Dartford and Gravesham NHS Trust

Darent Valley Hospital

Inspection report

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Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Our findings

Overall summary of services at Darent Valley Hospital

Good 

A summary of CQC findings on urgent and emergency care services in Kent and Medway.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Kent and Medway below:

Kent and Medway

The health and care system in this area is made up of many health and social care providers and is supported by stakeholders, commissioners and the local authority. We found front line staff working across all services were doing their best in very challenging circumstances and had continued to do so throughout the COVID-19 pandemic.

Increased system wide collaboration, particularly between health and social care was needed to alleviate the pressure and risks to patient safety identified in some services we inspected. However, we did find some good collaborative working; for example, staff in acute and ambulance services had been working together to reduce handover delays, and primary and community services worked together to reduce attendances in Emergency Departments.

We found some access issues in primary care and some GP practices were not allowing patients to enter the building without staff permission; since our inspections, action has been taken to ensure patients can access their GP Practice freely. We did find examples of innovative practice including employing a variety of different healthcare professionals in GP Practices and across Primary Care Networks to better meet the needs of their patients ensuring people receive the right care at the right time. There was also funding available to provide interpreting and translation services to support people from diverse communities and to support people arriving in the UK from Ukraine.

Primary Care Networks were working well with community services to alleviate the pressure on ambulance and acute services where possible, particularly in out of hours services. In addition, technology was being utilised to improve services and provide timely access to patient information, especially for staff providing out of hours care.

Staffing issues and high levels of absence due to COVID-19 had impacted on services across Kent and Medway. GP Practices in this area had a larger number of patients per GP and demand had increased; however, in many cases this was well managed. The NHS111 service had experienced staffing issues as well as increased demand; this had resulted in significant delays in call answering times for people trying to seek advice.

Ambulance response times had also been poor across Kent and Medway. Whilst operational staff had done all they could to maintain response times to serious and life-threatening calls, response times to less serious calls were unacceptable, and performance had continued to be poor for a long time. This had widespread impact on people in Kent and Medway, and particularly on people living in care homes. Social care staff had to provide long periods of enhanced care to people waiting for an ambulance response whilst also caring for other residents.

Our findings

There continued to be long ambulance handover delays at hospitals in Kent and Medway; however acute and ambulance services had worked well together to reduce these delays and improve handover processes.

Emergency departments inspected in Kent and Medway continued to be under significant pressure. However, we found some improvements since previous inspections, including improvements in leadership and the culture within the departments. Staff worked hard to meet current demands and felt positive about the improvements they had seen. Some social care services had raised concerns in relation to the care provided to people with dementia and autism in emergency departments. Where specific concerns were raised, these were being investigated.

There were delays in patients receiving care and treatment caused by poor patient flow across urgent and emergency care pathways. There were many urgent and emergency care pathways available within hospitals in Kent and Medway, however staff acknowledged these were not all working well or being fully utilised. Referral pathways between emergency department and urgent treatment centres aimed to meet people's needs and reduce pressure on acute services. However, we identified issues with inappropriate referrals, long waiting times and inconsistent risk assessments putting people at risk of harm. Patients also reported delays in their treatment due to inappropriate referrals. System partners were aware of issues with UEC pathways and had an action plan in place to address them.

We also found delays in patient discharge from hospitals and a shortage of social care capacity to enable people to leave hospital in a safe and timely way. In addition, social care services reported concerns about poor discharge processes. Examples included insufficient information about changes to medicines or people discharged into care homes who required a level of care for which staff were not trained to provide.

Staff working across Kent and Medway require additional support to manage the continued pressure on services. We also identified opportunities to upskill staff, for example, training additional social care staff in areas such as detecting early signs of deterioration in health. Increased collaboration between health and social care services and stakeholders is needed to address issues with patient flow across urgent and emergency care pathways. These pathways also require evaluation to ensure they are as efficient and effective as possible to meet the needs of people in Kent and Medway.

Urgent and emergency services

Good  

Dartford and Gravesham NHS Trust provides acute hospital services across Kent to approximately 350,000 people a year. The trust has a team of around 3,400 staff.

