and consultant led clinics.

During the inspection, we spoke with mothers and their families, cleaners, midwives, midwifery health care assistants, consultants, matron, the head and deputy head of midwifery.

Prior to the inspection, we held focus groups for staff and reviewed the trusts performance data.

Since the previous inspection there has been a change in leadership team with a new head of midwifery and deputy as well as the introduction of the clinical governance midwife.

The trust had also introduced the maternity transformation programme, birthing excellence success through teamwork (BESTT).

Summary of this service

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

- Medical staff training compliance rates were below the trust's 85% target. The compliance rates varied from 67% to 87% for mandatory training modules with an average of 80%.
- Safeguarding training amongst the medical staff fell below the trust’s own target of 85%.

Maternity

- Data requested for mental capacity training for medical and midwifery staff was not available therefore we could not determine whether staff had the knowledge and understanding of patients who lacked capacity to consent to some aspects of their care.
- The risk register for the hospital showed us the unit was reaching 96.2% for the last year for 1:1 care in labour and falling short of the 100% target.
- The midwife to birth ratio at the time of the inspection was 1:30. This was above the national benchmark of 1:28.
- There were insufficient staffing levels across the trust and this meant the labour ward co-ordinator was not supernumerary on each shift. This meant their ability to provide leadership support, deploy resources, and oversee the quality of care in the department may be affected.
- During the inspection, we reviewed the most recent caesarean section rate and found them to be 30%. This was higher than the England average.
- The maternity unit environment was generally tired, and in need of modernisation.
- There was a lack of recording of fridge temperatures and reporting out of range temperatures, which meant there was a risk to medicines and breast milk not stored correctly and posed an infection risk.

There was a lack of effective audit and quality assurance systems to monitor quality outcomes and benchmark against national standards.

However:

- We received positive feedback from patients via patient surveys and comments from the comment box.
- There was a key focus on education and training, with midwifery and nursing staff compliant in mandatory training in all areas other than information governance.
- There are staff shortages which have impacted on 1:1 care of women. However, staff recruitment drives have taken place. The risk has been placed on the risk register report and the head of maternity complete a staff review by June 2018.
- Staff are motivated and have been involved in fundraising events for the maternity unit
- Staff felt recent changes have been positive, staff feel valued and feel they work within a good team.
- The care provided reflected best practice and national guidelines.
- Managers identified the need for further improvement to feedback from lower level incidents and cross-site learning and staff engagement as an area for continued improvement.

Is the service safe?

Requires improvement 

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

- We were not given a breakdown of compliance for mandatory courses, within the Queen Elizabeth the Queen Mother hospital acute birth settings for medical staff. Therefore, we were unable to determine whether medical staff had met the trust target for completion of mandatory training.

Maternity

- We were not given a breakdown of compliance for safeguarding level two and three courses, within the Queen Elizabeth the Queen Mother hospital acute birth settings for medical staff. Therefore, we were unable to determine whether medical staff had met the trust target for completion of safeguarding training.
- The maternity unit environment was generally tired, and in need of modernisation.
- The temperature during the last inspection was reported to be intolerably hot for patients. Staff told us that the temperature within the unit was difficult to control due to the design of the building and they had been encouraged to complete an electronic reporting incident form each time the temperature went above a safe level. The World Health Organisation standard for comfortable warmth is between 16 to 20'C. We were told that ongoing temperature audits of the maternity unit were completed although we were not given any current information. A temperature audit completed in October 2017 showed us through May to June 2017 temperatures exceeded above 20'C, with the highest temperature recorded in June 2017 of 28.5'C.
- We observed sharps boxes, which were not labelled correctly, and one, which was overfilled, this posed a potential needle stick injury risk to staff and patients.
- Paediatric resuscitation trolley in the obstetric recovery room had two items out of date and on both trolleys, daily checks had not always taken place. We alerted the labour ward manager regarding the out of date items and we were told that this would be rectified and discussed within the safety huddle. The labour ward manager had also informed the head of midwifery following our observations.
- We observed that medicines, including intravenous fluids, were stored correctly. However, medication stored in fridges in Kingsgate ward and labour ward were all found to have not always been checked daily. Temperatures were recorded which were not in the required range and we could not see documentation to state that this had been reported to pharmacy.
- Due to the maternity unit having one obstetric theatre, we were told it was used for emergency caesarean sections only. This meant all planned caesarean sections were taken to general theatres. The time to travel to the general theatre was between five and six minutes. This raised concerns in relation to patient safety, as well as privacy and dignity, if there were to be two emergency cases at one time and one had to be transferred to general theatres. Staff and the head of midwifery were aware of the potential risks to having one obstetric theatre used for emergency cases, but due to the current configuration of the unit they told us it was not currently possible to have a second obstetric theatre.
- The department had CCTV in place and staff monitored movement onto the labour ward. Visitors and patients were monitored arriving onto the unit, but there was an unrestricted departure point so the system was not robust and not in line with the Royal College of Obstetricians and Gynaecologists 2008, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour 2.2.26 'Security is an issue of importance for staff, mothers and babies. A robust system must be in place for their protection. Babies born in hospital should be cared for in a secure environment to which access is restricted.'
- Following the previous inspection, venous thromboembolism scores were now being placed onto the maternity dashboard, however the amount of assessments completed were 92.5%, which do not meet trust target of more than 95%.
- National Institute of Clinical Excellence NG4 Safe Midwifery Staffing states women in labour should receive 1:1 care. The risk register for the hospital showed us the unit was reaching 96.2% for the last year for 1:1 care in labour and falling short of the 100% target.
- There were insufficient staffing levels across the trust and this meant the labour ward co-ordinator was not supernumerary on each shift. This meant their ability to provide leadership support, deploy resources, and oversee the quality of care in the department may be affected.

Maternity

- We did not find evidence to suggest the trust monitored the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour and staff did not provide this information. The National Institute for Health and Care Excellence states analysing a delay of 30 minutes or more between presentation and triage is a method of monitoring a midwifery red flag event. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. As the trust did not monitor this, there was a greater risk senior manager would be unaware of these issues
- In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in maternity, which met the reporting criteria set by NHS England from March 2017 to February 2018.

However:

- The trust set a target of 85% for completion of mandatory training and within the nursing/midwifery team at Queen Elizabeth the Queen Mother all key skills but one were met, information governance. We observed examples of staff training records showing completed training, training due and training outstanding. There was a clear system to track and monitor staff statutory and mandatory training, which staff demonstrated to us.
- From May 2017, the trust introduced a maternity specific training programme with each staff member undertaking five core-training days in key obstetric skills in fetal monitoring, essential life support skills in obstetrics, human factors, simulation and maternity update day. The five-day programme has overlapping themes featuring serious incidents. The trust aims for all obstetric staff to have completed the training by June 2018.
- There was good compliance with the World Health Organisation surgical check list with 99.70% completed. This meant that this safety standard was being applied in practice to safeguard patients from practices known to reduce preventable maternal and new-born deaths around the time of childbirth.
- All departments within the maternity unit were considered high risk or very high risk for infection control. The hospital was compliant with the Department of Health guidance recommending: 'All patients admitted to high risk units and all patients previously identified as colonised with or infected by Methicillin-resistant Staphylococcus aureus (MRSA) should be screened for MRSA. Patients were screened for methicillin-resistant staphylococcus aureus (MRSA) automatically at pre- clerking for an elective or emergency caesarean section.
- Fetal monitoring face to face training took place, which was in line with MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK and Each baby counts. Following on from the training, the department had midwifery fetal monitoring champions.
- Midwives told us that each woman attending antenatal had a green pre-birth plan. Inside the green plan there is a small discreet box which can be ticked if a woman has disclosed any domestic violence. We observed the domestic abuse policy which had recently been reviewed and gave clear guidance to staff. There were folders seen in the midwife's office with women who have safeguarding needs and there is a baby alert sticker and annotation in red on the white board placed inside the office to identify these women.
- The completion of safeguarding training was 85% above trust target for midwifery staff.
- The completion rate for staff infection control training was 96% compliant, which is above the trust target of 85%.
- Cleaning was sourced to an outside company and we observed evidence that domestic staff followed guidance of the required cleaning standards, practices and frequency of cleaning. Cleaning schedules and monthly cleaning scores were on display.
- Patients were continually risk assessed using a maternity obstetric early warning score (MEOWS) is to determine the degree of risk of an unexpected deterioration in the condition of a patient. Patient notes we reviewed showed comprehensive completion and evidence of escalation if a patient were seen to be deteriorating.

- There were completed risk assessments for patients with actions taken that were clearly documented. There was adequate use of the venous thromboembolism (VTE) score checklist, partogram (a composite graphical record of key maternal and fetal data during labour), World Health Organisation (WHO) checklist used in theatres, charts for growth and early warning scores
- A communication tool 'Situation, Background, Assessment and recommendation' (SBAR) had been introduced for staff handovers and advice calls between midwives and doctors at the last inspection. A daily huddle took place daily within the maternity unit. The huddle discussed patients, monitoring risks and safety. A handover sheet was used each day that gave full details of patient, event, and any concerns or complications
- We observed the protocol used for the assessment of fetal growth and staff could tell us how risk assessments take place at booking during pregnancy. Serial growth scans were arranged if there was an increased risk of fetal growth problems or if fundal height measurements were not accurate.
- We observed comprehensive risk assessments carried out for women who used services and risk management plans were developed in line with national guidance. Women were risk assessed on each visit to the department even if they arrived from the early pregnancy unit on to the wards. This ensured the continuous monitoring of risk. Risk assessments contained information on women's social and medical assessments and referral, as well as assessment of maternal mental health. Patients were triaged before arrival onto the unit. Patients with additional needs were flagged at this point so staff were aware at pre-admission if any extra care was needed.
- Staff recognised incidents and reported them in line with trust policy. 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.

Is the service effective?

Good ➔➔

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

- We found from discussions and observations with staff and patients that care was being provided in line with The National Institute for Health and Care Excellence (NICE) quality standard 22. We observed women accessing antenatal care and being supported in their birthing choices, staff were able to support women whose first language was not English by using a 24-hour translation and interpreting service, a 24-hour triage service for patients was in place.
- The national neonatal audit programme showed there were 66 eligible mothers identified for inclusion in audit. The mothers had delivered their babies between 24 to 34 weeks gestation. The audit showed 87.1% were given a complete or incomplete course of antenatal steroids. This was within the expected range nationally and above the national aspirational standard of 85%.
- The National Institute for Health and Care Excellence Quality Standard 37 was adhered to in respect to post-natal care. Examples included staff discharging patients with appropriate checks and with correct medicines. All patients we spoke with had been given breastfeeding advice and support.
- The observations and discussions we made reflected that the trust was following recommendations from National Institute of Care and Excellence Quality Standard 190: Intrapartum care. Women were offered a choice of birthing locations and choice of care throughout labour. We witnessed discussions between staff over patient's choice and how they accommodate them; this showed that were focused on the women's needs.

- The National Institute for Health and Care Excellence (NICE) quality statement 7 on skin to skin contact was adhered to in post-natal care. Skin-to-skin contact with babies soon after birth had been shown to promote the initiation of breastfeeding and protect against the negative effects of mother–baby separation. There was information about this on the wards, this was promoted in theatre and all staff encouraged women to do this.
- The National Institute for Health and Care Excellence (NICE) guideline quality statement six on intrapartum care on delayed cord clamping was evidenced in theatres. Delayed cord clamping meant more blood reached the baby immediately after birth and may help to prevent anaemia. Staff told us that they promoted delayed cord clamping of baby as well as skin to skin between mother and baby.
- The trust employed a public health consultant midwife who supports feeding. The hospital also employed a band four healthcare assistant to offer extra advice, support and guidance to women experiencing difficulties with breastfeeding. The staff member also supported mothers on how to feed their babies using aids for a 'hands-off' approach. Leaflets were available on infant feeding and there were poster displays around the unit.
- We observed the trust policy on infant feeding which included weighing babies. Staff were aware of the policy and were keen to support mothers on their feeding choices and all patients we spoke to said they had received support to breastfeed soon after birth, and continued on the post-natal ward.
- Women had access to a range of pain relief methods following NICE guidance CG190. This included Entonox (gas and air) and Pethidine (a morphine-based injection) for medical pain relief during labour.
- There was an audit programme for obstetrics, which showed most patient outcomes were in line with national standards. Audits were based on recognised national guidance including the National Institute for Health and Care Excellence (NICE), Royal College of Obstetricians and Gynaecologists 'Safer Childbirth: minimum standards for the organisation and delivery of care in labour'. Audits completed in obstetrics included gestational diabetes, national maternity and perinatal audit, term admission to neonatal unit, third and fourth perineal tear. The hospitals rates for 3rd and 4th degree tears assisted and unassisted were on average 1% for assisted and 1.8% for unassisted. This was within the trust target of below 5%.
- The department had a dedicated preceptorship midwife who identified training needs and supported staff. We observed clinical support and supervision for newly qualified midwives, junior doctors and students. Newly qualified midwives have a preceptorship period of 18 months and staff told us that they have were supported for longer to ensure they were confident and competent to undertake their role.
- Mental health assessments and specific wellbeing questions were included in the booking and pregnancy assessments at 28 weeks between patient and midwife.

However:

- The unit did not have Baby Friendly Initiative (BFI) accreditation but were keen to work towards this. The UNICEF UK Baby Friendly Initiative was launched in the United Kingdom in 1995 to work with the NHS to ensure a high standard of care for pregnant women and breastfeeding mothers and babies in hospitals and community health settings.
- Caesarean section rates were way above the expected trust target, with the total caesarean rate being in average 32.8% with target of less than 25%. Elective caesarean rates on average were 13.2%, target being less than 10% and emergency caesarean rates being 19%, target 20.7%. The head of midwifery identified these rates as a concern and told us that the department were completing an audit shortly to look at why rates were higher than the national average and above trust guidance.
- We observed the trusts current key recommendations to reduce intra partum death as part of MBRRACE (Mother and Babies: Reducing risk through audits and confidential enquiries). We found throughout the key recommendations the

trust was only partially compliant in most areas of recommendations. There was non-compliance in no assessment tool for risks on admission, induction of labour or regularly throughout labour and there was no proforma in place for fetal movements as recommended in Royal College of Obstetricians and Gynaecologists national quality improvement programme Each Baby Counts.

- The Association of Anaesthetists of Great Britain & Ireland states the time from the anaesthetists being informed that a woman has requested an epidural to the time the epidural is performed should not exceed 30 minutes and should only exceed 1 hour in exceptional circumstances. The trust did not provide us with recent data to show this target was met, therefore we could not be assured that the trust continued to monitor if it was meeting this target.
- The trust offered fetal anomaly screening in accordance with current UK National Screening Committee programmes. This was in line with NICE quality standard QS22: Antenatal care. The trust performance for fetal anomaly screening was 87.7%, which did not meet the acceptable testing rate of greater than 97%
- Staff told us that they had completed training on Mental Capacity Act and Deprivation of Liberty Safeguards. However, the requested trust data was not given, and we were unable to identify whether staff had reached the trust target for completion.

Is the service caring?

Good 

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

- We observed staff taking time to interact with patients and saw examples where staff demonstrated the importance of gaining the trust of women they were treating. Staff introduced themselves to patients and explained their roles within the department.
- Staff spoke and interacted with patients in a respectful and considerate way, which was reflected in the patient feedback seen in the friends and family comment box. Positive comments we observed were 'Quick and decisive action when complications arise, filled us with confidence', 'couldn't ask for better', 'reception lady absolutely great when we arrived as midwives in handover'. We also saw thank you cards and photographs around the department.
- A counselling service was available within the trust and was co-ordinated by a women's health counsellor. Counselling sessions took place within the postnatal ward, patient's home, counselling room or the neonatal intensive care. The counselling service also provided virtual sessions over skype or telephone. We observed patient information on these services and advice to women about support services available.
- One patient told us that after a difficult birth with her first baby at a different hospital she decided to come to Queen Elizabeth the Queen Mother. The patient told us 'we were given so much more time at every stage, we were informed this is what the protocol is, but this is your decision. We felt empowered to influence'. We were also told by a patient 'on the labour wards there is a difference between doctors and midwives, they have different approaches. Midwives are more understanding, they were supportive of our decisions and choice in front of the doctor. They gave everything the best chance to work out'.

Is the service responsive?

Requires improvement  

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

Maternity

- The trusts maternity dashboard information provided showed us that there had been no unit closures from April 2017 to March 2018. However, there had been 14 unit diverts to another hospital which was above expected targets. This showed that the unit at times were not able to provide planned services to meet the needs of the local people. We observed the trust had a policy in place and in date for guidance on unit closures. This guidance is significant for a hospital in an area with high deprivation indicators and where the additional financial burden of travel to a more distant hospital was likely to have a detrimental impact.
- The trusts maternity dashboard showed an average of 84% of women receiving antenatal care at Queen Elizabeth Queen Mother saw a midwife by 12 weeks and six days of pregnancy between April 2017 to March 2018. This was just below the trust's target of 90%.
- When requesting further information of how care is provided for patients with learning disabilities or bariatric patients the trust provided us with information, which was out of date. Therefore, we were unable to identify whether patients with additional needs or disabilities were being managed or well cared for.

However:

- A 24-hour triage system was in place for patients, the maternity day care service ran from 8am to 8pm. Once the day care service has ended, all out of hour's calls would come through to the labour ward and women would be triaged and seen as part of national guidance. The deputy head of midwifery told us that if any woman had concerns and wanted to come to the unit then they encouraged the patient to do so. Staff told us that the triage system in place did not affect patient care when they were busy and women appreciated being able to have access to a midwife for reassurance.
- We reviewed the trust website, which included a range of information for women and links to various pieces of information that signposted to external support. The trust had put together a series of films about the journey through pregnancy, labour and beyond.
- The maternity transformation programme was launched in May 2017. The programme focused on improving outcomes for mothers and babies and developed by the Department of Health's Safer Maternity Care action plan and used within the trusts maternity services. There were five areas focused within the plan which are leadership, learning, practice, teams, data and innovation. During the inspection we observed clear actions in place since the plan started.
- The trust followed guidance from Maternity Matters and there were four midwifery led rooms, all with ensuite bathrooms and two with a birthing pool available. When talking to staff it was clear that women were given safe birthing choices. Staff were also able to explain the exclusion criteria for water births, which we found appropriate for patient safety.
- We observed the new bereavement suite that was funded entirely by money raised by staff and the local community. We observed and listened to the thought and effort that had been put into creating a suite that was able to provide comfort and understanding at a sad time for a woman or family experiencing the loss of their baby. The suite was situated away from the maternity unit and had a separate entrance so that women would not have to hear babies crying or see pregnant women.
- At the previous inspection, staff had identified further training in NHS newborn and infant physical examination programme (NIPE) to prevent prolonged discharge times. This is an examination of a child shortly after birth. The examination includes a general physical check as well as an examination of the baby's eyes, heart, hips and testes in boys. Matron told us and we observed evidence that 10 staff have now been trained to complete the newborn and infant physical examination check, with a list seen of further staff waiting to attend training.

- Staff were able to signpost patients to the Patient Advice and Liaison Service department as appropriate. Staff at all levels told us complaints were discussed at meetings. We observed actions that were shared with staff via various mediums including newsletters and staff told us that complaints were discussed at ward meetings.

Is the service well-led?

Requires improvement  

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

- We reviewed governance meeting minutes from December 2017 to April 2018. The meetings were well attended by senior staff but we observed that the same ongoing actions continued each month with no end date and no clear direction. We were told by one member of staff 'there are lots of meetings, but nothing is put in action'.
- We found some trust data and guidance to be outdated and not reviewed within the timeframe specified within the policy or guidance. This did not provide the trust with assurance that staff were following up to date guidance or practice in certain key areas of care such as patients with additional needs.
- We found that there were high levels of risk identified on the register. For example, we had information provided from the risk register for the last 12 months, which showed continuous high level risk for caesarean sections. There had been no current audit in place, with the last audit completed in 2016, with no current investigation taking place or recent audit the trust would find it difficult to identify any common trends or themes as to why there is a high incidence of sections. During an interview with the head of midwifery, we were informed that they had recognised the high incidence for caesarean sections and there was an initial action plan in place to review the incidence of caesarean sections.
- There were arrangements in place to gain information to monitor, manage and report on quality and performance. However, not all information or guidance seen was in date nor were trends or risks identified reviewed in a timely manner.