This trust has four registered locations:

• Darent Valley Hospital

• Gravesham Community Hospital

• Queen Mary's Hospital

• Erith & District Hospital

We carried out an unannounced focused inspection of Darent Valley Hospital's urgent and emergency care services in the trust's emergency department.

As this was a focused inspection at Darent Valley Hospital emergency department we only inspected three of five of our key questions.

We assessed safe, responsive and well led. We did not inspect effective or caring at this visit but would have reported any areas of concern.

This inspection was carried-out as part of a pilot approach of the urgent and emergency care pathway across Kent and Medway, to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures. It was also to review actions we asked the trust to take from our last inspection. The emergency department was previously rated as requires improvement overall with safe, effective, responsive and well-led rated as requires improvement and caring rated as good.

We considered information and data on performance and looked at the experience of patients using urgent and emergency care in Darent Valley Hospital. This included the emergency department and areas where patients in that pathway were cared for while waiting for treatment or admission. We visited services and departments that patients may encounter or use during their stay. We also went to wards where patients from the emergency department were admitted for further care. This was to determine how the flow of patients who started their care and treatment in the emergency department and those cared for on medical wards, were managed by the wider hospital.

Our rating of services improved. We rated them as good.

See the urgent and emergency care section for what we found.

How we carried out the inspection

Urgent and emergency services

During the inspection we spoke with approximately 32 members of staff and 10 patients and their relatives, observed patient care, looked at patient waiting areas and clinical environments and attended staff huddles. We looked at 19 patients' care and treatment records, and at hospital policies, procedures and other documents relating to the running of services.

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

Darent Valley Hospital provides emergency department (ED) services for adults and children. The emergency department accepts patients transported by ambulance or those who arrive independently. It is open 24-hours a day, seven days a week.

Total ED attendances at Darent Valley Hospital between March 2021 and February 2022 were 125,828. Of these, 34,928 (28%) were children; 29,658 (24%) arrived by ambulance and 96,170 (76%) self-presented.

Since the COVID-19 pandemic, the ED at Darent Valley Hospital has been reconfigured to accommodate patients who test as positive with a designated area established.

There is a designated paediatric area, which has a restricted access door from the rest of the ED.

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The medical staff were not up to date with their mandatory and safeguarding training.
- Safety checks of emergency equipment were not always carried out or recorded.
- Staff did not always lock unattended computers to reduce the risk of unauthorised access.

Is the service safe?

Good ↑

Urgent and emergency services

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff but did not always make sure everyone completed it.

Staff received mandatory training in safety systems, processes and practices. All emergency department (ED) staff completed basic life support, immediate or advanced life support training depending on their role. The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training was provided in different formats including as part of the induction process for new starters, face to face classroom training and e-learning.

Staff knew how to access mandatory training and explained how the hospital computer system would flag-up any outstanding training or updates that were required. Senior ED staff had oversight of mandatory training completion and monitored training compliance rates.

The trust set a target of 85% for completion of all mandatory training except information governance and data security which had a completion target of 95%. As of February 2022, compliance with mandatory training for staff working in the ED was 92%. However, when mandatory training was broken down by role, medical staff compliance was 75%, nursing staff 97% and all other staff groups were 95% compliant.

The medical staff met the 85% target for one of the 19 mandatory training modules, seven modules were red rag rated and seven were amber. Nursing staff met all 19 of the mandatory training modules and all other staff met 16 out of the 19.

When the ED was taken as a whole the three targets not met were conflict resolution (77%), fire safety (82%) and paediatric basic life support (76%).

Post-inspection the department acknowledged training compliance had fallen below the trust target which they attributed to the effects of the COVID-19 pandemic. The directorate leadership team had prioritised training sessions to meet trust compliance. For example, the 20 staff members who had not completed the paediatric basic life support training had been booked on a course.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust had adult and children safeguarding policies which were in date and reflected current legislation and guidance. These policies provided staff with guidance on how to identify abuse and the processes to follow if they needed to raise a safeguarding concern. These policies covered other elements of safeguarding such as radicalisation and female genital mutilation. There was a quick reference guide for staff which gave details of how to make safeguarding referrals.

Urgent and emergency services

Safeguarding was part of the staff induction and mandatory training. Staff had the appropriate level of adult and children safeguarding training for their role. The trust set a target of 85% for completion of safeguarding training. ED staff met all four targets of the safeguarding training modules for which they were eligible. Although, when mandatory training was broken down by role, the medical staff were 72% and 79% compliant with their adult and child safeguarding training respectively, nursing staff 98% and 95% and all other staff 98% and 100%.

Staff we spoke with knew how to recognise and report safeguarding issues and knew who to escalate their safeguarding concerns to. The trust had two designated safeguarding leads who were the point of contact for the team. The ED did not have a nominated lead consultant or lead nurse responsible for safeguarding. Although we were told the paediatric unit was about to appoint someone into this role.

Information on safeguarding issues was displayed throughout the department. This was visible to patients, visitors and staff. The information displayed included the types of abuse, and who to contact if abuse was suspected or seen.

All patients under 18 that presented to the ED were checked on the national database for any safeguarding or other concerns. When concerns were identified, this was noted on the patient record for the clinical staff to see. Information about when children had attended the paediatric emergency unit was shared with health professionals and relevant authorities.

Members of the trust safeguarding team visited the paediatric emergency unit every morning to offer support and supervision to the team.

Staff knew how to make a multi-agency safeguarding hub referral and demonstrated this during our inspection. The multi-agency safeguarding hub brought together a team of multidisciplinary professionals from partner agencies into the same room to deal with all safeguarding concerns, where someone was concerned about the safety or wellbeing of a child.

The emergency department employed security guards through a third party 24-hours a day, seven days a week as abuse and physical and non-physical assault towards staff had increased during the COVID-19 pandemic. The security team had direct interactions with patients and relatives but told us they received no safeguarding or mental health training. Post inspection the trust informed us as part of their contract with the security service provider, anyone employed at the trust must be licenced by the security industry association (SIA). One of the requirements to being licenced is to undertake mental health training. Safeguarding was also included in the trust's service level agreement with their provider.

Cleanliness, infection control and hygiene

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

The department had dedicated housekeeping staff who were responsible for cleaning patient and public areas, in accordance with daily and weekly checklists. Cleaning records were up-to-date and demonstrated areas were cleaned regularly and deep cleaned when necessary. Cleaning equipment was stored securely in locked cupboards. This meant unauthorised persons could not access hazardous cleaning materials.

We saw cleaning staff on the unit throughout our inspection and our observations showed a visibly clean, tidy and clutter free clinical environment. Furnishings, such as chairs and flooring were wipeable and easy to clean.

We saw evidence of cleaning audits in the emergency department and who was responsible if cleaning standards fell below certain levels. Managers monitored and reviewed all areas of the department each month and documented areas that needed more cleaning or repairs. This information was fed back to cleaning or maintenance staff for action.

We checked clinical equipment and noted these to be visibly clean and labelled with green 'I am clean' stickers on them, detailing the date and time they were last cleaned.

Staff were required to complete infection prevention and control (IPC) training during their induction and then annually at the level appropriate to their role as part of their mandatory training. Staff were up to date with IPC training with records showing 95% compliance for the ED. However, when IPC training was broken down by role, medical staff were 82.5%, which was below the trust target of 85%, nursing staff 99.5% and all other staff groups were 98.5% compliant.

Staff followed IPC principles, the trust's policies and national best practice guidelines, including the use of personal protective equipment (PPE). In addition, new protocols and procedures had been produced in response to the COVID-19 pandemic. We observed staff being bare below elbows for more effective handwashing and wearing surgical masks at all times. Staff had access to PPE and wore disposable gloves when required. Staff had the facilities needed to effectively wash their hands to help prevent avoidable health acquired infections. The department was equipped with adequate hand-washing facilities and hand sanitiser gel was available throughout the department.

Managers audited staff compliance with infection control practices. The audit programme was used to maintain and improve standards and to help prevent the spread of infection. Staff compliance was reported to IPC specialists within the trust and any actions required were fed back to staff in the department. Post-inspection we requested results from IPC audits. Results were split into categories, for example, bare below the elbow, hand hygiene; and split by staff group, for example doctors, nurses, pharmacist. Audit results showed good compliance at 98%.