However:

- The previous inspection had highlighted a period of instability and poor governance systems and processes that were not consistently applied. During inspection we found there was new systems and processes in place and in the process of being developed which were much improved, but not all were fully embedded.
- A change in culture amongst senior staff at all levels appears to have taken place within the unit, but we received feedback that the change in attitude and culture around governance although happening is a slow process.
- The head of midwifery and gynaecology was new in post and alongside were two deputy heads of midwifery based at either hospital site. The maternity unit was managed by a matron, who was focussed in driving improvements in care as well as accessing funding and support to improve the maternity unit facilities and areas for patients. The senior team knew the unit and staff well and could clearly recognise and articulate the challenges and risks their team faced in delivering good care.
- The senior team have provided an optimistic vision for the service and have appointed a clinical governance midwife, we observed that the electronic incident reporting forms, serious incidents and risks are now being assessed and disseminated in to the midwifery team such as within team meetings, safety huddle and message of the week.

Maternity

- The trust launched its maternity transformation programme, birthing excellence success through teamwork (BESTT) benchmarking and agreeing actions to focus on how to improve outcomes for mothers and babies. The focus areas for the programme were drawn directly from the Department of Health's Safer Maternity Care action plan and then localised to address collaboratively agreed areas for improvement and innovation across trust maternity services.
- The 2017 staff survey results were not positive, staff felt stressed, tired and unsupported. During the inspection staff told us that there had been an improvement in culture within the unit due to a more visible leadership team who were approachable, positive and optimistic.
- Staff were encouraged to report incidents and receive feedback, staff liked the innovation taking place through the maternity transformation programme, the multi professional learning, training opportunities and the preceptorship period for newly qualified midwives.
- Clinical services managers and the head of midwifery sat on the trust's internal women's health clinical governance group. The committee met monthly and provided quality and safety assurances to the trust board. We observed that matron received copies of the minutes and disseminated any learning points or changes of practice to all relevant staff. Staff told us that they were informed about governance and changes in ward meetings, or via e-mail.
- There had been previous poor compliance in completing electronic incident report forms. Since the previous inspection there had been an increase in electronic incident reporting forms completed and a new clinical governance midwife to review, evaluate and share learning by reviewing risk and incidents. We observed evidence of shared learning from incidents within team meeting, daily safety huddles and on staff notice boards.
- Staff told us of a number of fundraising initiatives between staff and the local community. Through local community support the unit was able to build a purpose-built bereavement suite which also featured artwork from local artists.
- Funding was received to introduce the maternity transformation programme, birthing excellence success through teamwork (BESTT) and further funding has been obtained to develop the 'my own maternity app' which will be an app where women can carry their own maternity records, access information and personalise to add maternity appointments for antenatal or to discuss a condition or complication of pregnancy.

Areas for improvement

- The trust **MUST ensure** that all medical staff received the required levels of mandatory and safeguarding training.
- The trust **MUST** ensure 100% target for 1:1 care in labour
- The trust **MUST** develop robust quality measurement programme to ensure it can accurately monitor the quality of care, patients' outcomes, benchmark performance against National Institute for Health and Care Excellence Clinical Guidelines and other care standards.
- The trust **MUST ensure** it improves quality monitoring process and acts promptly where poor standards are identified to protect patients from receiving harmful care.
- The Trust **should** ensure it addresses the poor condition of the estate in the maternity department in a timely manner.

End of life care

Requires improvement 

Key facts and figures

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 2,685 deaths from December 2016 to November 2017.

The Palliative care team delivers a face-to-face visiting service five days per week from 9am to 5pm Monday to Friday. Out of hours and at weekends, a telephone advisory service is available from the Local Hospice to support the wards.

The palliative care team consisted of a palliative care nurse consultant and a palliative care social worker across the three hospital sites within the trust. There were two whole time equivalent clinical nurse specialists based at The Queen Elizabeth the Queen Mother Hospital and one whole time equivalent end of life care facilitator. Consultant in palliative medicine cover was provided by the local hospice for two clinical sessions a week at the Queen Elizabeth the Queen Mother Hospital.

There had been 496 referrals to the specialist palliative care team based at the Queen Elizabeth the Queen Mother hospital in the 12 months preceding our inspection. Of those 496 referrals 259 (52%) were for those patients with a diagnosis of cancer, 205 (41%) for those with a non-cancer diagnosis and the remaining 32 (7%) for were patients with both a cancer and non-cancer diagnosis. Examples of non-cancer diagnoses included sepsis, respiratory disease, heart failure and stroke.

During our inspection we visited a range of clinical areas wards including; care of the elderly; surgical and medical wards. We also visited the bereavement office, the chapel and the mortuary.

We met with 17 staff including; the palliative care nurse consultant; palliative care nurses; a care of the dying nurse; chaplaincy staff; bereavement staff; a mortuary manager, technicians and clinical lead; allied health professionals; matrons; ward managers; end of life care link nurses and healthcare assistants; registered nurses; consultants and junior doctors; healthcare assistants; and porters.

We were unable to speak with any patients or relatives. We reviewed eight patient records including; seven 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions.

Summary of this service

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

- Incidents were not being reported on the trusts electronic reporting system. For example, the practice of placing two deceased patients in a fridge space designed for one had been happening during particularly busy periods. Although a risk assessment had been carried out and the matter had been escalated, it had never been reported as an incident.
- We did not see a comprehensive record of a formal mental capacity assessments having taken place. A patients mental capacity was mentioned in the records, and on the do not attempt cardio pulmonary resuscitation orders. There was no face-to-face seven day service. The Palliative Care and end of life care service operated Monday- Friday 9am – 5pm. There was a 24 hour a day, seven day a week advisory line available for all hospital staff out of hours from the local hospice.

End of life care

- The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed worse than the England average for all of the five clinical indicators. The trust scored particularly poorly for the measure, "Is there documented evidence that the needs of the person(s) important to the patient were asked about?"
- Capacity issues within the mortuary led to processes for storing the deceased that did not ensure that people's dignity was respected during care after death. We were told, and were shown a table that demonstrated that this had happened during the winter, specifically once in February and 16 times in March.
- Complaints relating to the care of patients at the end of life were reviewed by the end of life care board and themes identified. However, it was not clear how these were shared with staff in a way that ensured lessons were learned and care improved.
- There was written material available for patients and their relatives regarding end of life. However, these were not available in any languages other than English.
- The challenges facing the service were known to the leaders and the mechanisms were in place for improvements to be made. However, action plans lacked details of how the improvements would be achieved.
- A formal agreement with the hospice regarding the provision of palliative care consultant cover had still to be finalised despite being in preparation for at least 18 months.

However,

- Fridge temperatures in the mortuary were monitored remotely through a system that could be accessed wherever there was access to the internet. A mobile phone app that linked to this system was available to the mortuary manager. This meant that temperatures could be monitored 24 hours a day, seven days a week.
- We found evidence that teams from different disciplines worked well across the hospital and weekly palliative care multidisciplinary team meetings were held at the Queen Elizabeth the Queen Mother Hospital.
- Staff treated patients and their relatives with kindness, dignity and respect. Staff were always willing to give relatives the time they needed to explain what was happening and what would happen next.
- Staff dealing with families that had recently been bereaved were conscious of the needs of those people. We saw that staff allowed relatives as much time as they needed to be with their loved ones soon after death.
- Family members of patients approaching the end of life had access to a large, clean and welcoming room where they could rest, prepare meals, sleep and wash so they didn't have to leave the hospital site.
- Chaplaincy services were available for those that requested it and could be provided by chaplains of different faiths as well as those with no faith.
- The leaders of the service were visible and approachable to all staff that dealt with patients approaching the end of their life.
- Staff described a positive working culture where there was a belief that all staff had the opportunity to contribute to the care of those patients approaching the end of their life.

Is the service safe?

Requires improvement 

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

End of life care

- Incidents were not being reported on the trusts electronic reporting system. For example, the practice of placing two deceased patients in a fridge space designed for one had been happening during particularly busy periods. Although a risk assessment had been carried out and the matter had been escalated, it had never been reported as an incident. This meant that a formal, electronic, trust wide record of each occurrence was not available. We did not see data in relation to incidents being collated and reported. There were no standing items on the end of life care board meeting agenda to discuss incidents as they occurred. Furthermore, there was no way of identifying incidents that specifically related to the care of patients that were end of life.
- Staff involved in the provision of end of life care could not be sure that all end of life care patients were being identified on the wards. It was largely dependent on the ward staff indicating correctly on the electronic patient tracking system that a patient was end of life.
- There was no formal service level agreement in place for palliative care medical input. At the last CQC inspection in September 2016 we were told that a service level agreement with the local hospice was being drafted. At this inspection the service level agreement was still in draft form.
- The area at the back of the mortuary was cramped with a public pathway that passed the area where funeral directors would park to collect the deceased. Although the doors to the rear of the mortuary were ordinarily kept shut, the frequency with which the deceased were collected by funeral directors or transferred across sites meant that people passing by could see what was happening. Members of the public that had visited the pharmacy could easily access this area and in turn access the rear of the mortuary if the doors were open. This problem could have been alleviated by erecting a fence.

However,

- Fridge temperatures in the mortuary were monitored remotely through a system that could be accessed wherever there was access to the internet. A mobile phone app that linked to this system was available to the mortuary manager. This meant that temperatures could be monitored 24 hours a day, seven days a week.
- Syringe drivers could be obtained from the medical equipment library. Each one was tagged which meant that they could be tracked and there was an audit trail of their use.
- Anticipatory medicines 'just in case' patients at the end of life experienced symptoms were available.

Is the service effective?

Requires improvement 

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

- Not all end of life care link workers had completed all of the training linked to their roles. For example, there were two mandatory training elements to the role of link worker. At the time of the inspection, 28 of the 41 link workers had attended the first part of the mandatory training. The second mandatory training programme had five elements. At the time of the inspection, two of the 41 link workers had completed all five parts of the training with five link workers having completed between one and four parts of the training. This meant that 34 (83%) of the link workers had not completed any of this part of the mandatory training.
- There was inconsistency in the recording of who had received syringe driver training. Each individual unit was responsible for ensuring that they held records that demonstrated that staff had received training and were competent to use syringe drivers. Details of who had been trained to use one type of syringe driver were held in one place while staff that had been trained in the use of a different syringe driver was held elsewhere. This meant that there was no single place where details of those that had been trained in the use of syringe drivers was kept.

End of life care

- Consent to care and treatment was not always sought in line with legislation and guidance. In three of the six 'do not attempt cardio pulmonary resuscitation' orders we were unable to find any documented formal mental capacity assessments.
- There was no face-to-face seven day service. The Palliative Care and end of life care service operated Monday- Friday 9am – 5pm. There was a 24 hour a day, seven day a week advisory line available for all hospital staff out of hours from the local hospice. People's nutrition and hydration and pain management needs were identified and met in relation to national guidance for caring for people in the last days and hours of life.
- The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed worse than the England average for all of the five clinical indicators. The trust scored particularly poorly for the measure, "Is there documented evidence that the needs of the person(s) important to the patient were asked about?" However, the trust were now carrying out audits of their own, in line with the Dying in Hospital audit.
- We did not see a comprehensive record of a formal mental capacity assessments having taken place. A patients mental capacity was mentioned in the records, and on the do not attempt cardio pulmonary resuscitation orders

However,

- The introduction of end of life link workers had increased the skills and competencies of generalist staff across the wards although further work to ensure that all link workers were fully trained was required.
- We found evidence that teams from different disciplines worked well across the hospital and weekly palliative care multidisciplinary team meetings were held at the Queen Elizabeth the Queen Mother Hospital.
- End of life care was managed across the trust in line with National Institute for Health and Care Excellence (NICE) guidance. For example, there was evidence that the trust had developed services in line with NICE guidance NG31 Care of dying adults in the last days of life. This included aspects of end of life care such as the identification of people at the end of life; assessment, care planning and review; care in the last days of life; and, anticipatory prescribing.

Is the service caring?

Good ➔➔

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

- Staff treated patients and their relatives with kindness, dignity and respect. Staff were always willing to give relatives the time they needed to explain what was happening and what would happen next.
- Staff dealing with families that had recently been bereaved were conscious of the needs of those people. We saw that staff allowed relatives as much time as they needed to be with their loved ones soon after death.
- The service ensured that patients wishes were taken into consideration if they wanted to donate their tissue or organs after death.
- Where possible the service arranged for patients' pets to be bought on to the hospital premises as well as organising 'pets as therapy' visits to the hospital.
- When breaking bad news staff were sensitive to the need of the person receiving it. For example, shortly after a patient had died we saw a senior member of staff call a relative. They carefully described what had happened and the same member of nursing staff met the family member at the entrance to the ward and accompanied them to see their relative.

However,

End of life care

- Capacity issues within the mortuary led to processes for storing the deceased that did not ensure that people's dignity was respected during care after death. We were told that the practice of storing two bodies in the space meant for one had occurred during busy periods, particularly during the winter months. Staff took practical measures to minimise the issue as much as possible by transferring the deceased between sites and keeping the time that two bodies would spend in the same space to a minimum. However, a fundamental lack of capacity meant that more than one body was stored in a fridge space meant for single occupancy.

Is the service responsive?

Requires improvement 

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

- The service had some systems in place so that they took account of the particular needs and choices of different people. However, there was no framework for advance care planning for patients at the end of life. For example, patients were asked about their preferred place of care at the end of life; however this was generally in the last days of life. There was some evidence of patients being supported to make decisions about the end of life in advance; however this was dependent on the support of individual clinicians rather than a trust wide approach. This meant that not all patients would have the opportunity to make decisions in advance of their health deteriorating. This was not in line with the local interagency policy recommendations for early conversations in relation to care decisions.
- A fundamental lack of mortuary capacity across the trust meant that more than one body was stored in a fridge space meant for single occupancy during busy times. This had happened in February and March 2018. We did not see this during our inspection and staff told us they followed trust criteria to ensure that local coroner requirements were met. There was no public mortuary in the area and the three acute hospital sites provided all mortuary services.
- Complaints relating to the care of patients at the end of life were reviewed by the end of life care board and themes identified. However, it was not clear how these were shared with staff in a way that ensured lessons were learned and care improved.
- There was written material available for patients and their relatives regarding end of life. However, these were not available in any languages other than English.

However,

- Patients that did not speak English as a first language could access interpreters if they needed them.
- Family members of patients approaching the end of life had access to a large, clean and welcoming room where they could rest, prepare meals, sleep and wash so they didn't have to leave the hospital site.
- Chaplaincy services were available for those that requested it and could be provided by chaplains of different faiths as well as those with no faith.
- There were protocols in place in the mortuary that allowed for different faiths and cultures to observe their particular practices. This meant that a body could be released in a short period of time if required. There were also processes in place across the hospital for family members to wash the body if that was part of their faith.
- Patients with dementia and / or sensory impairment had their care tailored to their own individual needs.

End of life care

Is the service well-led?

Requires improvement 

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

- The challenges facing the service were known to the leaders and the mechanisms were in place for improvements to be made. However, action plans lacked details of how the improvements would be achieved.
- Processes for managing risks, issues and performance were not always effective. Risks relating to the mortuary capacity were identified on the pathology risk register but not on the palliative care or corporate registers. Action to mitigate the risk and the impact of current activities was not comprehensively identified and there was evidence that the risk had not been properly escalated or managed. We were told that the palliative care risk register did not currently have any risks identified, however, staff told us there were ongoing issues with fast track discharge and the trust was not providing a seven day palliative care service which presented a risk to continuity of care for patients.
- A formal agreement with the hospice regarding the provision of palliative care consultant cover had still to be finalised despite being in preparation for at least 18 months.
- End of life care provision and the team's performance was not part of the trust wide dashboard of information. This meant that opportunities could be missed to review and improve performance at a corporate level.
- End of life care board meetings did not provide an opportunity to consider risks to the service and actions following meetings were not properly identified. Although there was some detail in the minutes of these meetings it was difficult to see what action had been agreed and exactly how those actions would be achieved. There were no standing items to discuss risk, or any incidents that had been reported that specifically related to end of life care. This meant that opportunities to make continuous improvements could be missed.

However:

- The leaders of the service were visible and approachable to all staff that dealt with patients approaching the end of their life.
- Staff described a positive working culture where there was a belief that all staff had the opportunity to contribute to the care of those patients approaching the end of their life.
- People's views were gathered through a bereavement survey across the trust. This provided feedback to staff on the experience of relatives.

Areas for improvement

We found areas for improvement in this service. The trust must;

- Ensure that consent to care and treatment is always sought in line with legislation and guidance in relation to records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR).

In addition, the trust should;

- Make sure that lessons are learned and improvements made when things go wrong.
- Make sure that staff responsible for training other staff have the skills, knowledge and experience to do so and that all ward staff receive training in the delivery of effective care, support and treatment for patients at the end of life.

End of life care

- Review the palliative care service with a view to providing a seven day face to face service.
- Make sure there is a framework and focus for identifying patients with an uncertain recovery who were at risk of dying, together with a framework for advance care planning.
- Make sure that capacity risks within the mortuary are comprehensively assessed and mitigated to ensure that the storage of the deceased is in line with the Human Tissue Authority published guidance and that people's dignity is respected during care after death.
- Ensure that discussions about preferred place of care are consistently held in advance of the last days of life and that the achievement of discharge to the preferred place of care is monitored.
- Ensure that a trust wide end of life care strategy and action plans are in place.
- Ensure that processes for managing risks, issues and performance are effective. Risks should be identified and recorded on the risk register and adequately mitigated.
- Make sure that governance structures and processes are supported by structured action planning and prioritising.
- Ensure that improvement plans are sufficiently detailed, structured and timely.

William Harvey Hospital

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Key facts and figures

William Harvey Hospital is an acute hospital located in Ashford, Kent. It provides an extensive range of inpatient, outpatient and elective and emergency services to patients in the greater Ashford area and specialist services to patients across East Kent. It has a postgraduate teaching centre that works in coordination with the local university.

Summary of services at William Harvey Hospital

Requires improvement ➔➔

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

We rated safe, effective, responsive and well-led as requires improvement, and caring as good. We rated three of four core services as requires improvement and one as good.

Urgent and emergency services

Requires improvement 

Key facts and figures

The trust has three urgent and emergency departments;

- Kent & Canterbury Hospital
- Queen Elizabeth The Queen Mother Hospital
- William Harvey Hospital

Urgent and emergency services are provided at William Harvey Hospital (WHH). The William Harvey Hospital site is a Level 1 Emergency Department that provided care to approximately 80,000 patients from May 2017 to April 2018. The emergency department is also a Major Trauma Unit and includes a Minor Injury Unit Service, acute thrombolysis stroke cover (24/7) and a separate paediatric provision.

The emergency department at William Harvey Hospital has a waiting area with 20 seats, three adult resuscitation bays and a child resuscitation bay. The emergency department has 14 major cubicles and two side rooms, a mental health assessment room and four minor injury assessment bays with a separate waiting area. The department has a new major assessment area with three rooms and 10 allocated spaces in the corridor for patient beds in the event of an over flow of patients. There is a clinical decision unit connected to the emergency department that had 34 beds for observing patients or awaiting investigation results. A paediatric waiting area and two paediatric treatment cubicles are also available.

Urgent and emergency services were last inspected in 2016 when overall, we rated it as requires improvement. Our inspection was unannounced and we inspected all five key questions.