There was a designated area for patients who presented with COVID-19 symptoms or were testing as COVID-19 positive. We did not go into this area but saw staff wearing PPE in line with national guidance when they entered the area. Signs were visible to prevent unauthorised people accessing the area. There was rapid testing for COVID-19.

The department had antibiotic stewardship protocols in place and a microbiology consultant was available, providing advice on the use of antibiotics and the treatment of infections.

Staff told us they tested themselves for COVID-19. All staff had been offered COVID-19 vaccinations and boosters in line with national guidance.

Environment and equipment

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

Since our last inspection in 2019 changes had been made to the ED to improve patient safety by limiting access to certain areas of the department to create a secure environment and changing the layout to increase use the of space and to improve patient flow.

There was a new seven-bay emergency streaming and treatment (ESAT) area, GP streaming area, isolation unit and a paediatric unit within the ED. This included a separate paediatric waiting area and triage area, and two paediatric resuscitation rooms, and changes had been made to the layout to majors B and the clinical decision unit (CDU).

Urgent and emergency services

The isolation unit was opposite to where the ambulances arrived, this meant patients with confirmed or suspected COVID-19 could be taken to the unit without needing to enter the main department which limited the chance of cross-infection.

The purpose of ESAT was to perform an initial assessment of all ambulance arrivals. There was easy access to the ESAT and the adult resuscitation unit from the ambulance unloading bay, which helped ambulance staff transfer ill and seriously ill patients to the care of the emergency team quickly. The adult resuscitation unit had five bays. The bays were large and spacious, allowing plenty of room for a full resuscitation team as well as emergency equipment.

Majors A area, which cared for patients who were ill but not in immediate life-threatening danger, was a large space with 10 individual cubicles and an examination room. Staffing stations were located in the centre of the majors department. This meant nurses and doctors had a good line of sight of the bed spaces.

Majors B area had four individual cubicles, one with a door for privacy, an examination room and an area for six patients who did not require a trolley and could sit in a chair. Leading off this area was the CDU, which had six recliner chairs where patients who did not meet the criteria for inpatient admission but were not well enough to go home without requiring further observation were observed.

The GP streaming area was opposite majors B and had a small waiting area, two clinic rooms and a room for carrying out clinical assessments.

There was a new paediatric ED. This was co-located but physically separate from the main ED and could only be accessed by authorised persons via a swipe card or the intercom. There was a separate paediatric waiting area inside the department. This area was bright and colourfully decorated. There was a play area and a television showing cartoons for younger children. The waiting room was directly supervised by a receptionist or a member of clinical staff which meant a deteriorating patient or disturbance would not go unnoticed.

There were two dedicated mental health assessment rooms in ED, one in majors A and another in the paediatric ED which met quality standards and provided a safe environment for patients and staff. There were no ligature points, furniture could not be lifted or moved, and the rooms had an alarm system with two doors that opened both ways.

The department had a separate viewing room for families to see their relative's body if they had passed away. *The Royal College of Emergency Medicine: End of life care for adults in the emergency department 2015* recommends this as good practice.

Self-presenting patients entered the ED through a dedicated entrance with clear signage. There was a large spacious waiting room and off this area were two triage rooms, a consultant room and clinic rooms. The layout of the main waiting area meant reception staff had line-of-sight of patients who self-presented to the department.

The ED was close to diagnostic imaging facilities which allowed for diagnostic procedures to be completed quickly if patients were waiting for a specialist review.

Senior staff carried out six-monthly environmental risk assessments. We reviewed these assessments and found them to be thorough. Hazards were identified, such as damage to doors and any chemicals used in the areas and actions or mitigation put in place to minimise the risk.

Sluice rooms in all areas of ED were tidy and kept locked. Chemicals were stored correctly.

Urgent and emergency services

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment, including the infant resuscitaire, was readily available and was routinely checked to ensure it was ready for use. We reviewed records which confirmed checks occurred daily. However, the checklist attached to the paediatric intubation trolley outside the paediatric resuscitation rooms indicated the equipment had not been checked since September 2021. We raised this with staff at the time of inspection who confirmed the equipment had been checked regularly since that date, however, they could not find records to demonstrate this.

Point of care testing equipment in the department included glucose meters, urine testing sticks and a blood gas machine. There was an ultrasound machine available in the resuscitation room for emergency use. Equipment was stored appropriately and there was evidence it had been serviced recently.

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

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Patients arriving by ambulance were taken straight to the resuscitation area or assessed in the consultant led ESAT area. The ambulance service pre-alerted the department if a patient was on route and needed urgent medical care. This was to make sure an appropriate team was waiting for the patient on arrival.

A National Early Warning Score (NEWS2) would be calculated for patients and this was used as an early warning system for ailments, for example, sepsis. NEWS2 is a recognised system used to detect deterioration in adult patients. It is based on six patient observations, breathing rate, amount of oxygen in the blood, blood pressure, heart rate, level of consciousness and temperature.

Staff told us since the implementation of the consultant led ESAT they felt there had been improvements in patient flow in the department, ambulance handover times and time to initial assessment by a doctor. This had led to improved care and outcomes for patients due to earlier diagnosis of patients.

Paediatric patients, if not needing resuscitation, would be taken by the ambulance crew to the paediatric ED and triaged by the dedicated children's team. Paediatric patients who did require resuscitation would be taken directly to the dedicated paediatric resuscitation area.

Self-presenting patients, including paediatric patients arriving between 8am and midnight were assessed on arrival to the building by the streaming nurse or GP and directed, depending on their clinical need to different areas of the department or other areas of the hospital. For example, the surgical assessment unit. High-risk patients would be taken straight to majors A or the paediatric ED.

All other patients, after checking in at the main reception, would be assessed by adult or paediatric triage nurses. Triage was used as a way to identify a patients' level of urgency and to treat them on their clinical priority rather than when they arrived in the department. We observed patients being triaged in both adult and paediatric areas and found assessments to be thorough and complete. Some patients, depending on clinical need, would be sent for further tests before seeing a doctor. For example, electrocardiograms, blood tests and urinalysis. This meant medical staff would already have some results when they examined patients.

All children and young people under 18 had an electronic child protection risk assessment completed. The electronic patient record system would flag any patients known to be at risk.

Patients taken through to the main or paediatric ED were risk assessed and clinically observed using NEWS2 or the paediatric early warning score (PEWS) during their stay in the department to help staff identify unwell patients or signs of deterioration. All records we reviewed had accurately calculated NEWS2 or PEWS scores. Where required, appropriate action was taken if the score was raised. The department completed monthly NEWS2 and PEWS audits for completeness and accuracy. From September 2021 to February 2022 audits showed an average of 94% and 95% compliance respectively.

Staff knew about and dealt with any specific risk issues, for example sepsis. There were pathways which identified a specific bundle of care to be provided including the timely administration of antibiotics. All patients were screened at the first time their observations were recorded using a screening tool. If this screening indicated the suspicion of sepsis, the sepsis six bundle was promptly started. Audits had identified targets were not being met in the management of sepsis. The department had carried out a comprehensive audit in October 2021 to identify where the issues were and to form an action plan. The department were planning on re-auditing in February 2022 but as yet the re-audit had not taken place because of the surge in COVID-19.

The department had implemented the use of the ED safety checklist. This was a checklist used to check and record clinical tasks that needed to be completed for each patient in the first few hours of being in ED and that they had been carried out in a timely way. It was structured in two parts, part one: provision of basic safe clinical care (time-based framework for vital sign measurement and calculation of the NEWS2, pain scoring, administration of drugs and front-loading investigations) and part two: value added tasks including referrals to drug and alcohol services, psychiatry liaison and occupational therapy and commencement of certain patient pathways. Post-inspection we asked the trust for evidence of patient safety checklist audits carried out in the ED. The trust informed us it had not carried out any audits on patient safety checklist but were planning on adding it to their audit plan for the coming year.

There were policies and procedures for staff to follow in relation to extra observation, supervision, restraint and, if needed, sedation. A range of clinical pathways existed. These ensured patients presenting with specific conditions could expect to receive standardised care and treatment aligned to best practice recommendations.