We spoke with 12 patients and carers, and over 40 members staff from different disciplines, including support and administration staff, nurses, doctors, managers and ambulance staff. We observed daily practice and viewed 20 sets of records. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

Summary of this service

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

- The service did not ensure mandatory training in key skills was completed by all staff. Training compliance for medical staff was worse than the trust target of 85%, in all six training modules.
- Staff did not always have up to date training on how to recognise and report abuse. William Harvey Hospital had not achieved target for staff compliance in safeguarding children level three and safeguarding adults level two.
- The approach to assessing and managing the risks to children at night was focused on clinical risks but did not take a holistic view of children's needs.
- There was a risk that staff may not have recognised or responded appropriately to signs of deteriorating health or medical emergencies.
- The service did not always have enough staff with the right qualifications, skills, training and experience to keep children safe from avoidable harm and abuse and to provide the right care and treatment.

Urgent and emergency services

- Staffing levels in the paediatric emergency department at William Harvey Hospital were not sufficient to keep the paediatric department open 24 hours a day.
- The service did not always store medicines well. During our inspection we saw several opportunities for unauthorised people to access a variety of medicines.
- William Harvey Hospital did not meet the audit standards in five out of six of their most recent *Royal College of Emergency Medicine* audits.
- The service monitored the effectiveness of care and treatment but did not always use the findings to improve them. Actions from audit results were often delayed and slow to complete.
- The service did not always make sure staff were competent for their roles. Staff did not always receive timely and effective appraisals.
- Staff did not always care for patients with compassion. People's emotional, and social needs were not always reflected in their care, treatment and support.
- Staff did not always understand the need to make sure that people's privacy and dignity was maintained. While this may not have been intentional, it resulted in patients not feeling valued or respected.
- Complaint themes and trends showed a quarter of complaints related to subjects that impacted care and compassion.
- The most recent staff survey showed that most staff did *not* respond positively to 'Care of patients/service users is organisation's top priority' (53%) and 'If friend/relative needed treatment would be happy with standard of care provided by organisation' (59%), both were poor compared to the benchmark average.
- The department remained under significant pressure to meet the needs of their patients. Flow through the emergency department was significantly held up due to low availability of beds in other departments. When patients were waiting for inpatient beds they were often waiting in the clinical decision unit or in the over flow corridor area. Although the department could discharge to ambulatory care, the unit was often too full to do so.
- There was little evidence of the learning applied to practice within the service from complaints.
- The service did not always take account of patients' individual needs. Patients had little privacy when discussing their illnesses or injuries when talking with the meet and greet nurse. Although there was a private room on request, this was not routinely offered.
- People could not always access the service when they needed it. Waiting times from treatment and arrangements to admit, treat and discharge patients were often slow and delayed.
- Senior leaders were not visible and approachable at every level. Staff we spoke with did not consistently know who their leaders were or how to gain access to them.
- Managers across the department did not always promote a positive culture that supported and valued staff. Staff satisfaction was poor. Staff we spoke with said they felt unsupported and undervalued by their immediate leaders and felt senior leaders did not understand the pressures they were facing.
- The department did not used a systematic approach to continually improve the quality of its services. Clinical and internal audit processes were inconsistent in their implementation and impact. We were not assured that local audits were always taking place.
- The trust did not have effective systems for identifying risks, planning to eliminate or reduce them. The organisation did not react sufficiently to risks identified through internal processes, but often relied on external parties to identify key risks before they started to be addressed.

Urgent and emergency services

- The trust had not made sufficient improvement since the last inspection. The trust had failed to ensure national safeguarding training requirements were fulfilled.
- Where changes were made, the impact on the quality and sustainability of care was not monitored.

However:

- Staff understood how to protect patients from abuse. All staff we spoke with knew who the safeguarding lead was and understood their responsibilities to safeguarding both adults and children.
- Since our last inspection a doctor had been allocated to the paediatric area and the department had a consultant with a sub specialty in children.
- The trust responded immediately to CQC concerns about paediatric care in the department at night. They implemented a short term plan to address concerns raised and were due to implement a more permanent plan approximately six weeks after the inspection.
- In the 2016/17 severe sepsis and septic shock audit, 92% of patients' observations were taken on arrival, this was better than the UK average of 69%.
- We saw pathways created to promote early treatment and improve patient outcomes in line with best practice guidance.
- We saw health care assistants engaging with patients in a compassionate manner.
- The outcome of complaints was explained appropriately to complainants. The responses addressed and answered all concerns raised by the complainants and offered a sincere apology.
- Senior leadership teams understood what the challenges were and acted to address them.
- Candour, openness, honesty, transparency and challenges to poor practice were the norm.
- Mortality and morbidity meetings were held weekly. Staff presented a case and the team discussed and identified learning.
- The department held weekly teaching sessions that all staff were welcome to attend.

Is the service safe?

Requires improvement 

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

- The service did not ensure mandatory training in key skills was completed by all staff. Training compliance for medical staff was worse than the trust target of 85%, in all six training modules. We found the same poor compliance across all six modules at our previous inspection.
- The Trust was unable to provide us with sepsis training figures for staff within the emergency department. Although the trust told us of a number of mandatory training sessions that ran, they did not have oversight of which members of staff had or had not completed this training.

- Staff did not always have up to date training on how to recognise and report abuse. William Harvey Hospital had not achieved target for staff compliance in safeguarding children level three and safeguarding adults level two. Medical safeguarding training compliance, for adult level 2, was significantly worse (34%) than the compliance at our last inspection (74%). Although, all staff we spoke with knew who the safeguarding lead was and understood their responsibilities to safeguarding both adults and children.
- The trust did not provide us with minutes from any of their safeguarding meetings. This meant we could not be assured learning was shared at these meetings.
- The service did not always look after their premises well. The department did not look clean in all areas. Toilets were unkempt, and dust gathered in the corners. For example, we saw a shower room in the clinical decision unit that appeared dirty. There was a dirty, wet towel on the floor, a broken shower door and a broken shower handle resting behind the toilet. We observed the department's cleaning check sheet but found no cleaning schedule for May 2018. There were also no cleaning check sheets in the toilets to indicate when they had last been cleaned. This was not in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 2.
- The service did not have suitably designed premises for patients to wait. The design and layout of the waiting areas did not enhance patient safety. The meet and greet nurse could not always see patients sat in both of the emergency department waiting rooms. Corridors were used to keep up to 10 patients, in beds, that were over flowing from the department and awaiting transfer or discharge.
- There was only one staffroom for the emergency department, this was small and used for meetings. This was not in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 15.
- During the hours the children's area of the emergency department was closed (10pm to 7am), children shared waiting areas with adults. There was no audio and visual separation from the adult patients and there were no facilities available for the distraction of the distressed children in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 43.
- Equipment in resuscitation trolleys, was not always accessible in a reasonable time. An adult resus trolley was mixed with both adult and paediatric resus equipment. This was because children shared the area with adults at night. However, this meant in the event of a cardiac arrest staff would not be able to respond in a timely and effective manner.
- There was a risk that staff may not have recognised or responded appropriately to signs of deteriorating health or medical emergencies. The emergency severity index (ESI) triaging system was not being used as it was designed and so patients may have been streamed without a thorough assessment.
- The trust did not provide us with evidence that vital observations were being recorded within 15 minutes of a patient being streamed to majors.
- The approach to assessing and managing the risks to children at night was focused on clinical risks and did not take a holistic view of children's needs. For example, children considered low clinical risk sat in the waiting room with adults. We reviewed the paediatric pathway. This did not clearly specify the pathway for children through the emergency department out of hours. Staff we spoke with told us they felt the environment was unsafe for children during these times and were unhappy working at night because of the risk it posed to children.
- The escalation plan for the paediatric emergency department when only one or no paediatric nurses were on duty did not assure us of effective assessment and response to the risk of children. This escalation plan detailed that 'all stable paed majors to wait in main waiting area'. The stability of unwell children is uncertain and children decline rapidly compared with adults. This plan did not recognise the risk of children rapidly declining from stable to unstable.

- The service did not always have enough staff with the right qualifications, skills, training and experience to keep children safe from avoidable harm and abuse and to provide the right care and treatment. There was not always a minimum of one registered paediatric nurse on shift during the night. When the paediatric department was closed, overnight, the meet and greet nurse triaged the children. There was no assurance that this nurse had paediatric training or could suitably identify risks to children.
- CQCs concerns about paediatric care in the department at night were addressed by the trust immediately after the inspection and plans to address these concerns were implemented. As part of the plan the trust provided assurances that the paediatric emergency department would have 24/7 cover with paediatric registered nurses from 23 July 2018.
- At the last inspection, the emergency department was not meeting the Royal College of Emergency Medicine (RCEM) recommendations, that A&E consultants should provide 16 hours of cover per day, seven days per week. Although the trust had improved this cover, the trust was still not meeting this recommendation as the emergency department medical rota showed consultant cover for only 14 hours a day, from 8am till 10pm.
- The emergency department used a different record system to the psychiatric liaison service. The two systems did not communicate with each other. This meant the staff in the emergency department did not have the full psychiatric history of patients attending the emergency department.
- The service did not always store medicines well. During our inspection we saw several opportunities for unauthorised people to access a variety of medicines. We found that three medicines cupboards were left unlocked and open with easy access to people walking past.
- We found two out of the four resuscitation trolleys we inspected were not tamper proof. This meant people had access to emergency medicines kept within. We also found one resuscitation trolley that had an unsealed case of paediatric emergency medicines resting on top of the trolley.

However:

- Staff understood how to protect patients from abuse. All staff we spoke with knew who the safeguarding lead was and understood their responsibilities to safeguarding both adults and children. The emergency department had a Child Protection Information Sharing System embedded in their screening tool. This is a national alert system to help prevent child abuse. Children could not be discharged until the screening tool was completed.
- The service controlled infection risk well. We saw good infection prevention control and sterile technique while cannulating a patient. Sharps management complied with Health and Safety (sharps instruments in healthcare) regulation 2013. We observed staff changing gloves and washing hands in between patients, and all staff were bare below the elbows.
- The resuscitation unit equipment was very well organised with colour coded drawers and clearly labelled equipment in glass fronted cabinets. We observed equipment check sheets were carried out daily and completed for equipment in all areas.
- The department had a new Rapid Assessment and Treatment (RAT) area, led by a doctor, to provide early assessments and decisions of patients brought in by ambulances. This had significantly improved the environment ambulance patients were waiting in.
- There was an escalation policy for patients with presumed or confirmed sepsis who needed immediate review.
- All checklists we reviewed, were clear and easy to follow. This reduced the risk of human error. For example, the checklist for rapid sequence intubation followed three simple stages; prepare team and patient, prepare equipment and prepare for difficulty.

- Since our last inspection a doctor had been allocated to the paediatric area and the department had a consultant with a sub specialty in children. It is recommended by the Royal College of Paediatrics and Child Health, *Standards for children and young people in Emergency Care Settings* (2012) that emergency departments seeing more than 16,000 children per year should have at least one consultant with sub-specialist training in paediatric emergency medicine. William Harvey hospital saw 15,356 from May 2017 to April 2018. Although attendance was not above 16,000 the department was still meeting this standard.
- Staff kept appropriate records of patients' care and treatment. We looked at a total of 20 patient records. All records were filed away tidily with no loose paperwork. The records were easy to read and clearly signed and dated.
- Electronic records were designed to give staff up to date and accurate information on a patient's history as well as real-time information across services. We saw a consultant track a patient's journey through the emergency department, with up to date results and waiting times. We also saw that staff had access to previous diagnostic results and treatments.
- The service prescribed, gave and recorded medicines well. Controlled drugs were stored and managed appropriately in all areas. We reviewed the March 2018 medication safety report for the trust. This identified themes and trends related to medicine incidents. We also saw that key messages were highlighted to share learning from incidents across the trust.
- The service managed patient safety incidents well. Staff understood their responsibilities to raise concerns and report incidents and near misses. We found serious incidents were thoroughly investigated, duty of candour was applied, questions from patients were answered

Is the service effective?

Requires improvement 

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

- Sepsis guidelines had not been updated to reflect separate assessment by age group. Although staff told us this was in progress, we did not see any documents to evidence this. The service managed patient safety incidents well. Staff recognised incidents 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.
- The department carried out a Commissioning for Quality and Innovation National (CQUIN) sepsis audit that showed of the adult patients who presented to the emergency department with severe sepsis, from January 2018 to March 2018, 20% were not administered antibiotics within one hour. The longer it takes to administer antibiotics the higher the risk to patient mortality and morbidity.
- Not all walk-in patients received timely access to appropriate pain medicines in line with RCEM: Emergency Department Care (2017) Quality Statement 24. We asked six patients, in pain in the waiting area, if they were offered pain relief. Five out of the six patients said they had not been asked to score the severity of their pain and they had not been offered pain relief.
- Following our inspection, we asked the trust to provide us with their most recent pain audit results. We did not receive a response that enabled us to review data to show that pain in adults was effectively audited.
- William Harvey Hospital failed to meet any of the audit standards in five out of six of their most recent *Royal College of Emergency Medicine* audits.

- In the 2016/17 Moderate and Acute Severe Asthma report, William Harvey Hospital failed to meet any of the standards. For example, standard 1a, when an asthma patient arrived in the emergency department, the hospital administered oxygen to ensure levels were between an acceptable range only 29% of the time. We were not provided with any updated internal audit results or changes to improve these results. The trust did not appear to audit this indicator at a local level outside of the national RCEM audits.
- In the 2016/17 Consultant sign-off audit, William Harvey Hospital failed to meet any of the standards. For example, standard 1, a patient with non-traumatic chest pain aged 30 and over was reviewed by a consultant only 4% of the time. Although the hospital made changes we were not provided with any updated internal audit results or changes to improve these results. The trust did not appear to audit this indicator at a local level outside of the national RCEM audits to confirm these changes were effective.
- In the 2015/16 Vital signs in children audit, William Harvey Hospital failed to meet any of the standards. For example, Standard 1, the hospital took a child's (with a medical illness) vital observations within 15minutes of arrival or triage only 16% of the time. We were not provided with any updated internal audit results or changes to improve this result. The trust did not appear to audit this indicator at a local level outside of the national RCEM audits within the emergency department.
- In the 2015/16 Procedural sedation in adults audit, William Harvey Hospital failed to meet any of the audit standards (which were all 100%). For example standard 1, patients undergoing procedural sedation in the emergency department only had documented evidence of pre-procedural assessment 12% of the time. We were not provided with any updated internal audit results or changes to improve these results. The trust did not appear to audit this indicator at a local level outside of the national RCEM audits.
- We requested the trust provide us with their most recent audit results on mental health in the Emergency Department. The trust provided us with a 2014/2015 RCEM audit report. We were not provided with any up to date results or action plans. The trust did not appear to audit this indicator at a local level outside of the national RCEM audits.
- The service monitored the effectiveness of care and treatment but did not always use the findings to improve them. Actions from audit results were routinely delayed and slow to complete. We requested action plans that had been created to improve the Royal College of Emergency Medicine audit results. We were provided with plans that were incomplete. The action plans did not always evidence that they had been shared at meetings. The plans did not always show that they had had a divisional sign off and although most actions had a completion date, it was unclear if these actions had been completed within target. Many of the action plans were brief and limited. We did not see evidence that any of the actions were re-audited or effective.
- Data showed that 9% of patients re-attended the emergency department within 7 days from January 2018 to April 2018, this remained worse than the England average and national standard (5%). A higher re-attendance rate suggests that a higher number of patients did not have an effective or positive outcome when they first attended the department.
- The service did not always make sure staff were competent for their roles. Staff still did not always receive timely and effective appraisals. At the time of our previous inspection, William Harvey Hospital appraisal compliance was below target at 55%. At this inspection, appraisal compliance for staff was 64% and still below the trust target of 85%. We reviewed the most recent staff survey that showed poor response from staff regarding the effectiveness of their appraisals. Staff were asked 12 questions relating to their personal development. Five out of twelve questions scored below the benchmark average.

- The department did not have a paediatric resuscitation team at all times. The trust told us that a doctor with European Paediatric Life Support training was not always present in the department out of hours but would be available on the hospital site. This was not in line with Resuscitation Council guidelines that states 'organisations should have a separate paediatric resuscitation team.' Having access to a doctor with EPLS training somewhere on the hospital is not a paediatric resuscitation team.
- Health care assistants were not always supported to participate in training and development. We spoke with three health care assistants, all three felt they had not been given opportunity to develop, they felt they had been recruited with false promise and held back in their careers.
- Staff of different kinds did not always work together as a team to benefit patients. We saw poor joined up care between staff in the resuscitation unit and an ambulance crew. We observed a consultant who began treating a patient and dismissed the paramedic without any member of staff taking a handover. This was not in line with handover best practice as outlined in the British Medical Association guidance '*Safe handover: Safe patients*' (2017), that states the need for 'efficient transfer of high quality clinical information at times of transition of responsibility for patients' because 'poor handover can lead to fragmentation and inconsistency of care'.

However:

- In the 2016/17 severe sepsis and septic shock audit, 92% of patients' observations were taken on arrival, compared with the UK average of 69%.
- The trust carried out local audits to address both standards in the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit. This showed the department had improved in both standards.
- The department carried out a Commissioning for Quality and Innovation National (CQUIN) sepsis audit that showed sepsis screening was improving. Data from January 2018 to March 2018, showed that 93% of adults and 100% of children, who met the sepsis criteria, were screened for sepsis.
- We saw pathways created to promote early treatment and improve patient outcomes in line with best practice guidance. For example, the department created a torsion pathway that used a scrotal pain assessment tool to quickly identify a child or young man who needed to be seen by a surgeon within 15 minutes. Data showed that the time from streaming to a clinician assessment had remained under 15minutes since mid April 2018.
- The department used a number of checklists that guided clinicians to carry out procedures correctly and safely. We saw the rapid sequence intubation (RSI) checklist had been recently updated to reflect changes to the Difficult Airway Society (DAS) guidelines.
- Staff gave patients enough food and drink to meet their needs and improve their health. Staff we spoke with understood the importance of patients receiving sufficient nutrition and hydration. Patient nutrition and hydration was supported by dietitians within the hospital clinical decision unit. Patients could be referred if there were concerns about their weight and calorie intake.
- There were processes to make sure pain relief medicines were effective for patients in the majors area of William Harvey Hospital. Out of 12 records, four showed a pain score above three. All four of these patients received prompt pain relief medicine and their pain score was assessed after to ensure the pain medicines worked.
- We saw systems to make sure pain was well managed for children. When triaging children, the system would not allow staff to close the records without entering a pain score. This ensured staff were prompted to assess children's pain and offer pain relief as soon as possible, in line with RCEM: Emergency Department care (2017) Quality Statement 44.

- The hospital shared important information with relevant healthcare professionals so patients could have good continuation of care after discharge. There were pathways for referral to NHS hospitals both in an emergency and routine situation and staff worked together to understand and meet the range and complexity of patient needs.
- The department provided a variety of services that patients could access 24/7, or had an out of hours arrangement. For example, patients could access a pharmacy telephone helpline to answer any questions about medicines prescribed by the hospital. This helpline was available Monday to Friday, 10am till 4pm.
- National priorities to improve the population's health were supported. People using services were supported to manage their own health. We also saw information for patients on how to find emotional support and guidance.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff we spoke with could describe their responsibilities to ensure patients consented when they had the capacity to do so.
- Staff demonstrated they had the experience to manage patients with dementia and learning difficulties, although we were not assured they had the appropriate training to do so.

Is the service caring?

Requires improvement 

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

- People's emotional, and social needs were not always viewed as important or reflected in their care, treatment and support. For example, we saw a member of staff enter a bay to turn off a patient's machine alarm. They entered and left without saying hello, smiling or acknowledging the patient in any way.
- Staff were not responding to patients in a timely or effective manner. We heard and saw one patient's observation machine ringing for over ten minutes before alerting a member of staff. We asked the patient if the nurse had explained why the alarm was ringing. The patient told us they had not been informed.
- Staff did not always understand the need to make sure that people's privacy and dignity was maintained. While this may not have been intentional, it resulted in patients not feeling valued or respected. We saw patients in beds in corridors for extended periods of time. Beds in corridors were not screened off from people passing through, so there was no privacy. There were no call bells for these patients which meant patients would have had to call across the corridor to nursing staff if they needed them.
- Staff did not always care for patients with compassion. We observed two nurses in the corridor assigned to care for three patients in beds. We saw the nurses interacting with one another. There was no interaction with the patients. During our inspection we returned to the corridor over 12 times, at no point did we see them talk to or engage with the three elderly patients waiting in the corridor.
- The friends and family test also raised concerns around privacy and dignity. One response stated 'I was disturbed… to see at least half a dozen mostly elderly women stuck in corridors in quite degrading conditions. My young daughter was very distressed by this too. No dignity or privacy. Staff milled about as though this was normal but patients and those with someone with them looked utterly miserable and helpless'.
- Feedback left by patients on the NHS Choices website was more negative than positive about the care provided. Six patients left feedback in May, five of the six patients gave the department one star out of five.

Urgent and emergency services

- Complaint themes and trends showed a quarter of complaints related to subjects that impacted care and compassion. Complaint data showed that approximately 25% (25 out of 99) of informal complaints related to staff attitude, communication, dignity and nursing staff. We also saw that approximately 25% (26 out of 98) of formal complaints related to the same categories.
- The most recent staff survey showed that most staff did *not* respond positively to 'Care of patients/service users is organisation's top priority' (53%) and 'If friend/relative needed treatment would be happy with standard of care provided by organisation' (59%), both were poor compared to the benchmark average.
- We could not be assured that staff were proud of the care provided. The staff survey results showed that 66% of staff did *not* answer positively to 'Able to provide the care I aspire to'. This was poor compared with the benchmark average and not in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 50.
- We were not assured that the meet and greet nurse recognised when patients needed to talk in private. The friends and family test for May 2018 raised similar concerns, one comment stated, 'No privacy at triage or booking in – personal details could be heard by all!'.
- The nursing staff were not prioritising a caring environment. Some people were not given information or helped in other ways to be involved in their care and treatment. We spoke to an elderly patient who had been in the hospital for a procedure but was then admitted to the emergency department because they were unwell. The patient asked us what was happening as they had been in the corridor for over three hours. We asked the nurse in the corridor what was happening. The nurse could tell us they were waiting to discharge the patient and reschedule the procedure for another day but had not shared this information with the patient. We had to request that the nurse communicated this information with the patient. This was not in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 26, 'are patients routinely given forecasts'.
- The Emergency Department survey 2016, showed four areas that scored worse than other trusts. All four areas were themed around communication. We reviewed the friends and family test results for May 2018 where we saw a number of comments about poor communication. For example, 'not listened to... no understanding of the pain I was in' and '… no one called for 90 minutes … felt like nothing was happening'.
- Three out of 12 patients we spoke with, described their care negatively, such as 'I don't know what is going on', 'they don't have time' and 'rushed'.

However:

- We saw health care assistants engaging with patients in a compassionate manner.
- We reviewed many 'thank-you' letters provided to the department. These demonstrated staff commitment to providing compassionate care. For example, 'thank you so much … for taking the time to have a chat with me', and 'thank you so much for your care and attention during my sickness'
- Medical staff made sure patients could ask questions about their care. We saw a consultant explaining test results to a patient. The consultant asked both the patient and their husband if they had any questions. The consultant listened to their questions patiently and answered them thoroughly and in a way the patient could understand.
- We spoke with 12 patients, seven of these patients were happy with the care they received describing their care as 'spot on' and 'good'.

Urgent and emergency services

Is the service responsive?

Requires improvement 

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

- The department remained under significant pressure to meet the needs of their patients. During our inspection we saw three patients who had been waiting over nine hours for a bed and the corridor used for overflow patients was in constant use throughout the two days of our inspection.
- People could not always access the service when they needed it. Waiting times from treatment and arrangements to admit, treat and discharge patients were often slow and delayed. From January 2018 to April 2018, 22% (2683) of patients were in the emergency department for over six hours, 43% (5245) of patients were admitted in under four hours and 48% (2140) of patients were waiting between four and 12 hours from the decision to admit to admission. Data showed that 2% (587) of patient's left the department without being seen during these months.
- Staff told us they did not have access to a specialist link dementia nurse to provide specialist advice and support for dementia patients.
- The service did not always take account of patients' individual needs. Patients had little privacy when discussing their illnesses or injuries when talking with the meet and greet nurse. Although there was a private room on request, this was not routinely offered. This was not in line with Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 4.
- Flow through the emergency department was significantly held up due to low availability of beds in other departments. When patients were waiting for inpatient beds they were often waiting in the clinical decision unit or in the over flow corridor area. Although the department could discharge to ambulatory care, the unit was often too full to do so.
- Child and Adolescent Mental Health Services (CAMHS) did not have a contact available on site so these responses were slower than for adults.
- There was little evidence of the learning applied to practice within the service from complaints. We asked eleven members of staff if they knew of any learning from a complaint. None of the eleven staff members could give us an example.

However:

- The department held a number of meetings to ensure capacity was planned and discussed. For example, staff held two video conferences at 8am and 5pm, with other sites, to discuss capacity.
- The emergency department met the communication needs of children. The trust had given the emergency department access to play therapists from the paediatric ward that showed their commitment to best practice. Play therapy uses play to understand and communicate with children about feelings thoughts and behaviour.
- The emergency department used a frailty screening tool to identify and measure frailty as early as possible in patients over the age of 65. The screening tool was simple, quick and easy to use.
- If patients with mental health needs needed extra support or supervision, the department had access to additional staff to provide one to one care. The department also had support from the psychiatric liaison team who could attend the department to offer support.

- Technology was used to support timely access to care and treatment. A television in the waiting area displayed the estimated waiting time for minor injuries and the number of patients in the emergency department. This information could also be accessed on the Trust website so that patients could access services at a time to suit them.
- The outcome of complaints was explained appropriately to the complainant. We reviewed the service's responses to three complainants. All three responses were kindly written and details of the investigation were openly shared. The response addressed and answered all concerns raised by the complainant and offered a sincere apology. Although, there was little evidence of the learning applied to practice within the service from complaints.

Is the service well-led?

Requires improvement 

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

- The department did not have a strategy for what it wanted to achieve and workable plans to turn it into action. Some concerns raised in the previous report had not been improved, for example ensuring all staff had attended mandatory training.
- Nursing staff we spoke with were not familiar with the trust's vision and did not always understand how their role contributed to achieving the strategy. Staff felt they were 'firefighting' and did not feel confident the department had a strategy to improve.
- The stability of the leadership team within the department was unclear. The department had an interim matron who was also the paediatric nurse lead. The trust had struggled to find suitable candidates to fill the matron post permanently.
- Only one person within the William Harvey Hospital Emergency department had received Duty of Candour training.
- There were not appropriate security arrangements to keep staff and others safe and protected from violence, particularly at weekends and out of hours. If there was an emergency in another area, the security would leave the emergency department unattended to provide support.
- The department did not use a systematic approach to continually improve the quality of its services. Clinical and internal audit processes were inconsistent in their implementation and impact. We were not assured that local audits were always taking place.
- Risks, issues and poor performance were not always dealt with appropriately or quickly enough. We were not assured that the trust always actioned and learnt from audit results. We reviewed action plans for all of the RCEM audits. These action plans were slow to implement. We found that concerns raised at previous inspections were little improved or addressed. For example, mandatory training figures.
- The information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant. There were a number of examples where we asked the trust to provide data to evidence effective working. The trust were repeatedly unable to provide data or did not provide relevant or reliable information.
- Leaders and staff did not always receive information to enable them to challenge and improve performance. We were not assured that the trust had effective oversight of the number of children that were being cared for across the trust's emergency departments. The senior leadership team had been provided incorrect information that told them the emergency departments across the trust saw 270 children out of hours per year, this figure was actually 4,698.

- The trust did not have effective systems for identifying risks, planning to eliminate or reduce them. The organisation did not react sufficiently to risks identified through internal processes, but often relied on external parties to identify key risks before they started to be addressed. Staff raised concerns with us regarding safe staffing for paediatrics, it was not until we raised this as a concern that there was a control measure put in place for the risk to children.
- Where changes were made, the impact on the quality and sustainability of care was not monitored. For example, in response to the consultant review Royal College of Emergency Medicine audit, the department added a new check to the system to prompt junior doctors to request a consultant review before closing a patient's record. The impact of these changes were not monitored.
- Managers across the department did not always promote a positive culture that supported and valued staff. Staff satisfaction was poor. Staff we spoke with said they felt unsupported and undervalued by their immediate leaders and felt senior leaders did not understand the pressures they were facing.
- The trust had not made sufficient improvement since the last inspection. The trust had failed to ensure national safeguarding training requirements were fulfilled. Safeguarding training levels had stayed well below target for the previous three inspections. This showed that the department may not have had an effective strategy to improve.
- Although the department was involved in a variety of audits to monitor patient outcomes, staff were not always involved in these audits.

However:

- The leaders we spoke with understood the challenges to safe care, treatment and quality. Senior leadership teams understood what the challenges were and acted to address them. For example, the trust acted quickly to secure suitable staff to care for children out of hours following concerns raised during the inspection.
- Candour, openness, honesty, transparency and challenges to poor practice were the norm. For example, when we identified an open medicine cupboard, the member of staff who had left it open did not hesitate to accept responsibility. This showed that staff felt able to admit mistakes and learn from them.
- Although staff were clearly busy, and often showed signs of feeling under pressure, there was a family feel in the department and genuine care and affection between staff. In meetings and huddles, staff communicated openly and without hesitation, and there was no hesitation to offer support to one another.
- All levels of governance in the organisation functioned effectively and interacted with each other appropriately. Staff at all levels were clear about their roles and understood what they were accountable for. All staff we spoke with knew who to escalate concerns to and could detail meetings they attended and the purpose of them.
- Governance and performance patient safety meetings were held regularly. We reviewed urgent care & long-term conditions governance & patient safety meeting minutes. These meetings were held monthly and had a standing agenda where patient safety was at the center.
- Mortality and morbidity meetings were held weekly. Staff presented a case and the team discussed and identified learning. Identified learning was written into actions and this was shared with the wider team. We saw learning shared from the meeting in May 2018. For example, staff were asked to consider using a specialised mattress to help treat hypothermia, and were reminded this was available on request.
- There was a departmental risk register, which measured the cause and effect of the risk and documented the controls to manage that risk. There was clear alignment between what staff felt were the departments biggest risks and what was on the departmental risk register.

- The trust website clearly displayed a number of ways to share patient views. They had a 'talk to us' section of the website that made it easy for patients to complain, comment, compliment or raise a concern. Patients could contact the trust by phone, email, in person or using a web based form.
- Staff had access to wellbeing links, these members of staff helped to provide support to staff who had any concerns regarding their health and wellbeing.
- The department was committed to improving services through learning and training. The department held weekly teaching sessions that all staff were welcome to attend. We observed one of these sessions and saw that staff of all grades attended to learn and contribute to the improvement and development of the department.

Areas for improvement

- The trust **MUST** ensure they record when vital observations are first taken for walk in patients so that they can monitor their ability to assess, recognise and respond appropriately to the deteriorating patient as well as mitigate any risk to the health and safety of the service user.
- The trust **MUST** ensure medicines are not accessible to the public, this includes emergency medicines within resuscitation trolleys.
- The trust **MUST** ensure staff have the right level of safeguarding training to meet compliance targets and to protect service users from abuse and improper treatment.
- The trust **MUST** ensure adult and paediatric emergency equipment is held in separate resuscitations trolleys in an organised and easily accessible manner.
- The Trust **MUST** ensure children are waiting in areas suited to their needs, this includes having facilities available for the distraction of the distressed child and ensuring audio and visual separation between adult and children waiting areas, at all times.
- The trust **MUST** ensure that sufficient numbers of paediatric nurses are present in the emergency department, at all times, to care for children.
- The trust **MUST** ensure staff have the right training and appraisal to meet compliance targets and to carry out the duties they are employed to perform.
- The trust **MUST** ensure it improves quality monitoring processes and acts promptly where poor standards are identified to improve the standard of care patients' receive.
- The trust **SHOULD** act to ensure the culture supports high-quality, sustainable care.
- The trust **SHOULD** ensure that patients are always involved in their care and treatment.
- The trust **SHOULD** ensure that patients are always treated with dignity and respect.
- The trust **SHOULD** ensure patients are always offered a private room to discuss their presenting complaint when they walk into the emergency department.
- The trust **SHOULD** ensure the emergency department has access to a paediatric resuscitation team at all times.
- The trust **SHOULD** ensure sepsis guidelines are updated to reflect separate assessment by age group.
- The trust **SHOULD** ensure staff have a suitable area to rest when they take their breaks that will not be being used for meetings.
- The trust **SHOULD** ensure there are appropriate security arrangements to keep staff and others safe at all times.

Urgent and emergency services

- The trust **SHOULD** facilitate a review to ensure the management and the board understand the culture in the department.

Surgery

Good ↑

Key facts and figures

Surgical services at the hospital included an eight-theatre operating complex and seven wards, offering 159 beds. The theatre suite facilities included anaesthetic rooms and recovery areas along with storage for sterile instruments and consumables, plus administrative and staff rest facilities. One theatre (number eight) was equipped with laminar flow air filtration for use in orthopaedic or other cases where airborne germs was a risk. A separate recovery area was provided for children.

Apart from the operating theatres, the service at WHH comprised of:

- Surgical Admission Unit (SAU), which accepted and prepared elective cases for theatre (predominately orthopaedic, general and head and neck surgery). The unit, located on the same 'surgical floor' as the Kings' wards, also admitted non-elective cases for emergency surgery.
- Kings A2, a 20-bedded general surgical ward split between three bays of six beds and two side rooms
- Kings B, a 27-bedded general surgical ward split between four bays of six and three individual side rooms
- Kings C1, a 27-bedded hip fracture unit of the same configuration as Kings B
- Kings C2, a 24-bedded elective orthopaedic ward split between three bays of eight beds
- Kings D male, a 25-bedded general trauma ward split into four bays of six and one side room
- Kings D female, an 18-bedded trauma ward split into two bays of six beds; one bay of three and two individual side rooms
- Rotary ward, an 18-bedded head and neck unit admitting ear, nose and throat surgery along with ophthalmic and maxillofacial surgery cases. The ward offered single and double-bedded rooms.
- A Surgical Emergency Assessment Unit (SEAU) was located near the main entrance to the hospital. This recently constricted facility contained six trolleys and was designed to take patients directly from GP admission or emergency surgical referrals from the emergency department. The unit operated weekdays between 0830 and 2000 hours and accepted patients up until 1800.
- A trauma and orthopaedic unit adjoined the SEAU. Although it formed part of the outpatients' department, the facility offered five clinic rooms and a purpose-built bariatric room used by the surgical division. Facilities included a plaster room and space for the on-call orthopaedic team which enabled them to conduct a 'virtual fracture clinic'.

During our inspection, we visited the theatre complex and each ward or unit. We also viewed the hospital facilities for medical gases, clinical waste and emergency power. We talked to clinical and operational managers, doctors, nurses, therapists and support staff including administrative, facilities and housekeepers (30 staff in all). We spoke with five patients, one relative and reviewed five sets of patient records. In addition, we examined a variety of policy and procedure documents, performance data, meeting minutes and staff competency records.

Summary of this service

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

Surgery

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. There was an open and transparent culture of incident reporting and investigation. Incidents were recorded on electronic systems that incorporated fail-safes about aspects such as duty of candour. Managers investigated incidents and shared lessons learned with staff to continuously improve patient safety.
- All the areas we inspected were visibly clean and tidy. The service controlled infection risks very well. Staff kept themselves, equipment and the premises clean and used effective control measures to prevent the spread of infection.
- The service maintained suitable premises and sufficient equipment to support safe care and treatment.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Nursing staff turnover and vacancy rates were close to trust averages and where bank or agency staff were used, the trust had sufficient controls in pace to manage risk. Medical staff turnover and vacancy rates were below trust averages.
- Records were clear, up-to-date and available to all staff providing care. The service used safety monitoring results well. Staff collected safety thermometer information, such as rates of falls, pressure ulcers and catheter-acquired urinary tract infections and shared it with staff, patients and visitors.
- The service provided care and treatment based on national guidance and best practice. The service carried out audits to check staff followed internal policies and guidance.
- Patients had good outcomes following surgery. Results from national audits showed the service performed well, with patient outcomes close to the same as other NHS acute hospitals nationally.
- The service made sure staff were competent for their roles. Managers appraised staff performance, and we saw evidence of meaningful appraisals. Competency records we reviewed provided assurances staff had the skills they needed to do their jobs.
- Staff of different kinds worked very well together as a team to benefit patients. We saw positive examples of multidisciplinary working between different staff groups.
- Staff obtained patient consent and understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.
- Staff cared for patients with compassion, kindness and respect. Feedback from patients confirmed that staff treated them well and were involved with their families in decisions about their care and treatment.
- Managers promoted a positive culture that supported and valued staff. Staff spoke positively about the culture and described good working relationships with colleagues and managers.
- The service acted to actively engage with staff and seek their views through focus groups and other forums.

However:

- Referral to treatment times (RTT) for admitted pathways for surgery were worse than the England average. In December 2017, 57% of patients were treated within 18 weeks, which was worse than the England average of 72%.
- While we saw improvement in mandatory training rates in nursing and other staff groups, compliance rates for medical staff was 67% on average and medical staff did not meet the trust target of 85% of training for any mandatory training course. This meant that medical staff might not have the most up to date information about these critical areas.
- We saw a similar trend in safeguarding training. Nursing staff compliance rates exceeded the trust target while medical staff training rates were 28%, appreciably below the 85% trust training target.

Surgery

Is the service safe?

Good ➔➔

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

- The service controlled infection risk very well. All the areas we inspected were visibly clean and tidy. Staff kept themselves, equipment and the premises clean and used effective control measures to prevent the spread of infection.
- The service maintained suitable premises and sufficient equipment to support safe care and treatment.
- Patients were risk assessed in key safety areas using nationally recognised tools and nursing staff escalated any concerns about deteriorating health. Decisions about changes to care or treatment plans were made by staff that were competent to do so.
- Staff kept records of patients' care and treatment in line with Nursing and Midwifery Council and General Medical Council guidance and standards. Progress notes were complete, clear, legible, dated and signed. Patients' records were readily accessible to those who needed them and when not in use were stored securely in locked notes trolleys.
- Overall, we found that medical services prescribed, gave, recorded and stored medicines safely. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with staff to continuously improve patient safety.
- The service used safety monitoring results well. Staff collected safety thermometer information, such as rates of falls, pressure ulcers and catheter-acquired urinary tract infections and shared it with staff, patients and visitors. The hospital used 'safety cross' displays on wards and units and were transparent about harm-free care.
- Recruiting and retention of nursing staff was a concern raised by staff and managers alike, and was included on the divisional and corporate risk registers. During our inspection we saw that actual staff on duty matched staffing templates used and this information was clearly displayed on performance boards in each ward. The trust had acted to address the shortfall in staffing such as recruiting overseas nurses.

However:

- The service did not always provide mandatory training in key skills and make sure all staff completed it. While mandatory training rates among nursing staff met corporate targets, compliance rates for medical staff averaged 67%. Medical staff did not meet the trust target of 85% of training for any mandatory training topic. This meant that medical staff might not have the most up to date information about these critical areas.
- Safeguarding training compliance rates were variable, nursing staff compliance rates exceeded the trust target. However, medical staff training rates were 28%, appreciably below the 85% trust training target.
- We acknowledge that all staff we spoke to understood how to protect patients from abuse and the service had systems and processes in place to help staff identify and report concerns. Patients and relatives said they felt safe on the wards and were always treated respectfully by staff.

Is the service effective?