The emergency department completed the safeguarding and managing risk tool (SMART) for patients identified as at risk. This tool was used to determine the level of staffing observation required, and if the patient needed to be referred to the psychiatric in-reach liaison service or child and adolescent mental health services for further assessment.

Staff reported, and audit data confirmed, patients were often left waiting in the department for over 12 hours whilst they waited for an acute mental health bed or assessment by a specialist mental health team. These services were provided by partner organisations and not by the trust.

Nurse staffing

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

Managers calculated and reviewed the number and grade of nurses and support staff needed for each shift. Managers used an online rostering system to monitor and adjust the skill mix across shifts and staff levels.

Urgent and emergency services

Currently the department, including the paediatric ED, planned 27 to 28 staff per shift with 20 being registered nurses, with a mix of senior and junior nurses on duty. The paediatric ED was staffed by registered children's nurses, with always a minimum of two on shift. On the day of our inspection the ED was fully staffed.

Each shift had a nurse in charge (NIC) who had oversight of how the department was operating and a silver shift quality facilitator, who was usually the matron, whom the NIC could escalate concerns to. In addition, certain areas, for example majors B, had a co-ordinator who oversaw the running of that area.

Emergency nurse practitioners (ENPs) were used in the department, for example in streaming, triage and the majors B area. ENPs were qualified to assess, diagnose, treat and discharge patients with certain injuries without having to refer to a doctor.

The department had two dedicated practice development nurses and a nurse consultant to provide support and education to clinical staff and to improve their professional practice. Staff were complimentary about having these roles in the team and how they had made a positive difference to performance.

The service had a vacancy rate for qualified nursing staff in the ED of 10%. The turnover rate of staff was 8%. The sickness rate in the department for nursing staff was 7% over the previous six months. This was higher than the service aimed for but included staff who were absent due to COVID-19 related issues.

The department used bank and agency staff to cover gaps in the rota to make sure staffing levels kept patients safe. Bank and agency staff we spoke with said they were given a good induction to the department and the team were supportive and helpful.

Medical staffing

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

The service had enough medical staff to keep patients safe. The department at the time of our inspection employed 12 whole time equivalent (WTE) emergency department consultants. There was consultant cover between 8am and midnight seven days a week which adhered to the Royal College of Emergency Medicine recommendations of 16 hours per day. Outside of these hours a consultant was on-call and could be contacted.

The service had a good skill mix of medical staff on each shift which included, consultants, specialty doctors and registrars, and reviewed this regularly. In addition, the department employed twenty-eight WTE trust grade doctors including ED front-door GPs, which were doctors working in a non-training post and 3.5 WTE advanced clinical practitioners.

The trust did not employ a paediatric emergency medicine consultant but there was a paediatric registrar in the department 24-hours a day seven days a week. In addition, the paediatric ED was located next to the paediatric assessment unit and worked closely with them and could use the expertise of medical colleagues from the paediatric services.

The department had weekly training sessions for the medical team. Middle grade doctors and doctors in training felt supported by the consultant tier in the department who they could escalate any concerns to.

Urgent and emergency services

The service did not have a vacancy rate for medical staff in the emergency department overall. However, the department did have a vacancy rate of 44% for specialty registrars. The turnover rate of staff was 10% and the sickness rate was low at less than 1% over the previous six months.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

Records

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

When patients arrived at the ED they were booked in on the trust's electronic patient administration system. This system was used to register patients, monitor their movement through the department and request and review investigations. The computer system also had the facility to alert staff about specific needs of patients such as those living with a learning disability or dementia.

Computer systems in the department were protected by password to prevent unauthorised persons accessing patient information. However, we saw computers were not always locked and that staff remained logged-in to the system when computers were left unattended. This meant there was a risk of unauthorised access to patient information.

The department used paper-based records for patient notes and assessments. For example, the medical history taken on assessment, present medical details, observations and treatment given. This information then needed transcribing on to the electronic patient system or scanned to be added to the patient's medical notes.

Records were stored securely. Patients' records were all stored in areas that were secure and in locked trolleys. We did not see any patients notes left unattended.