Good ↑

Surgery

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

- Since our last inspection we saw improvements in the way staff understood their roles and responsibilities under the Mental Capacity Act 2005 and supported patients who lacked the capacity to make decisions about their care. We saw evidence the service obtained patient consent for surgery in line with General Medical Council guidance.
- We found a service that provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. New and updated guidance was evaluated and effectively shared with staff.
- The service made sure staff were competent for their roles. The trust had recruitment policies and procedures together with job descriptions to help ensure staff were appropriately experienced, qualified, competent and suitable for their post. All new permanent and temporary employees undertook trust and local induction with additional support and training when required.
- Managers appraised staff performance, and we saw evidence of meaningful appraisals.
- Staff of different kinds worked together as a team to benefit patients. At meetings, we observed positive and proactive engagement between all members of the multidisciplinary team.
- Patients had good outcomes following surgery. The service participated in a range of national audits, including the national bowel cancer audit, the national emergency laparotomy audit, and patient reported outcome measures (PROMS). The results showed the service performed well, with patient outcomes comparable to other NHS acute hospitals nationally.
- Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service followed the Royal College of Surgeons' guidance on fasting before surgery.
- Staff regularly assessed and recorded patients' pain and responded accordingly. Patients we spoke with told us staff promptly offered pain relief when required.

However:

- Patients having elective surgery at William Harvey Hospital had a worse than expected risk of readmission following elective surgery compared with the England average between November 2016 to October 2017.

Is the service caring?

Good 

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

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Without exception, we saw all grades of clinical and support staff treating patients with kindness, compassion, courtesy and respect.
- People's privacy and dignity needs were consistently understood and respected. We observed physical and intimate care interactions between staff and patients where procedures were explained and consent asked.
- Staff provided emotional support to patients to minimise their distress. Staff supported and encouraged links to external resources to help patients, families and carers cope with their emotional needs.

- Patients also had access to physiotherapists and occupational therapists that provided practical support and encouragement for patients with both acute and longer-term conditions. Patients spoke highly of the therapy staff and told us of the help and support they received from them.
- Staff involved patients and those close to them in decisions about their care and treatment. Staff took into consideration peoples' opinions and beliefs. Staff provided emotional support to patients to minimise their distress. The hospital had arrangements in place to provide support when needed, which included help from specialists such as end of life, diabetes and dementia nurses.
- Patients we spoke with on the wards described how nursing staff responded promptly when they rang their call bells for assistance.

Is the service responsive?

Requires improvement 

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

- People could not always access the service when they needed it. Referral to treatment times for admitted pathways for surgery were worse than the England average. In December 2017, only 57% of patients were treated within 18 weeks, which was worse than the England average of 72%.
- While we acknowledge the trust was working to address this, the most recent data (January to April 2018) showed referral to treatment rates had remained the same and not improved.

However:

- The trust planned and provided services in a way that met the needs of local people. We saw new facilities introduced since our last inspection such as the virtual fracture clinic and surgical assessment unit, all of which contributed to improved flow of surgical and orthopaedic cases.
- We saw good examples of contingency service planning during our visit, such as the uninterruptable power supply arrangements for the hospital
- The trust had an integrated discharge team and we saw that discharge information was monitored through daily board rounds and MDT meetings.
- Indicators such as cancelled operations and referral to treatment times were equal to or better than England averages.
- Staff took account of patients' individual needs, including that of patients living with dementia, learning disabilities, or obese patients. The 2017 patient-led assessment of the care environment survey showed the trust scored 86% for dementia care, which was significantly better than the England average of 76% and 91% for care of people with disabilities against an average of 82%.
- The service treated concerns and complaints seriously, investigated them comprehensively and learned lessons from the results, which were effectively shared with all staff.

Is the service well-led?

Good 

Surgery

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

- The trust had managers with the right skills and abilities to run a service providing high-quality sustainable care. We saw examples of strong local ward and department leadership.
- The trust operated a divisional governance model, which helped to provide a forum for clinicians and managers to be involved in the planning of hospital activities. We saw regular and recent minutes of meetings which demonstrated how information on incidents and complaints were investigated, learning shared and good practice promoted.
- The service used a systematic approach to continually improve the quality of its services. Performance management was well embedded into the wards and units we visited. The service used a quality dashboard, which measured and monitored the service's monthly performance in key areas against trust targets. We saw that the service compared performance to the previous month to identify trends. This meant managers could identify emerging concerns, and obtain assurances they were performing well or improving.
- The service had effective systems for identifying risks and planning to eliminate or reduce them. There was a trust wide risk register for the division as well as a local level risk hazard log to document site level risks. Managers we spoke with were aware of the risk registers and knew the main risks and the actions needed to reduce the risks. We saw items on the register matched the things senior staff told us about, such as bed capacity and outliers from other specialities. This demonstrated senior staff understood the risks to the service and acted to mitigate them.
- Managers promoted a positive culture that supported and valued staff. Staff generally spoke positively of the culture and described positive working relationships with colleagues and managers. Staff felt confident to raise concerns and report incidents and told us their managers encouraged them to do so.
- The trust engaged well with staff to plan and manage services. Staff told us they felt well supported, valued and that that their opinions counted. At a local level, the staff we spoke with understood what the vision, values and strategy for the division were and how their work contributed to achieving the vision. We learned from staff and managers about how staff had contributed to the strategy through a series of "listening events".
- The service had a positive focus on training and developing its own staff. The service had recently introduced an "improvement journey" programme to support nurses recently promoted from band five staff nurses to band six junior sisters/charge nurses. The service hoped this would help fill some of the nursing vacancies by helping improve staff retention.

Maternity

Requires improvement 

Key facts and figures

East Kent University Hospitals NHS Foundation Trust has 50 maternity beds across two sites; Queen Elizabeth The Queen Mother Hospital and William Harvey Hospital.

The William Harvey Hospital in Ashford delivers more than 4000 births annually. William Harvey Hospital has 11 labour beds, three induction of labour rooms and 28 beds on the maternity ward that is used for postnatal & antenatal women. The site has one bereavement suite and a six-bedded midwifery led birth unit.

During the inspection, we spoke with mothers and their families, cleaners, midwives, midwifery health care assistants, consultants, matron, the head and deputy head of midwifery.

Prior to the inspection, we held focus groups for staff and reviewed the trusts performance data.

Since the previous inspection there has been a change in leadership team with a new head of midwifery and deputy as well as the introduction of the clinical governance midwife.

The trust had also introduced the maternity transformation programme, birthing excellence success through teamwork (BESTT).

Summary of this service

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

- Training compliance for medical staff was much worse than the trust target of 85%. This meant that not all medical staff received the mandatory training required to undertake their rolls.
- Safeguarding training amongst the medical staff was worse than the trust's target of 85%. Of the 28 medical staff eligible for level two and three training there was a compliance rate of 64%.
- Despite the staff achieving a 88% compliance rate with mental capacity training, the staff we talked with showed a varied understanding of mental capacity and deprivation of liberty safeguards. This meant that not all staff were aware of their individual responsibilities. This was also identified at our last inspection.
- Data supplied by the trust showed very poor compliance rates of 57% with the World Health Organisation Safer Surgery check list. This meant that this safety standard was not being applied in practice to safeguard patients from practices known to reduce preventable maternal and new-born deaths around the time of childbirth.
- The midwife to birth ratio at the time of the inspection was 1:30. This was worse the national benchmark of 1:28. We noted this risk was reported on the trust risk register which identified compliance with one to one staffing in labour between 90-95% at the William Harvey Site. This meant that the trust was failing to ensure one to one care was provided to all mothers in line with best practice. However, the trust had recruited 5 staff who were due to commence work just after the inspection which brought the ratio back to an acceptable level to provide appropriate individualised care to patients in labour.
- We were concerned about the security of the entry system to Folkestone ward. There was a risk of tailgating and the distance and visibility of the entry point from the main desk area did not support staff to be vigilant.
- During the inspection we identified a high caesarean section and third degree tear rates which was rate worse than the England average.

Maternity

- The maternity unit environment was generally cramped, lacking suitable storage facilities and in need of modernisation. There was a general lack of responsiveness to staff when they raised concerns with the estate and facilities service. This meant when things fell into disrepair, they were not fixed in a timely way which affected patient satisfaction and frustrated staff.
- Managers identified the need for further improvement to feedback from lower level incidents and cross-site learning and staff engagement as an area for continued improvement.
- There was a lack of a mature and proactive audit and quality assurance systems to monitor quality outcomes, benchmark against national standards and drive service improvement. This meant the provider was missing an opportunity to regularly assess and monitor the service provided. However, we recognise that this concern had been identified by the senior leadership team and Maternity Faculty and this was being addressed.

However:

- The feedback we received from many patients was consistently positive, very complimentary of the staff, and the service they received.
- The service had sourced sponsorship from a baby wrap sling company who helpfully provided the unit with wraps for all mothers who undergo a caesarean section. Mothers wore the wrap to theatre and their baby was placed in the wrap immediately after birth. This meant that babies born were less likely to have a sudden drop in temperature and provided an immediate and invaluable skin to skin contact to aid bonding.
- Staff felt recent changes had been very positive and had driven the major culture shift. Examples of the contributing factors included the new 'hands on' and 'approachable' senior leadership team, work undertaken by the Maternity Faculty which was providing a multidisciplinary, 'no blame' and candid approach to education which had a positive effect on the wider team dynamics.
- The care provided reflected best practice and national guidelines, patients received care and treatment that was standardised and evidenced based.
- Nursing and midwifery staff protected patients from the risk of inappropriate or unsafe care because there were systems to ensure that incidents were identified, reported, investigated and learned from to prevent recurrence.
- Patients were protected from the risk of health acquired infections during their admission because staff followed national and best practice guidance.
- The faculty of multi-professional learning in maternity provided training that exceeded that of other maternity units. The teaching programme was aligned to the service incident reporting tool, risk register and staff need. This unique approach to providing training meant that the unit was actively addressing clinical risk, preventing recurrence and ensuring all staff had the competency they needed to carry out their roles in line with national guidance and best practice guidelines.
- There were systems and processes to ensure comments and complaints were responded to, learned from and used to improve the service.
- There was a notable and positive shift in the culture of the department. For example, staff told us 'it felt different' and 'things were getting better'.
- The new leadership team was having a positive impact on the quality of leadership and support provided to staff. There was an air of optimism and excitement in the department, which appeared to be driven by happier staff, who felt involved, and were encouraged and supported to innovate and deliver a better service.

Maternity

Is the service safe?

Requires improvement ➔➔

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

- The service did not ensure that all eligible medical staff completed mandatory training in key skills. Training compliance for medical staff was worse than the trust target of 85%, and ranged between 54% and 79% for the various modules.
- Safeguarding training amongst the medical staff fell below the trust's own target of 85%.
- Two fridges on Folkstone ward had been condemned just before the inspection. Medication requiring cold storage had to be moved to another clinical area to ensure it was stored in line with manufactures guidelines. The second fridge was used for the storage of breast milk. During the inspection, there was no facility to store breast milk. This meant any mother wishing to store milk was unable to do so.
- The maternity unit environment was cramped, lacking suitable storage facilities and in need of modernisation. The bathroom facilities in Folkestone ward were in poor condition and did not support infection control and prevention best practice guidelines. The floor in side room four on the maternity led unit was also in need of repair. Staff had reported their concerns about these facilities several times and no action had been taken. We were informed during our inspection that the trust had allocated funding to ensure these areas were renovated as a matter of urgency.
- Data supplied by the trust showed very poor compliance rates with the World Health Organisation (WHO) checklist of 57%. In an additional data request for WHO audits, we asked for any associated action plans implemented as a result of poor scores. We did not receive any evidence that poor performance was addressed. This meant that this safety standard was not being applied to safeguard patients from essential practices known to reduce preventable maternal and new-born deaths around the time of childbirth. When shortfalls were identified, the service did not evidence the necessary actions taken to improve.
- At the time of the inspection the midwife birth ratio was one to thirty. This was worse than what is outlined in the Birthrate plus guidance. We noted this risk was reported on the trust risk register which identified compliance with one to one staffing in labour between 90% and 95% at the William Harvey Site. This meant that the trust was failing to ensure one to one care was provided to all mothers in line with best practice.
- There was some evidence that learning from lower level incidents was not always shared with the clinical teams. It was clear that the practice of providing feedback required further attention to ensure better communication and learning. Staff we talked with provided a mixed response when asked how learning from incidents was disseminated. This meant that the learning outcomes of investigations required further development to prevent future recurrence.
- Whilst we were provided with evidence that Duty of Candour was applied in the maternity service, there was some concern that there was a varied approach to candour amongst the consultant group. Staff told us that some consultants were 'excellent' at being open when things went wrong and others had not fully embraced the regulations and required regular prompting to do so. This meant there was a concern that Duty of Candour regulations may be inconsistently applied in the department.

However:

- Nursing and midwifery staff had the required amount of mandatory training to ensure they could meet patient's care needs.

- Nursing and midwifery staff had undertaken the required level of safeguarding training. Mothers and babies were protected from the risk of abuse because staff were able to demonstrate knowledge of safeguarding systems, processes and identify the signs of abuse.
- The department had employed five additional staff who were due to commence work after the inspection. This would bring the staffing ratio back to within the England Average.
- The department had embraced learning from serious incidents and root cause analysis investigations. Examples of this include changes to practice for Cardiotocography (CTG) monitoring and safeguards against medications overdose. CTG is a technical means of recording the foetal heartbeat and the uterine contractions during pregnancy. The learning and practice changes were communicated via the social media group, perinatal meeting minutes, BESST posters and notice boards in the clinical areas, message of the week, and staff meetings.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.

Is the service effective?

Good ➔➔

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

- Patients received care and treatment that reflected national guidance and best practice guidance.
- Service policies and procedures reflected evidence based practice. Examples included implementation of a sepsis pathway and auditing of its application and patient outcomes as a result.
- In the 2017 National Neonatal Audit, based on data for January 2016 to December 2016, the hospital performance was within the expected range nationally.
- National Institute for Health and Care Excellence (NICE) quality standard 22 was in place. This standard relates to the care provision for all women up to 42 weeks of pregnancy and includes antenatal care in the hospital and community setting.
- Patients told us they were offered a choice in terms of their preferred birthing location. This was in line with National Institute for Health and Care Excellence Quality Standard 190: Intrapartum care. There was specific criteria and guidance for staff to follow at times where individual choice had to be balanced with clinical risk. This meant that staff were supported to make decisions to ensure the best outcomes possible for patients and their new-borns.
- Patients and their babies had their nutritional and hydration needs met. We saw patients had access to adequate food and drink during the inspection. The patients we talked with told us they were provided with a daily menu that offered sufficient choice.
- Patients had their individual pain needs assessed and managed in line with best practice guidance. The National Institute for Health and Care Excellence Clinical Guideline 190 indicated patients had access to a range of pain relief. The unit provided Entonox (gas and air) and Pethidine (a morphine-based injection) for medical pain relief during labour. Epidurals were also available.
- The faculty of multi-professional learning in maternity provided training that exceeded that of other maternity units. The teaching programme was aligned to the service incident reporting tool, risk register and staff need. This unique approach to providing training meant that the unit was actively addressing clinical risk, preventing recurrence and ensuring all staff had the competency they needed to carry out their rolls in line with national guidance and best practice guidelines

Maternity

- Essential life support (ELSO) and simulation training in obstetrics training was also provided to staff. Topics include; Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE), Each baby counts, Management of major obstetric haemorrhage and maternal collapse, vaginal breech delivery, shoulder dystocia, Neonatal collapse. This training was delivered by an external international organisation. This course concluded with an assessment of each individual clinician's competency to undertake these skills. East Kent Foundation Trust are the only maternity unit in the England to have undertaken this quality assurance process.
- The faculty also provided an 'out of hospital' simulation course has been built in collaboration with the local ambulance trust. This ensured community midwives and support workers, paramedics and ambulance technicians learned together.
- The department had changed its approach to foetal monitoring training after some concerns were identified. Training was provided face to face rather than via an online training tool. This approach was modelled on a system used in a London NHS trust with some of the lowest perinatal and maternal morbidity and mortality rates in the Western world. This change to training was in line with the latest Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) report, and Each Baby Counts. Each Baby Counts is the Royal College of Obstetricians and Gynaecologists's national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.
- The maternity service at the hospital provided a service seven days a week, twenty four hours a day. The care and treatment delivered by the service had a multidisciplinary focus.
- Staff in the department had compiled information leaflets for patients in different languages which provided health promotion advice.

However:

- We were provided with a list of audits from the units audit programme. There was insufficient evidence to demonstrate that clinical audit activity in the department was given the prominence required to measure outcomes and improve practice. A new clinical lead had recently been appointed and also had taken responsibility for audit activity in the department. Whilst we were told by the senior team that there were plans to improve the frequency and quality of the audits in the department, at the time of the inspection, there was a lack of structure, oversight or impact from the activity.
- At our last inspection, we noted the trust did not monitor the average waiting times for epidurals. The Association of Anaesthetists of Great Britain & Ireland states the time from the anaesthetists being informed that a woman has requested an epidural to the time the epidural is performed should not exceed 30 minutes and should only exceed one hour in exceptional circumstances. This meant that despite indenting this at our last inspection, no action was taken to monitor the timeliness of epidural medications and therefore the department had no way of assessing if it was compliance with the standard.
- Despite the staff achieving a 88% compliance rate with mental capacity training, the staff we talked with showed a varied understanding of mental capacity and deprivation of liberty safeguards. This meant that not all staff were aware of their individual responsibilities. This was also identified at our last inspection.
- During the inspection we identified a high caesarean section and third degree tear rates which was rate worse than the England average.

Is the service caring?

Good 

Maternity

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

- We observed staff treat patients and their loved ones with dignity and respect. The interactions we witnessed were kind, caring and attentive to patients' individual preferences and care needs.
- The service was actively encouraging service users to provide feedback and using it to improve the patients' experience.
- Comments we received from patients included "I feel very safe here and I am happy my baby is in good hands", "They spent a lot of time explaining things to me, the care is truly individual" and 'the midwifes have been brilliant'.
- From January 2017 to January 2018, the trust's maternity Friends and Family Test (birth) performance (% recommended) was similar to the England average. As of January 2018, the trust performance for birth was 97%.
- In the first instance patients were supported emotionally by the immediate clinical staff. In addition there was other specialist support available to those who needed it. For example, this included but was not restricted to, referrals to psychologists, perinatal mental health midwifes, breastfeeding specialists.

Is the service responsive?

Good  

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

- We saw that services were delivered in a way that focused on people's needs and individual preferences. This included making reasonable adjustments for mothers with mental health needs, intellectual disabilities and cultural needs.
- From quarter 2 of 2016/17 to quarter 3 of 2017/18 the bed occupancy levels for maternity were generally better than the England average, with the trust having 57% occupancy in quarter 3 2017/18 compared to the England average of 58%.
- The service had staff with specialist roles that provided additional support and information to staff and patients who used the service.
- The trust website had a series of information links and videos available for pregnant mothers called the Journey-pregnancy, labour and beyond. This footage provided important information for newly expectant mothers.
- The service had sourced sponsorship from a baby wrap company who provided the unit with wraps for all mothers who undergo a caesarean section. Mothers wore the wrap to theatre and their baby was placed in the wrap immediately after birth. This meant that babies born were less likely to have a sudden drop in temperature and provided an immediate and invaluable skin to skin contact to aid bonding.
- The department provided a suitable environment and emotional support for patients who had suffered a bereavement.
- Interpreting services were available. It could be booked in advance of clinical appointments. The service was able to provide access to information leaflets in different languages.
- The service had recognised access and flow in the department as a concern. In response to this, a discharge co-ordinator had been recruited to ensure the process was improved. The feedback we received indicated the speed of the discharges had improved. It also had an impact on the patient satisfaction as there was a more coordinated and standardised approach to the process. We saw evidence of a standardised check list in operation to ensure that all patients received the right checks and necessary after care information before leaving the department.

- There was an appropriate exclusion criteria for water births. Whilst the service aimed to support mothers to have the birth of their choice, it also had to ensure the choices were safe for patients and new-borns. Staff were able to tell inspectors about the exclusion criteria. This meant staff were able to undertake individual risk assessments appropriately and provide consistency of advice for women when considering the relative risk associated with where they wish to give birth.
- The service handled complaints in line with trust policy and used feedback to improve the services delivered.

However:

- No live simulation transfers were conducted on the Singleton Unit. The trust told us in the event of a real transfer the extra member of staff pre-called the lift and opened the door in order for a smoother and quicker transfer. However, during the inspection we noted the staff did not have a key to lock the lift or expedite its descent to the ground floor. Staff we talked with said that they never had a problem with the lift during an emergency transfer. We were not aware of any risk assessment that had been undertaken to assess the risks of unforeseen delays and the clinical impact a delay may have.
- The unit did not have Baby Friendly Initiative (BFI) accreditation but were keen to work towards this. The UNICEF UK Baby Friendly Initiative was launched in the United Kingdom in 1995 to work with the NHS to ensure a high standard of care for pregnant women and breastfeeding mothers and babies in hospitals and community health settings

Is the service well-led?

Requires improvement 

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

- New systems and processes that were being developed were much improved, but not yet fully embedded. Due to this, we received mixed feedback on the current confidence levels in the governance process. However, we were continuously told that the new systems and processes were much improved and would with time, prove be effective.
- There was a lack of robust audit and quality assurance systems to monitor quality outcomes, benchmark against national standards and drive service improvement. This meant the provider was missing an opportunity to regularly assess and monitor the service provided. However, we recognised that this was being addressed at the time of the inspection.
- We asked the trust to provide evidence to demonstrate how key performance indicators were monitored and any actions taken to address poor performance. The trust provided evidence of a 'clinical dashboard' was reviewed monthly at the divisional performance meeting and bi-monthly CCG performance meetings. However, data on the dashboard indicated concerns with key areas such as elective and emergency caesarean rates, Venous thromboembolism assessments. These appeared to be outside of the expected range for a prolonged time. This meant that we were not provided with assurance that poor clinical performance with key performance indicators was being managed effectively in a timely manner.
- We identified infection control concerns with the bathroom facilities in the maternity unit. The staff were able to evidence the actions they took to have the concerns addressed. However, there was little evidence these were addressed before the inspection.

However:

Maternity

- We noted a significant turnover of personnel from the management team since our last inspection. This had resulted in a long period of instability, poor oversight, and governance systems and processes that were not consistency applied. However, the leadership at this inspection presented themselves as a cohesive, insightful and proactive team. They showed insight into the previous failings, and described the affirmative actions being taken to bridge the historical leadership gaps.
- At out last inspection we identified several concerns relating to the culture in the department. During this inspection, we noted a significant and positive improvement. Staff told us that this was one of the major changes in the last 12 months. Data from the last culture check survey also showed improvements.
- Staff felt the many elements of change have been very positive and have driven the major culture shift. Examples provided included the new 'hands on' and 'approachable' senior leadership team and work undertaken by the Maternity Faculty which was leading a multidisciplinary, no blame approach to education which was having a positive effect on the wider team dynamics.
- Staff engagement had greatly improved since our last inspection. Staff reported feeling more involved and having their opinions and experience valued and respected.
- We requested the departmental governance meeting minutes. There was a standardised agenda which was laid out in line with the CQC Key Lines of Enquiry. We reviewed these and found they contained a sufficient level of detail.
- The trust launched its maternity transformation programme, birthing excellence success through teamwork (BESTT) benchmarking and agreeing actions to focus on how to improve outcomes for mothers and babies. The focus areas for the programme were drawn directly from the Department of Health's Safer Maternity Care action plan and then localised to address collaboratively agreed areas for improvement and innovation across trust maternity services.

Outstanding practice

- It was notable that the department had made great strides to drive learning, improve patient outcomes and inspire innovation. It is possible the notable change was associated with the collaborate and multidisciplinary team approach between clinical leaders and the team in the Maternity faculty. Staff repeatedly told us they felt these changes had a significant impact on their job satisfaction, clinical competency and drive to deliver better care.
- The service had secured funding to develop a smart phone Maternity Application which provided mothers with information throughout and after their pregnancy. The application (which was about to be rolled out formally in May) contained many useful features. Some of the functions included mood monitoring, electronic records, service feedback function, access to health information from reliable national sources in line with current best practice guidance and emergency contact numbers which were also presented in other languages for non-English speaking mothers.
- The provision of baby wraps to all mothers who have a caesarean section.
- The unit has taken a unique and ambitious approach to education. Examples of this include aligning the educational agenda to the top ten clinical risks, incident reporting system, maternity emergency's and the needs of the team. Examples of the training delivered include external assessment of all staffs competency to deal with medical emergencies.
- The department had top of the range simulators and simulation suite which staff had worked hard to fundraise for. This suite provided an opportunity for staff to experience in hospital and out of hospital emergencies. A new simulator had arrived during the inspection that was capable of simulating real birthing situations and could be taken into the clinical areas. This was to ensure that staff could experience simulated emergencies in the clinical setting for the next phase of training development.

Maternity

- The staff in the department were commendable fundraisers and went above and beyond on several occasions to ensure the department could access additional resources. Examples of this included the refurbishment of the bereavement room, acquiring a new kitchen fittings and fixtures, new fridges and living room furniture for the proposed staff room.
- There were 40 human factors trainers in the trust who are midwives, support workers, obstetricians, theatre staff, anaesthetic staff, neonatal nurses, neonatologists, Emergency department and ambulance service. This was the largest number of human factor trainers from any provider in the UK.
- Essential life support and simulation training in obstetrics was provided to staff. This course concluded with an assessment of each individual clinician's competency to undertake essential skills. East Kent Foundation Trust was the only maternity unit in England to have undertaken this quality assurance process.

Areas for improvement

- The trust **MUST ensure** that all medical staff received the required levels of mandatory and safeguarding training.
- The trust **MUST** develop robust quality measurement programme to ensure it can accurately monitor the quality of care, patients' outcomes, benchmark performance against National Institute for Health and Care Excellence Clinical Guidelines and other care standards.
- The trust **Must ensure** it provides one to one care for labouring mothers.
- The trust **MUST ensure** it improves its local quality monitoring process and acts promptly where poor standards are identified to protect patients from receiving harmful care.
- The trust **should** ensure it provides appropriate refrigerated milk storage for mothers wishing to breastfeed.
- The trust **should** consider providing appropriate breastfeeding facilities for mothers.
- The Trust **should** ensure it addresses the poor condition of the estate in the maternity department in a timely manner.

End of life care

Requires improvement 

Key facts and figures

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 2,685 deaths from December 2016 to November 2017.

The Palliative care team delivers a face to face visiting service five days per week from 9am to 5pm Monday to Friday. Out of hours and at weekends, a telephone advisory service is available from a local hospice to support the wards.

The palliative care team consisted of a palliative care nurse consultant and a palliative care social worker across the three hospital sites within the trust. There were two whole time equivalent clinical nurse specialists based at William Harvey Hospital and one whole time equivalent end of life care facilitator. Consultant in palliative medicine cover was provided by the local hospice for two clinical sessions a week at William Harvey Hospital.

There had been 559 referrals to the specialist palliative care team based at William Harvey hospital in the 12 months preceding our inspection. Of those 559 referrals 59% were for those patients with a diagnosis of cancer, 39% for those with a non-cancer diagnosis and the remaining 2% for were patients with both a cancer and non-cancer diagnosis. Examples of non-cancer diagnoses included sepsis, respiratory disease, heart failure and stroke.

During our inspection we visited a range of clinical areas such as the emergency department, intensive therapy unit, critical care, and wards including; care of the elderly; surgical and medical wards. We also visited the bereavement office, the chapel and the mortuary.

We met with 31 staff including; the palliative care nurse consultant; palliative care nurses; a care of the dying nurse; chaplaincy staff; bereavement staff; a mortuary manager, technicians and clinical lead; allied health professionals; matrons; ward managers; end of life care link nurses and healthcare assistants; registered nurses; consultants and junior doctors; healthcare assistants; and, porters.

We spoke with two patients and two relatives. We reviewed 15 patient records including; 10 ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) decisions; two medication records and three care records.

Summary of this service

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

- Information was not always available for staff to deliver safe care and treatment to patients at the end of life. Care records for patients on the ‘care of the dying patient and their family plan’ were seen to be inconsistently completed or not used appropriately for patients at the end of life.
- Anticipatory prescribing for medicines ‘just in case’ patients at the end of life experienced common symptoms was not always in line with trust guidance.
- Lessons were not always learned and improvements made when things went wrong. There were no examples of reported or recorded incidents relating to the care of patients at the end of life, however there was evidence of incidents relating to the mortuary and anticipatory prescribing.

End of life care

- Records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR) were not maintained.
- Staff did not always have the skills, knowledge and experience to deliver effective care, support and treatment. A range of end of life care training was available but not all link nurses on the wards had completed the mandatory training for the role.
- The palliative care service was not available face to face seven days a week.
- Patients were not always identified who were in need of extra support. For example, there was no framework in place for identifying patients in the last year of life or those with an uncertain recovery who were at risk of dying. There was no framework for advance care planning.
- Capacity issues within the mortuary led to processes for storing the deceased that did not ensure that people's dignity was respected during care after death. We were told that the practice of storing two bodies in the space meant for one had occurred during busy periods, particularly during the winter months.
- The trust did not record the percentage of patients who were discharged to their preferred place of care at the end of life. Discussions about preferred place of care were not consistently held in advance of the last days of life.
- There was no organisation specific end of life care strategy or aligned action plans.
- Processes for managing risks, issues and performance were not always effective. Risks were not always identified and recorded on the risk register or adequately mitigated.
- Governance structures were in place; however their effectiveness was impacted by a lack of structured action planning and prioritising.
- There were quality assurance processes evident, for example, in relation to audit and surveys. However, improvement plans were not detailed, structured or timely.

However:

- Syringe drivers were accessible and the administration of medicines via the pump was appropriately monitored.
- Anticipatory medicines 'just in case' patients at the end of life experienced symptoms were available.
- People's needs were assessed and care and treatment delivered in line with evidence based guidance to achieve effective outcomes.
- People's nutrition and hydration and pain management needs were identified and met in relation to national guidance for caring for people in the last days and hours of life.
- People's care and treatment outcomes were monitored through trust participation in the national end of life care audit there was evidence of improvement over time and trust participation in relevant quality improvement initiatives.
- The learning needs of staff had been identified and there was a range of training initiatives aimed at engaging generalist staff in improving patient care for those at the end of life.
- The service ensured that people are treated with kindness, respect, and compassion, and that they are given emotional support when needed. Staff were committed to ensuring the patient experience at the end of life was as positive as possible.
- People could access care in a timely way. Ninety eight percent of patients were seen within 72 hours of referral.

End of life care

- Spiritual support services were available to patients of different religions and beliefs, including for those patients with no particular faith.
- Leaders were visible and approachable. The end of life care board was made up of a range of senior staff including executive directors, matrons, consultants, hospice staff and members of the specialist palliative care team.
- An end of life care working group had been established at William Harvey Hospital to improve end of life care, although comprehensive action plans were not in place.
- There were governance structures and culture to support end of life care, with clear leadership at executive and senior staffing levels and an end of life care board responsible for decision making.
- People's views were gathered through a bereavement survey across the trust. This provided feedback to staff on the experience of relatives.
- There was some evidence of innovation, in particular with the development of a nationally recognised compassion symbol in collaboration with the local hospice.

Is the service safe?

Requires improvement 

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

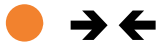
- There was evidence that staff identified and responded appropriately to changing risks to patients at the end of life, for example through the use of triaging processes for patient referral. However, we saw one example of a patient whose condition had improved who should have been removed from the 'care of the dying patient and their family' plan who had not been.
- Information was not always available for staff to deliver safe care and treatment to patients at the end of life. Care records for patients on the 'care of the dying patient and their family plan' were seen to be inconsistently completed or not used appropriately for patients at the end of life. We saw one example of a patient on the plan who should have been taken off of it due to a change in their condition and another patient who had a delay of more than 26 hours from the decision being made to the plan being commenced. A patient tracking list was in place to alert the care of the dying facilitator to patients commencing on the plan, however errors in inputting the correct data into the system to raise the alert meant that the alert would not always be raised.
- March 2018 care of the dying record audits showed that the use of the 'care of the dying patient and their family plan' was significantly lower at William Harvey Hospital at 53%. This was in comparison to an uptake of 90% for the other two hospitals in the trust and an overall uptake of 77%.
- Anticipatory prescribing for patients 'just in case' they experienced symptoms that were common at the end of life was in place with guidance available on the trust intranet and through the palliative care team. However, we saw examples of where the dosage of one medicine prescribed by the specialist palliative care team was outside of the range recommended in the guidance. While the dosage was within the therapeutic range for its intended purpose, this practice had the potential to cause confusion for non-specialist staff responsible for prescribing.
- Lessons were not always learned and improvements made when things go wrong. For example, there were no examples of reported or recorded incidents relating to the care of patients at the end of life. Staff were aware of the

processes for reporting but there was not a consistent culture of reporting specific to end of life care. There was no standing agenda item for end of life care incidents for the end of life care board. There were examples of incidents that staff told us about but that had not been recorded via the electronic reporting systems relating to prescribing at the end of life and capacity issues within the mortuary.

However:

- The maintenance and use of equipment kept people safe, for example, through the availability of syringe drivers and monitoring of the administration of medicines via syringe drivers.
- Fridge temperatures in the mortuary were monitored remotely through a system that could be accessed wherever there was access to the internet. A mobile phone app that linked to this system was available to the mortuary manager. This meant that temperatures could be monitored 24 hours a day, seven days a week.
- Anticipatory medicines 'just in case' patients at the end of life experienced symptoms were available.

Is the service effective?

Requires improvement 

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

- Consent to care and treatment was not always sought in line with legislation and guidance. For example, records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR) were not maintained.
- Staff did not always have the skills, knowledge and experience to deliver effective care, support and treatment. A range of end of life care training was available. End of life care link staff were responsible for training and supporting ward staff, however not all link staff had attended the training to deliver this. For example, while 73% of link staff had attended the 'dying in hospitals course', only 30% had a record of attending training in the use of the end of life care documentation and only 19% had received training in symptom control. On wards where staffing vacancy rates were high not all staff knew who their end of life care link nurse was and not all staff had received training other than when they commenced in post as part of their induction. This meant that there was a potential for some ward areas to not receive the level of training needed to adequately care for patients at the end of life.
- The palliative care service was not available face to face seven days a week.
- Patients were not always identified who were in need of extra support. For example, there was no framework in place for identifying patients in the last year of life or those with an uncertain recovery who were at risk of dying.

However:

- People's needs were assessed and care and treatment delivered in line with evidence based guidance to achieve effective outcomes. For example, the individual care plan for the dying person was based on relevant National Institute for Health and Care Excellence (NICE) guidance and there was evidence of the review of national guidance as part of governance processes within the service.
- People's nutrition and hydration and pain management needs were identified and met in relation to national guidance for caring for people in the last days and hours of life.
- There was evidence of staff teams working together within and across organisations to deliver effective care and treatment.

End of life care

- People's care and treatment outcomes were monitored through trust participation in the national end of life care audit. Where outcomes were identified as being below average, there was evidence of improvement over time and trust participation in relevant quality improvement initiatives.
- The learning needs of staff had been identified and there was a range of training initiatives aimed at engaging generalist staff in improving patient care for those at the end of life. This included the development of end of life care link staff from nursing and healthcare assistant staff groups.

Is the service caring?

Good 

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

- The service ensured that people are treated with kindness, respect, and compassion, and that they are given emotional support when needed. For example, staff consistently took time to interact with patients at the end of life and their families.
- Staff were committed to ensuring the patient experience at the end of life was as positive as possible. For example, we were told of a number of situations where staff had supported family events such as weddings and where family members experienced support and acts of kindness from staff.
- Staff understood the impact that a person's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially. For example, there were processes in place to support family members as well as patients, including the development of the compassionate communities service that provided support to the bereaved and those caring for someone at the end of life in the community.
- People's privacy and dignity were respected. Staff on the wards and members of the specialist palliative care team were seen to respond in a compassionate, timely and appropriate way when patients were distressed or in pain.

However;

- Capacity issues within the mortuary led to processes for storing the deceased that did not ensure that people's dignity was respected during care after death. We were told that the practice of storing two bodies in the space meant for one had occurred during busy periods, particularly during the winter months. Staff took practical measures to minimise the issue as much as possible by transferring the deceased between sites and keeping the time that two bodies would spend in the same space to a minimum. However, a fundamental lack of capacity meant that more than one body was stored in a fridge space meant for single occupancy.

Is the service responsive?

Requires improvement 

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

- The service had some systems in place so that they took account of the particular needs and choices of different people. However, there was no framework for advance care planning for patients at the end of life. For example, patients were asked about their preferred place of care at the end of life; however this was generally in the last days of

life. There was some evidence of patients being supported to make decisions about the end of life in advance; however this was dependent on the support of individual clinicians rather than a trust wide approach. This meant that not all patients would have the opportunity to make decisions in advance of their health deteriorating. This was not in line with the local interagency policy recommendations for early conversations in relation to care decisions.

- The trust did not record the percentage of patients who were discharged to their preferred place of care at the end of life. Data showed that 47% of patients did not have their preferred place of care discussed with them. This meant that patients were less likely to die in their preferred place of care.
- Complaints relating to the care of patients at the end of life were reviewed by the end of life care board and themes identified. However, not all palliative care staff were aware of the details of complaints and it was not clear how these were shared with staff in a way that ensured lessons were learned and care improved.
- A fundamental lack of mortuary capacity across the trust meant that more than one body was stored in a fridge space meant for single occupancy during busy times. We did not see this during our inspection and staff told us they followed trust criteria to ensure that local coroner requirements were met.
- Facilities for caring for patients at the end of life such as side rooms and quiet rooms for having difficult conversations with relatives were limited in some wards. Staff in the mortuary told us they discouraged relatives from viewing their loved ones in the mortuary because the facilities were not conducive to this as it was a working mortuary with post mortems being held regularly. However, the palliative care nurse consultant told us this had been raised following and NHS Improvement (NHSI) critical friend visit and as a result they were planning on developing a business case to make improvements. There was a relative's suite within the hospital where relatives of patients at the end of life could rest and have refreshments; however survey results showed that not all relatives were made aware of this facility.

However:

- People could access care in a timely way. For example, general ward staff told us that the specialist palliative care team would generally visit the patient on the day of referral. Ninety eight percent of patients were seen within 72 hours of referral.
- The services provided reflect the needs of the population served and they ensure flexibility, choice and continuity of care. For example, the service supported patients with cancer and those with other conditions such as heart disease, dementia and respiratory conditions.
- Interpreters were available to support communication with patients and relatives of whom English was not their first language.
- Written information was not available in different languages or formats for patients with sensory needs.
- Spiritual support services were available to patients of different religions and beliefs, including for those patients with no particular faith. Different faith protocols were in operation within the mortuary.

Is the service well-led?

Requires improvement  

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

- Leaders had an understanding of the challenges to quality and sustainability; however actions to address them were not always comprehensive. For example, audit and survey results were collated to identify areas for improvement, but analysis and actions were not always sufficiently detailed or timely.

End of life care

- While the trust had been involved in the development of a regional end of life care strategy, there was no trust wide strategy or specific action plans associated with this.
- Processes for managing risks, issues and performance were not always effective. Risks relating to the mortuary capacity were identified on the pathology risk register but not on the palliative care or corporate registers. Action to mitigate the risk and the impact of current activities was not comprehensively identified and there was evidence that the risk had not been properly escalated or managed. We were told that the palliative care risk register did not currently have any risks identified, however, staff told us there were ongoing issues with fast track discharge and the trust was not providing a seven day palliative care service which presented a risk to continuity of care for patients.
- The trust's governance structures were not always effective because there was a lack of structured action planning and prioritising. For example, there was an ongoing issue with an incomplete service level agreement for the medical cover from the hospice. We were told this had been drafted following our previous inspection in 2016 but had yet to be finalised and agreed. An interagency policy was in place for end of life care but it was unclear how the trust was working toward achieving the priorities in a timely, structured way.
- There were quality assurance processes evident, for example, in relation to audit and surveys. However, improvement plans were not detailed, structured or timely. For example, a 2018 bereavement survey showed evidence of deteriorated satisfaction with the service but it was not clear how the trust were planning on addressing this as the actions were the same as the 2017 survey.