We checked 19 paper records and saw some were incomplete. For example, times when care occurred such as triage time and seen by the doctor time, incomplete sepsis screening information and frailty scores not always completed. However, we did see that regular observations had occurred, and nursing care plans were generally well completed with clear assessment plans. The department audited patients' notes for completion. We saw results from the January 2022 audit which was consistent with our findings. Shortfalls in record keeping had been identified by the department and an action plan put in place to address these issues. Dates to re-audit were arranged to see if increased completion of records had occurred.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Emergency medicines were stored securely, and frequent checks were completed to ensure medicines were available and safe to use. Medicines stocklists were reviewed to ensure critical medicines would be available. Staff also had access to stocklists for other wards so were aware of where they could find medication they needed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. There were no pharmacists based within the department, but they did have access to a pharmacist if needed.

Staff completed medicines records accurately and kept them up to date. There were appropriate arrangements for the recording of medicines administration and prescription charts showed medicines were being given as directed as directed. Staff stored and managed all medicines and prescribing documents safely. FP10 prescription pads and forms were stored securely and their serial numbers were tracked throughout the department.

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

Incidents

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

Staff raised concerns and reported incidents and near misses in line with trust policy. The policy included definitions of incidents and their level of harm and how incidents should be reported, investigated and actions taken.

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

The service had reported no never events in the ED in the last 12 months. A never event is a serious incident which is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Between March 2021 and February 2022, the ED reported 2765 incidents. Of these, 68% of incidents were rated as no harm, 22% rated at low harm (minimal harm – patient required extra observation or minor treatment) and 10% rated as moderate harm (short term harm - patient required further treatment, or procedure), there were two incidents of severe harm (permanent or long-term harm) and two deaths. Of the 272 moderate harm incidents, 264 of these were non-reported community acquired pressure damage which had been noted on hospital admission.

Six incidents during this period had been recorded as serious incidents requiring investigation. The hospital had completed investigations with action plans for four of the incidents and two cases remained open.

The department considered each incident as a learning experience. They were proactive in reviewing incidents and making changes as a result whether that be additional staff training or a change of a working practice or procedure. Staff told us learning from incidents was shared with them via meetings, emails and handovers. Data shared post-inspection showed the main four incident categories during March 2021 and February 2022 were pressure damage; security, abuse or non-physical assault; clinical assessment and diagnosis; and mental health issues.

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

Urgent and emergency services

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

Staff could explain duty of candour and understood their responsibility to be open and honest with patients and their relatives when something had gone wrong. The hospital had a duty of candour policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of the person using the service or severe, moderate or prolonged psychological harm. From March 2021 to February 2022, the department had 10 incidents which required the duty of candour process to be instigated.

Patient safety alerts were a set agenda item at the monthly clinical governance meeting. Senior ED staff ensured actions from patient safety alerts were acted upon where needed and information shared with staff.

Is the service responsive?

Good ↑

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

Service delivery to meet the needs of local people

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

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

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

Since our last inspection the department had increased the throughput of patients by reconfiguring the department, this included introducing the consultant-led emergency streaming and treatment (ESAT) area, streaming at the front door and building a new paediatric ED within the department.

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

Urgent and emergency services

The majority of self-presenting patients needed to book in at reception. The reception desk had varying heights so there was a lower desktop where patients could sit when checking in and the desk was also accessible for patients in wheelchairs. There were accessible toilets in the waiting area.

There was a television screen in the waiting room which displayed the waiting times for different areas of ED, such as triage, majors and paediatrics. When we arrived in the morning this screen was not working, which we were told was common. However, by the afternoon the IT issues had been sorted and the screen was displaying information.

During the inspection we saw there was adequate seating for patients and other visitors in the waiting areas we reviewed. However, due to the COVID-19 pandemic not all visitors were allowed to wait with their loved ones which had reduced crowding in the waiting areas.

There was signage throughout the department and signs to areas were clear and visible. This included fish stickers on the floor for children and their parents to follow to locate the paediatric ED, and different coloured arrows to find the X-ray and CT scanning departments. The department had volunteers and porters who could support patients and families to access the correct areas of the department.