However:

- Leaders were visible and approachable. The end of life care board was made up of a range of senior staff including executive directors, matrons, consultants, hospice staff and members of the specialist palliative care team.
- An end of life care working group had been established at William Harvey Hospital to improve end of life care, however comprehensive action plans were not in place.
- There were arrangements with partners and third-party providers to encourage appropriate interaction and promote coordinated, person-centred care. The trust was part of an interagency network that had developed and end of life care strategy and interagency policy.
- There was a culture of improving end of life care and staff were aware of developments. There was an emphasis on developing the skills of staff in relation to end of life care with a range of courses available and the trust had a focus on ward based training in end of life care. However, not all end of life care link staff with responsibilities for delivering the training had completed the training for the role.
- There were governance structures to support end of life care, with clear leadership at executive and senior staffing levels and an end of life care board responsible for decision making.
- People's views were gathered through a bereavement survey across the trust. This provided feedback to staff on the experience of relatives.
- There was some evidence of innovation, in particular with the development of a nationally recognised compassion symbol in collaboration with the local hospice.

Areas for improvement

We found areas for improvement in this service. The trust must;

- Ensure that consent to care and treatment is always sought in line with legislation and guidance in relation to records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR).

End of life care

In addition, the trust should;

- Take action to make sure that records for patients on the 'care of the dying patient and their family plan' are consistently completed.
- Take action to ensure that anticipatory prescribing for medicines is in line with trust guidance.
- Make sure that lessons are learned and improvements made when things go wrong.
- Make sure that staff responsible for training other staff have the skills, knowledge and experience to do so and that all ward staff receive training in the delivery of effective care, support and treatment for patients at the end of life.
- Review the palliative care service with a view to providing a seven day face to face service.
- Make sure there is a framework and focus for identifying patients with an uncertain recovery who were at risk of dying, together with a framework for advance care planning.
- Make sure that capacity risks within the mortuary are comprehensively assessed and mitigated to ensure that the storage of the deceased is in line with the Human Tissue Authority published guidance and that people's dignity is respected during care after death.
- Ensure that discussions about preferred place of care are consistently held in advance of the last days of life and that the achievement of discharge to the preferred place of care is monitored.
- Ensure that a trust wide end of life care strategy and action plans are in place.
- Ensure that processes for managing risks, issues and performance are effective. Risks should be identified and recorded on the risk register and adequately mitigated.
- Make sure that governance structures and processes are supported by structured action planning and prioritising.
- Ensure that improvement plans are sufficiently detailed, structured and timely.

Kent & Canterbury Hospital

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Key facts and figures

Kent and Canterbury Hospital is an acute hospital located in Canterbury, Kent and serving the greater Canterbury area. It was originally built in the 1930s with newer buildings built in the 1960s. It provides a range of inpatient and outpatient services as well as treatment for minor injuries and illnesses. The hospital is a centre for specialist services in East Kent, for instance, vascular, urology an neurology. It has a postgraduate teaching centre that works in coordination with the local university.

Summary of services at Kent & Canterbury Hospital

Requires improvement ➔➔

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

We rated safe, effective, responsive and well-led as requires improvement, and caring as good. We rated two core services as requires improvement and one as not enough information to rate.

Urgent and emergency services

Not sufficient evidence to rate

Key facts and figures

Kent and Canterbury Hospital has an Urgent Care Centre which was open 24 hours a day, seven days a week including bank holidays. The service provides care to approximately 30,000 patients a year.

Summary of this service

The Kent and Canterbury Emergency Care Centre has three separate areas, a Level 3 minor injury unit (including a four-bed paediatric unit), vascular and urological emergency unit and a resus unit.

The minor injuries unit (MIU) provides treatment for minor illness and injury to children over one year old and adults.

The vascular and urology emergency unit provides care to people of all ages with urgent vascular or urological conditions.

The resus area had three bays, two for adults and one for children. This unit was primarily used for vascular and urology emergency patients. These patients are treated in the resus then transferred within the hospital if they can be treated at Kent and Canterbury.

The resus unit is sometimes used for self-referred patients who need to be transferred to the emergency departments at William Harvey Hospital or Queen Elizabeth the Queen Mother Hospital due to their condition. In these cases, patients are transferred to the other hospital by emergency ambulance, but treated in resus area until the ambulance arrives.

Urgent and emergency services were last inspected in 2016 when overall, we rated the service as requires improvement. Our inspection was unannounced and we inspected all five key questions.

We have performed a focused review of the emergency services at Kent and Canterbury hospital. This report summarises our findings. However, there is insufficient information to rate this service.

Is the service safe?

Not sufficient evidence to rate

We had inadequate information to rate this service. We found:

- They had not achieved target for nursing staff compliance in safeguarding children level three and safeguarding adults level two. These rates were worse than the target trust target of 85%.
- There were three staff members currently out on long term leave which meant the department could not cover all shifts internally. On the day of inspection two booked NHS agency staff had not arrived to cover their shift.
- Kent and Canterbury Hospital Emergency Care Centre was a nurse led unit. This meant there was no one in the Emergency Care Centre who could urgently prescribe IV antibiotics for sepsis patients in line with national guidance. The unit relied on the on-call registrar to come to the unit from another part of the hospital to see the patient, however, there had been confusion about whether this was part of the registrar's role.

- The provider did not check ambient temperatures in the urgent care centre. The provider checked and recorded refrigerator temperatures daily. However, when out of range temperatures were recorded, these were not reported or escalated. We reviewed temperatures recorded from 1 January through to 16 May 2018. Over this period, out of range temperatures were recorded on 32 occasions; they were not escalated and no further action was taken.

However:

- Staff we spoke with knew who the safeguarding lead was and understood their responsibilities to safeguarding both adults and children. Staff we spoke with could identify the differing signs of abuse and could give examples of when they had made a safeguarding referral.
- The service had improved their mandatory training rates. Rates for every mandatory training module had increased. Four areas exceeded the 85% target, one met the target and one fell 3% below the target. This showed a commitment to ensuring staff had training and competency required to work in the department.
- The resuscitation area equipment was very well organised with colour coded drawers and clearly labelled equipment in glass fronted cabinets. We observed equipment check sheets were carried out daily and completed for equipment in all areas.
- Staff could describe markers and appropriate actions when patients showed signs of sepsis and that they carried sepsis reminder cards so they had this information to hand. When sepsis patients were identified they were transported by blue light ambulance to one of the emergency departments in the trust.
- The Matron at Kent and Canterbury Hospital liaised with the Medical Director to ensure that the current process for the 'hot' on-call registrar to come to the unit to prescribe IV antibiotics for septic patients was a priority.
- The resus trolley at Kent and Canterbury Hospital was located centrally in the unit. It was sealed so that it could be easily accessed by staff in an emergency, but not in other situations.
- From March 2017 to February 2018, the trust reported no incidents classified as never events for urgent and emergency care.
- Staff told us they had never seen an ambulance waiting to hand over patients at this hospital. Updated data for May 2018 at Kent and Canterbury Hospital, showed that 40% of ambulance handovers were completed in under 15 minutes. Data showed that 4% of patients waited over 30 minutes to be handed over and only 2% of patients waited over an hour to be handed over.

Is the service effective?

Not sufficient evidence to rate

We had inadequate information to rate this service. We found:

- In the CQC Emergency Department Survey, the trust scored 6.8 for the question "Were you able to get suitable food or drinks when you were in the emergency department?" This was about the same as than other trusts.
- In the CQC Emergency Department Survey, the trust scored 5.5 for the question "How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.
- The trust scored 7.3 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.

Urgent and emergency services

- The service was open 24 hours a day, seven days a week including bank holidays. X-ray facilities were available to support the department Monday through Friday from 8:00 am to 8:00 pm and Saturday and Sunday from 8:00 am until 4:00 pm.

However,

- Staff may not have had the support for their role and progression through the appraisal process. Appraisal rates were 7% lower than trust targets. Appraisals may not have been effective when they did occur, the trust's 2017 Staff survey showed overall poor staff satisfaction regarding the effectiveness of appraisals.

Is the service caring?

Not sufficient evidence to rate

We had inadequate information to rate this service. We found:

- The trust's urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average from January 2017 to December 2017.
- As of January 2017, the trust performance was 72.9% compared to the England average of 86.7%.

Is the service responsive?

Not sufficient evidence to rate

We had inadequate information to rate this service. We found:

- Staff were responsive to the needs of individuals. Staff described prioritising patients living with dementia and learning disabilities when possible to minimise the stress and confusion associated with waiting in a medical facility.
- Staff communicated with individuals so they could understand and manage their own care.
- Link nurses were available to provide expertise about patients with learning disabilities and dementia. Staff knew who their link nurses were and how to access them.

Is the service well-led?

Not sufficient evidence to rate

We had inadequate information to rate this service. We found:

- Staff told us they generally felt supported by the leaders in the Urgent Care Centre. Staff knew their managers and felt they were accessible.
- Some staff told us senior management were visible and approachable.
- Staff we spoke with felt confident they were working toward the trust's values.
- Staff felt supported, valued and respected by their peers. We observed staff in each unit of the department (minor injuries unit and vascular and urology) worked as close teams and there were positive working relationships between these staff. However, we observed and staff told us that each part of the unit worked separately and there was not always colleague to colleague support between areas.

- All staff we spoke with, told us they were very proud of their own work and that of their colleagues. They felt that the teams worked together to manage patient care. Staff told us they felt the teams were closer than in other departments they had worked in.
- The department provided examples of innovation in the department. For instance, there was a virtual fracture click to provide virtual support to most patients with fractures, the department used an electronic records system which forced note takers to consider safeguarding, venous thromboembolism (VTE) and other patient risks before progressing through the patient's notes and the department was training a nurse to become an emergency nurse practitioner (ENP).

However,

- However, they reported that the more senior management were not visible or accessible. One staff member told us they would not know any members of senior management if they walked through the department.
- Some staff told us they did not believe senior management listened to their views about changes in the trust, so they had stopped engaging in communications and programs about change.
- Staff in the department voiced concerns about when decisions would be made and how this would affect their department and individual's jobs. The trust had been working on the clinical strategy with the clinical commissioning groups and sustainability and transformation partnerships to develop the plans in line with regional needs for several years. The new strategy was expected to be foundational for many of the decisions about the trust in the future and would affect the trust's governance and leadership. But the lack of decision had fostered uncertainty in the department.

Outstanding practice

We found examples of outstanding practice in this service.

- Equipment in the resuscitation area was very well organised with colour coded drawers and clearly labelled equipment in glass fronted cabinets. The cabinets made it easy to see when a piece of equipment was missing. This meant staff could quickly find the correct equipment they needed to treat a deteriorating patient.

Surgery

Requires improvement 

Key facts and figures

Kent and Canterbury hospital provides a range of surgical services including general surgery, urology, vascular and ophthalmology.

The service consists of six main operating theatres, three operating theatres for day surgery and one theatre in the ophthalmology suite. There are two surgical wards, Clarke ward (urology) and Kent ward (vascular). Clarke ward had capacity for 36 inpatient beds and Kent ward had 20 inpatient beds.

We carried out an unannounced onsite inspection of Kent & Canterbury hospital on the 16 and 17 May 2018. During our inspection we visited all surgical areas including main theatres, day surgery, the ophthalmology suite and the two surgical wards. We spoke with two relatives and six patients. We spoke with 33 members of staff including students, nurses, operating department practitioners, pharmacists, administrative staff, housekeeping staff and consultant anaesthetists.

We observed care being provided to patients and reviewed 11 sets of patient records.

The trust had 53,563 surgical admissions from November 2016 and October 2017. Emergency admissions accounted for 15,456 (29%), 29,881 (56%) were day case, and the remaining 8,266 (15%) were elective.

Summary of this service

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

- The environment which surgical services were provided did not always suit the purpose. Patients in the second stage of recovery after an ophthalmic operation were placed in the waiting area with a screen to separate them from other patients and visitors. This meant that their privacy was compromised. We raised this on site and the trust took action to address our concerns.
- Referral to treatment times (RTT) were generally below the England average from January 2017 to December 2017. For example, 63% of urology patients were treated within 18 weeks compared with the England average of 77%.
- The overall theatre utilisation between May 2017 and May 2018 was 50%. This was lower than the trust target of 80% which meant that there was poor use of staffing resources and decreased efficiency within theatres.
- Staff were not aware of the trust's vision and strategy. Some staff felt concerns they raised were not addressed by local leaders.
- It was unclear how many risks were on the risk register and what issues they referred to.
- Patients undergoing elective and non-elective surgery had a higher than expected risk of readmission.
- Theatre staff were rostered to work extended hours which included on call cover. Staff were not having the 11 hours of rest between shifts. This breached the European working time directive (EWTD).

However;

- Surgical services were consultant led. Junior doctors told us they received sufficient support and supervision from consultants.
- Staff completed patient care records legibly and signed and dated all entries.

Surgery

- Patients were always assessed, treated and cared for in line with professional guidance. Staff completed risk assessments for clinical risks including falls, pressure ulcers and venous thromboembolism (VTE).
- Staff understood the impact of the care they provided. We observed staff speaking and treating patients with respect and dignity. Staff explained to patients how to look after themselves and also gave written information for patients to refer to in their own time.

Is the service safe?

Requires improvement 

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

- The service did not provide mandatory training in key skills to all staff and make sure everyone completed it. Mandatory training compliance had improved since our last inspection. However, we found that mandatory training rates remained low for some staff groups, particularly for medical and dental staff and in some topics, such as information governance.
- Not all staff understood how to protect patients from abuse and how to work with other agencies to do so. Staff demonstrated a variable understanding of their safeguarding responsibilities and safeguarding procedures. Some staff were unable to tell us what constituted abuse and junior staff demonstrated a limited understanding. However; they said they would raise any concerns with a senior member of staff. Staff were not aware of who the safeguarding lead was.
- The service did not always have suitable premises and equipment and look after them well. There was inappropriate use of the ophthalmology suite's waiting room. A second recovery area had been created by using a screen to divide the waiting room in two. Patients who were observed to be in stage two of post anaesthetic recovery (responsive/ mobile), were placed in the second recovery area. Patients were not always monitored by staff and there were no call bells for patients to use if they needed nursing assistance in the event of an emergency. After raising this issues with the theatre matron, the trust provided us with an action. All patients were to be taken to the surgical ward post recovery for safe discharge.
- The service did not have enough staff with the right qualifications, skills, training and experience. Theatre staff worked extended hours. For example, staff were rostered to work a day shift and then provided on call cover followed by another day shift. This breached the European working time directive (EWTD) which states that there should be 11 hours rest a day. After raising this issue with the theatre matron, the trust reviewed and changed their policy for staff rostering to ensure it adhered with the European working time directive.
- The service did not always prescribe, give, record and store medicines well. Some medicines in the fridge had expired, which meant that they were unsafe to consume or may not be as effective.
- Ward staff stored food and drinks in clinical areas used to prepare medicines for administration.

However;

- The service controlled infection risk well. Staff demonstrated good infection control practices in theatre including waste management, specimen handling, surgical techniques and maintenance of sterile field. Staff cleaned theatre equipment appropriately between cases using disinfectant wipes in adherence to the trust decontamination procedure.

- Risk assessments were completed for skin damage, falls, nutrition and venous thromboembolism (VTE). We reviewed 11 sets of patient records and noted that assessments were recorded in full in all the patient records. The service used the national early warning score (NEWS) to monitor triggers of sepsis and staff demonstrated a good understanding of sepsis its recognition and treatment.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There was sufficient medical staffing to meet patients' needs. Junior doctors told us they received adequate consultant supervision and nursing staff said there was a responsive medical team supporting the surgical wards. The on call arrangements included one consultant, one registrar and one senior house officer (SHO) for each speciality (urology and vascular). A consultant anaesthetist was available Monday to Friday 8am to 7pm. Diagnostic services such as CT and X-ray were available 24 hour a day.
- Staff kept appropriate records of patients' care and treatment. We reviewed 11 sets of patient records and saw they were comprehensive and well documented. Records were easily accessible to those who needed them and authorised to review them.
- The service managed patient safety incidents well. Staff were aware of how to report an incident and all said they were confident in using the electronic system used by the hospital. Incidents were discussed at handovers, team briefings and at staff meetings. Communication folders were also used to ensure staff who were not present at team briefings were informed.

Is the service effective?

Good

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

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Trust policies and procedures were evidence based and adhered to national guidance. Practice guidelines were available to staff on the trust intranet to ensure practice remained in line with national guidance. Staff knew where to find policies and were notified of any updates at briefings.
- Staff gave patients enough food and drink to meet their needs and improve their health. We reviewed a varied food menu, which catered for patients' individual religious, cultural or dietary needs as well as texture modification. The menu included 16 different meat and fish dishes and vegetarian choices from curries and roast dinners to pasta dishes.
- Pain relief was taken into consideration prior to discharge. Staff ensured that patients had understood the arrangements that had been made. Pain medication prescribed post operatively was included in the patients discharge letter.
- The hospital's performance in the 2015/16 Patient Outcomes Measures (PROMS) survey for groin hernias and hip replacements was similar to the England average. Their performance for knee replacements was better than the England average.
- The service made sure staff were competent for their roles. Managers Educational opportunities were good and available for staff who wanted to progress. Most of the staff we spoke with had or were currently being supported by the trust to undertake further training to gain additional qualifications.
- The surgical service had an appraisal completion rate of 86%. This met the trust target of 85%. Most staff we spoke with, had had their annual appraisal meeting. Staff were notified of when the meeting was due a month in advance so they could complete a form with a list of objectives they wanted to achieve for the forthcoming year.

Surgery

- Staff of different kinds worked together as a team to benefit patients. Staff worked well together and we able to assess and plan ongoing care and treatment in a timely manner. Multidisciplinary meetings were held every Wednesday afternoon and were attended by staff from different professional backgrounds.
- Day surgery was open Monday to Friday 7am to 8pm and occasionally had a weekend operating list.
- The trust had a stop smoking service. Staff could refer patient to the service by phone and patient were able to self-refer. The service offered patients inpatient bedside behavioural support, nicotine replacement therapy (NRT) while in hospital or to take home on discharge if appropriate.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care. We also saw evidence the service obtained patient consent for surgery in line with General Medical Council guidance. Patients we spoke with told us they had received information regarding the procedures they were undergoing verbally and in written form before surgery. All consent was obtained on the day of the procedure. We reviewed 11 patient care records and each contained fully completed consent forms signed and dated by both the patient and consultant.

However;

- All patients at Kent & Canterbury hospital had a higher than expected risk of readmission for elective and non-elective admission when compared to the England average. For elective procedures, those having vascular surgery had the highest readmission rate amongst the three specialities urology, general and vascular surgery.
- The service had identified that they were at risk of not complying with standards for medical education and training for trainee doctors set by the General Medical Council (GMC) and Health Education England (HEE) because of the lack of surgical variety. This was on the risk register and the trust had begun addressing the issue by rotating junior doctors to other hospital sites that formed East Kent Hospitals University NHS Foundation Trust.

Is the service caring?

Good 

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

- Staff cared for patients with compassion. Patients commented positively on the care they had received. Patients felt staff respected their privacy and dignity. We observed that staff maintained the dignity of patients during surgery.
- Staff provided emotional support to patients to minimise their distress. Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. We observed staff delivering kind, compassionate care, aimed to provide the best experience to all who used the service.
- Staff involved patients and those close to them in decisions about their care and treatment. Staff gave patients information to understand and manage their own care. We observed a nurse discussing pressure area care with a patient who had returned from theatre. The nurse gave the patient a leaflet to explain pressure area care and the patients' role in helping their own recovery process. The leaflet included advice on pressure care for when the patient returned home.

However;

- The average response rate for the Friends and Family test for surgery at Kent & Canterbury was 24%. This was worse than the England average of 29%.

Surgery

Is the service responsive?

Requires improvement 

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

- People could not always access the service when they needed it. At the last inspection, we noted that the referral to treatment time was worse than the England average. This was still the case at this inspection. As of December 2017, 57% of patients were treated within 18 weeks. This was worse than the England average of 72%. Recent data from January to April 2018 showed that there had been no improvements in referral to treatment time for admitted pathways within the 18-week timeframe.
- At the last inspection, we recommended that the service should improve theatre utilisation. At this inspection, the utilisation rate was similar to the last inspection. The theatre utilisation target was 80%. Between May 2017 and May 2018, 50% of all theatre sessions at Kent & Canterbury met the 80% target. Only 16% of theatre sessions exceeded 100% theatre occupancy.
- Although the average length of stay was better than the England average we noted that the readmission rate from November 2016 to October 2017 was worse than the England average for elective and non-elective patients. This could be as a result of patients being discharged from the hospital too early.

However;

- The average length of stay for elective surgeries was 2 days. This was lower than the England average of 3.9 days. Similarly, the average length of stay for non-elective surgery was also low at 1.7 days compared with England average of 5days.
- The service took account of patients' individual needs. Discharge expectations were discussed at pre- admission for planned admissions or at the time of admission for emergency cases. The integrated discharge team worked with the ward staff and community services to meet individual's needs when planning ongoing care in the community for surgery patients. For example, the team arranged ongoing physiotherapy or rehabilitation care from local community providers.
- The service had a comprehensive network of specialist nurses which included learning disability and dementia nurses. Patient's requiring reasonable adjustments were identified at pre-assessment and a specialist nurse would be allocated to support the patient through the patient pathway. Relative were encouraged to complete a "My healthcare passport" on behalf of the patient, at the earliest opportunity to help staff plan care to accommodate patients with learning difficulties or living with dementia.
- There was an inpatient physiotherapy service that specialised in vascular surgery. Physiotherapists regularly worked with amputee patients to re-educate them on weight bearing and maximising muscle strength and joint mobility. The physiotherapist encouraged this, so patients could gain a good level of independence before being discharged home or into the community.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. Information relating to concerns and complaints was shared with each individual team. The matrons also used the communication document to ensure every member of staff was aware of complaints.

Surgery

Is the service well-led?

Requires improvement  

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

- Staff were not aware of the trust's vision and strategy. Senior staff in charge of the daily running of the surgical unit told us they did not have a local vision or strategy. This was attributed to the uncertain future of the hospital. Staff were unsure whether surgical services were to be moved away from the Kent & Canterbury site and how changes would impact their jobs. This resulted in low staff morale.
- The trust did not always engage well with staff to plan and manage appropriate services, and collaborated with partner organisations effectively. Staff told us they did not see the value in speaking up about issues as they felt nothing would be done. One member of staff told us they had raised a concern with surgical leads about patient safety but their concern was not addressed.
- The service did not always use a systematic approach to continually improve the quality of its services and safeguard high standards of care by creating an environment in which excellence in clinical care would flourish. At ward level staff meetings did not take place regularly. The most recent meeting had taken place on Clarke ward in February 2018. The area matrons told us information was shared through the communication documents, which only allowed the flow of information to travel in one direction. Staff could not use this forum to escalate information up to the hospital's divisional leads.
- The trust had systems for identifying risks, planning to eliminate or reduce them, however, they were not always effective. It was unclear from the risk register and from the information we were told about the number and type of risks there were on the risk register. During our inspection the theatre matron told us there were eight risks on the register, with the most recent relating to ventilation in theatres. The risk register provided by the hospital for May 2018 had five open risks and none from Kent & Canterbury's surgical team.

However;

- The service had managers with the right skills and abilities to run a service providing high-quality sustainable care. Surgical services were consultant led and surgical staff in all areas reported that they were well supported by consultant leads. Nursing leadership at the local level was good with the majority of staff confirming that their line manager and matron were approachable, responsive and involved staff in the ward development.
- The service used a systematic approach to improve the quality of some of its services and safeguard high standards of care. Theatres used a management computer system detailing the timeliness of theatres. Theatre staff were aware of theatre lists running times and could give other areas an update to effectively manage any delays. Adjustments were made in regard to moving patients from one theatre list to another if it was appropriate to avoid further delays.
- The surgery department provided a hospital at home service which allowed patients to be cared in their own home and still receive inpatient care. This allowed patients to be safely discharged quickly and patients avoided being at risk of falls, delirium and decline and contracting hospital acquired infections, usually associated with long hospital stays.
- In the 2017 NHS staff survey, the trust achieved its highest response rate to date at 50.3%, which demonstrated a willingness of staff to engage and provide honest feedback. The trust had set up regular listening events and staff forums to encourage more engagement. Most staff had not had an opportunity to attend due the nature of working in surgery.

Surgery

Areas for improvement

In addition, the trust should:

- Continue to review and take action to ensure that surgical areas are fit for purpose.
- Continue to improve referral to treatment times to ensure that patients are treated in an acceptable timeframe following referral to the service in line with national standards.
- Ensure that medicines are regularly checked and out of date medicines are removed from the fridges.
- Avoid storing food and drinks in clinical areas.
- Improve theatre utilisation for better use of staff resources and increased efficiency.
- Ensure regular staff meetings take place to improve staff engagement and the sharing and learning from incidents.
- Take action to ensure trust values are embedded across all staff groups.

End of life care

Requires improvement 

Key facts and figures

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 2,685 deaths from December 2016 to November 2017.

The Palliative care team delivers a face to face visiting service five days per week from 9am to 5pm Monday to Friday. Out of hours and at weekends, a telephone advisory service is available from a local hospice to support the wards.

The palliative care team consisted of a palliative care nurse consultant and a palliative care social worker across the three hospital sites within the trust. There were 1.8 whole time equivalent clinical nurse specialists based at Kent and Canterbury Hospital and one whole time equivalent end of life care facilitator. Consultant in palliative medicine cover was provided by the local hospice for two clinical sessions a week at Kent and Canterbury Hospital.

There had been 533 referrals to the specialist palliative care team based at Kent and Canterbury hospital in the 12 months preceding our inspection. Of those 533 referrals 60% were for those patients with a diagnosis of cancer, 40% with a non-cancer diagnosis. Examples of non-cancer diagnoses included sepsis, respiratory disease, heart failure and stroke.

During our inspection we visited a range of clinical areas such as wards including; care of the elderly; the renal ward; surgical and medical wards. We also visited the bereavement office, the chapel and the mortuary body store.

We met with 26 staff including; the palliative care nurse consultant; palliative care nurses; a care of the dying nurse; chaplaincy staff; bereavement staff; a mortuary manager, technicians and clinical lead; allied health professionals; matrons; ward managers; end of life care link nurses and healthcare assistants; a clinical pharmacist; registered nurses; consultants and junior doctors; healthcare assistants and a rehabilitation assistant.

We spoke with six patients and one relative. We reviewed 17 patient records including; 13 ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) decisions; two medication records and two care records.

Summary of this service

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

- Anticipatory prescribing for medicines ‘just in case’ patients at the end of life experienced common symptoms was not always in line with trust guidance.
- Lessons were not always learned and improvements made when things went wrong. There were no examples of reported or recorded incidents relating to the care of patients at the end of life, however there was evidence of incidents relating to the mortuary and anticipatory prescribing.
- Staff did not always have the skills, knowledge and experience to deliver effective care, support and treatment. A range of end of life care training was available but not all link nurses on the wards had completed the mandatory training for the role.
- The palliative care service was not available face-to-face seven days a week.

End of life care

- Patients were not always identified who were in need of extra support. For example, there was no framework in place for identifying patients in the last year of life or those with an uncertain recovery who were at risk of dying. There was no framework for advance care planning.
- Capacity issues within the mortuary led to processes for storing the deceased that did not ensure that people's dignity was respected during care after death. We were told that the practice of storing two bodies in the space meant for one had occurred during busy periods, particularly during the winter months.
- The trust did not record the percentage of patients who were discharged to their preferred place of care at the end of life. Discussions about preferred place of care were not consistently held in advance of the last days of life.
- There was no organisation specific end of life care strategy or aligned action plans.
- Processes for managing risks, issues and performance were not always effective. Risks were not always identified and recorded on the risk register or adequately mitigated.
- Governance structures were in place; however their effectiveness was impacted by a lack of structured action planning and prioritising.
- There were quality assurance processes evident, for example, in relation to audit and surveys. However, improvement plans were not detailed, structured or timely.
- However:
- Care records for patients on the 'care of the dying patient and their family plan' were seen to be completed appropriately.
- Anticipatory medicines 'just in case' patients at the end of life experienced symptoms were available.
- Records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR) were not always completed on the trust form. However, records indicated that decisions were made in the patient's best interest and there was evidence that the two stage capacity test had been recorded.
- Syringe drivers were accessible and the administration of medicines via the pump was monitored in line with trust policy.
- People's needs were assessed and care and treatment delivered in line with evidence based guidance to achieve effective outcomes.
- People's nutrition and hydration and pain management needs were identified and met in relation to national guidance for caring for people in the last days and hours of life.
- People's care and treatment outcomes were monitored through trust participation in the national end of life care audit there was evidence of improvement over time and trust participation in relevant quality improvement initiatives.
- The learning needs of staff had been identified and there was a range of training initiatives aimed at engaging generalist staff in improving patient care for those at the end of life.
- The service ensured that people were treated with kindness, respect, and compassion, and that they were given emotional support when needed. Staff were committed to ensuring the patient experience at the end of life was as positive as possible.
- People could access care in a timely way. All patients were seen within 48 hours of referral, 98% of patients were seen within 24 hours of referral.

End of life care

- Spiritual support services were available to patients of different religions and beliefs, including for those patients with no particular faith.
- Leaders were visible and approachable. The end of life care board was made up of a range of senior staff including executive directors, matrons, consultants, hospice staff and members of the specialist palliative care team.
- An end of life care working group had been established at Kent and Canterbury Hospital to improve end of life care.
- There were governance structures and culture to support end of life care, with clear leadership at executive and senior staffing levels and an end of life care board responsible for decision making.
- People's views were gathered through a bereavement survey across the trust. This provided feedback to staff on the experience of relatives.
- There was some evidence of innovation, in particular with the development of a nationally recognised compassion symbol in collaboration with the local hospice.

Is the service safe?

Requires improvement 

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

- Anticipatory prescribing for patients 'just in case' they experienced symptoms commonly experienced at the end of life was in place with guidance available on the trust intranet and through the palliative care team. However, we saw an example of where the dosage of one medicine prescribed by the specialist palliative care team was outside of the range recommended in the guidance. While the dosage was within the therapeutic range for its intended purpose, this practice had the potential to cause confusion for non-specialist staff responsible for prescribing.
- Lessons were not always learned and improvements made when things go wrong. For example, there were no examples of reported or recorded incidents relating to the care of patients at the end of life. Staff were aware of the processes for reporting but there was not a consistent culture of reporting specific to end of life care. There was no standing agenda item for end of life care incidents for the end of life care board. There were examples of incidents that staff told us about but that had not been recorded via the electronic reporting systems relating to capacity issues within the mortuary.

However:

- The maintenance and use of equipment kept people safe, for example, through the availability of syringe drivers and monitoring of the administration of medicines via syringe drivers.
- Care records for patients on the 'care of the dying patient and their family plan' were seen to be completed. The trust had audit processes in place to monitor the use of the care record and there was evidence of improvements over time.
- Fridge temperatures in the body store were monitored daily by staff, including on weekends and bank holidays.
- Anticipatory medicines 'just in case' patients at the end of life experienced symptoms were available.

Is the service effective?

Requires improvement 

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

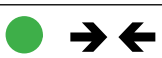
End of life care

- Staff did not always have the skills, knowledge and experience to deliver effective care, support and treatment. A range of end of life care training was available. End of life care link staff were responsible for training and supporting ward staff, however not all link staff had attended the training to deliver this. For example, while 73% of link staff had attended the 'dying in hospitals course', only 33% had a record of attending training in the use of the end of life care documentation and only 16% had received training in symptom control.
- The palliative care service was not available face to face seven days a week.
- Patients were not always identified who were in need of extra support. For example, there was no framework in place for identifying patients in the last year of life or those with an uncertain recovery who were at risk of dying.

However:

- Consent to care and treatment was sought in line with legislation and guidance. For example, records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR) were seen. These were not always recorded on the trust assessment form but patients notes reflected best interest decision making and evidence of the two stage capacity assessment in most cases.
- People's needs were assessed and care and treatment delivered in line with evidence based guidance to achieve effective outcomes. For example, the individual care plan for the dying person was based on relevant National Institute for Health and Care Excellence (NICE) guidance and there was evidence of the review of national guidance as part of governance processes within the service.
- People's nutrition and hydration and pain management needs were identified and met in relation to national guidance for caring for people in the last days and hours of life.
- There was evidence of staff teams working together within and across organisations to deliver effective care and treatment.
- People's care and treatment outcomes were monitored through trust participation in the national end of life care audit. Where outcomes were identified as being below average, there was evidence of improvement over time and trust participation in relevant quality improvement initiatives.
- The learning needs of staff had been identified and there was a range of training initiatives aimed at engaging generalist staff in improving patient care for those at the end of life. This included the development of end of life care link staff from nursing and healthcare assistant staff groups.

Is the service caring?

Good 

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

- The service ensured that people were treated with kindness, respect, and compassion, and that they were given emotional support when needed. For example, staff consistently took time to interact with patients at the end of life and their families.
- Staff were committed to ensuring the patient experience at the end of life was as positive as possible. For example, we were told of a number of situations where staff had supported family events such as weddings and where family members experienced support and acts of kindness from staff.
- Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially.

End of life care

- People's privacy and dignity were respected. Staff on the wards and members of the specialist palliative care team were seen to respond in a compassionate, timely and appropriate way when patients were distressed or in pain.

However;

- Capacity issues within the mortuary led to processes for storing the deceased that did not ensure that people's dignity was respected during care after death. We were told that the practice of storing two bodies in the space meant for one had occurred during busy periods, particularly during the winter months. Staff took practical measures to minimise the issue as much as possible by transferring the deceased between sites and keeping the time that two bodies would spend in the same space to a minimum. However, a fundamental lack of capacity meant that more than one body was stored in a fridge space meant for single occupancy.

Is the service responsive?

Requires improvement 

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

- The service had some systems in place so that they took account of the particular needs and choices of different people. However, there was no framework for advance care planning for patients at the end of life. For example, patients were asked about their preferred place of care at the end of life; however this was generally in the last days of life. There was some evidence of patients being supported to make decisions about the end of life in advance; however this was dependent on the support of individual clinicians rather than a trust wide approach. This meant that not all patients would have the opportunity to make decisions in advance of their health deteriorating. This was not in line with the local interagency policy recommendations for early conversations in relation to care decisions.
- The trust did not record the percentage of patients who were discharged to their preferred place of care at the end of life. Data showed that 26% of patients did not have their preferred place of care discussed with them. This meant that patients were less likely to die in their preferred place of care.
- Complaints relating to the care of patients at the end of life were reviewed by the end of life care board and themes identified. However, not all palliative care staff were aware of the details of complaints and it was not clear how these were shared with staff in a way that ensured lessons were learned and care improved.
- A fundamental lack of mortuary capacity across the trust meant that more than one body was stored in a fridge space meant for single occupancy during busy times. We did not see this during our inspection and staff told us they followed trust criteria to ensure that local coroner requirements were met.
- Facilities for caring for patients at the end of life such as side rooms and quiet rooms for having difficult conversations with relatives were limited in some wards. There was a relative's suite within the hospital where relatives of patients at the end of life could rest and have refreshments; however survey results showed that not all relatives were made aware of this facility.

However:

- People could access care in a timely way. For example, general ward staff told us that the specialist palliative care team would generally visit the patient on the day of referral. All patients at Kent and Canterbury Hospital were seen within 48 hours of referral.
- The services provided reflected the needs of the population served and they ensured flexibility, choice and continuity of care. For example, the service supported patients with cancer and those with other conditions such as heart disease, dementia and respiratory conditions.

- Interpreters were available to support communication with patients and relatives for whom English was not their first language. However, written information was not available in different languages or formats for patients with sensory needs.
- Spiritual support services were available to patients of different religions and beliefs, including for those patients with no particular faith. Different faith protocols were in operation within the mortuary.

Is the service well-led?

Requires improvement 

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

- Leaders had an understanding of the challenges to quality and sustainability; however actions to address them were not always comprehensive. For example, audit and survey results were collated to identify areas for improvement, but analysis and actions were not always sufficiently detailed or timely.
- While the trust had been involved in the development of a regional end of life care strategy, there was no trust wide strategy or specific action plans associated with this.
- Processes for managing risks, issues and performance were not always effective. Risks relating to the mortuary capacity were identified on the pathology risk register but not on the palliative care or corporate registers. Action to mitigate the risk and the impact of current activities was not comprehensively identified and there was evidence that the risk had not been properly escalated or managed. We were told that the palliative care risk register did not currently have any risks identified, however, staff told us there were ongoing issues with fast track discharge and the trust was not providing a seven day palliative care service which presented a risk to continuity of care for patients.
- The trust's governance structures were not always effective because there was a lack of structured action planning and prioritising. For example, there was an ongoing issue with an incomplete service level agreement for the medical cover from the hospice. We were told this had been drafted following our previous inspection in 2016 but had yet to be finalised and agreed. An interagency policy was in place for end of life care but it was unclear how the trust was working toward achieving the priorities in a timely, structured way.
- There were quality assurance processes evident, for example, in relation to audit and surveys. However, improvement plans were not detailed, structured or timely. For example, a 2018 bereavement survey showed evidence of deteriorated satisfaction with the service but it was not clear how the trust were planning on addressing this as the actions were the same as the 2017 survey.

However:

- Leaders were visible and approachable. The end of life care board was made up of a range of senior staff including executive directors, matrons, consultants, hospice staff and members of the specialist palliative care team.
- An end of life care working group had been established at Kent and Canterbury Hospital to improve end of life care and there were clear action plans and monitoring relating to this.
- There were arrangements with partners and third-party providers to encourage interaction and promote coordinated, person-centred care. The trust was part of an interagency network that had developed and end of life care strategy and interagency policy.

End of life care

- There was a culture of improving end of life care and staff were aware of developments. There was an emphasis on developing the skills of staff in relation to end of life care with a range of courses available and the trust had a focus on ward based training in end of life care. However, not all end of life care link staff with responsibilities for delivering the training had completed the training for the role.
- There were governance structures to support end of life care, with clear leadership at executive and senior staffing levels and an end of life care board responsible for decision making.
- People's views were gathered through a bereavement survey across the trust. This provided feedback to staff on the experience of relatives.
- There was some evidence of innovation, in particular with the development of a nationally recognised compassion symbol in collaboration with the local hospice.

Areas for improvement

The trust should;

- Take action to ensure that anticipatory prescribing for medicines is in line with trust guidance.
- Make sure that lessons are learned and improvements made when things go wrong.
- Make sure that staff responsible for training other staff have the skills, knowledge and experience to do so and that all ward staff receive training in the delivery of effective care, support and treatment for patients at the end of life.
- Review the palliative care service with a view to providing a seven-day, face-to-face service.
- Make sure there is a framework and focus for identifying patients with an uncertain recovery who were at risk of dying, together with a framework for advance care planning.
- Make sure that capacity risks within the mortuary are comprehensively assessed and mitigated to ensure that the storage of the deceased is in line with the Human Tissue Authority published guidance and that people's dignity is respected during care after death.
- Ensure that discussions about preferred place of care are consistently held in advance of the last days of life and that the achievement of discharge to the preferred place of care is monitored.
- Ensure that a trust wide end of life care strategy and action plans are in place.
- Ensure that processes for managing risks, issues and performance are effective. Risks should be identified and recorded on the risk register and adequately mitigated.
- Make sure that governance structures and processes are supported by structured action planning and prioritising.
- Ensure that improvement plans are sufficiently detailed, structured and timely.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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

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

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

The inspection was led by Head of Hospital Inspections for the South East, Catherine Campbell. Gillian Hooper, National Professional Advisor of Well Led Reviews, acted as executive reviewer supporting our inspection of well-led for the trust overall.

The team included one inspection manager, 11 hospitals inspectors, two pharmacy inspectors, one mental health inspector, 22 specialist advisers, and one expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.