The hospital communicated with patients to make sure the ED was the right place for them to attend. For example, information on “Think NHS 111 First” was on the hospital website. This is a service that can book an appointment at the ED or signpost the patient to an alternative health service which was more suitable to their needs. However, we spoke with a number of patients who told us they had attended the ED having struggled to get an appointment with their GP or dental practice, or had been directed to go to ED by the NHS 111 service even though their condition could have been treated elsewhere, such as an urgent treatment centre. Staff said they had seen an increase in the inappropriate use of the emergency department since the COVID-19 pandemic and this put a strain on the department.

The service worked with other organisations to plan services. Leaders regularly engaged with commissioning groups and local community services to plan the urgent and emergency care system in Kent and Medway. The trust had a system-wide collaborative focus on admission avoidance, the flow pathway and discharge. They worked with their system partners across their integrated care system to make sure patients got the right care at the right time and place to improve outcomes for patients.

Meeting people’s individual needs

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

Staff told us they treated every patient as an individual, which meant they made reasonable adjustments to meet the needs of patients with a learning disability, mental health issues or who were living with dementia. Staff gave us examples and we observed during the inspection how staff considered individual needs before care was given.

The ED had processes in place to fast-track patients who self-presented with specific conditions. This included children, oncology patients and other high-risk patients.

Posters in the waiting areas showed patients the different areas they may be streamed to during their ED journey depending on their illness, these including seeing an ED doctor, speciality doctor, GP or being referred for tests.

Urgent and emergency services

ED staff were aware of the specialist nurses in the trust. Staff told us they would contact them if patients with specific needs attended the department, such as patients living with dementia or patients with a learning disability.

We saw signs informing hearing impaired patients there was a hearing loop. This is a special type of sound system for use by people with hearing aids. The hearing loop provided a magnetic, wireless signal that was picked up by the patient's hearing aid when it was set to a certain setting. This helped reduced background noise and competing sounds that lessen clarity of sound in a public area.

The department had measures to help meet the Accessible Information Standard. A standard which aims to make sure people who have a disability, impairment or sensory loss can access information they can understand and receive the communication support they need from health and care services.

The department had access to an interpreting and translation service for those whose first language was not English or where patients required a British sign language interpreter. Staff we spoke with were aware of how to access these when required.

Access and flow

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

The trust continuously looked at ways to improve the management of patient flow through the hospital, which included ways to improve the layout and configuration of the department and pathways through the department.

ED managers and the trust continuously monitored treatment within agreed timeframes and national targets to demonstrate the emergency care performance, and to see if changes implemented had made improvements.

Since our last inspection in 2019, the footprint of the department had changed. Patients arriving by ambulance were now taken straight to the resuscitation area if required or assessed in the consultant led ESAT area. Paediatric patients were taken straight to the paediatric resuscitation area if required or straight to the paediatric ED. Patients arriving by ambulance were booked in at the ESAT which had helped to reduce handover times between the ambulance crew and the ED team. However, only one reception staff member was employed to carry out this role in the ESAT. When no one was available the ambulance crew had to book patients in at the main reception and would need to join the self-presenting patient queue to do this. This delayed the handover of the patient into the care of the ED team.

Self-presenting patients arriving between 8am and midnight were assessed on arrival at the main entrance by the streaming nurse. The streaming nurse had streaming options so patients could be seen by the appropriate healthcare professional within the hospital and wider system. For example, patients may stay in the ED to be seen by the team or signposted to other areas such as the early pregnancy unit, gynaecology assessment unit, surgical assessment unit or the urgent treatment centre. By doing this it helped patients who needed urgent care to get the right advice in the right place, first time.

During the inspection we saw the streaming queue ebb and flow, at its minimum no patients were queuing and at its maximum there were nine. When the queue got to more than approximately four, patients would need to queue outside whatever the weather condition and this included paediatric patients. Staff said if the queue became too long an additional streaming nurse or GP, if available, would come and help stream the patients to reduce the queue.

Outside of these hours there was a notice on the streaming desk that asked all patients (adults and children) to go straight to the main reception desk in ED.

Once streamed, if patients were not high-risk or signposted to a different service, they would need to check in at the main reception. Adult patients checked in by the main ED reception would wait to be triaged by the triage nurse in the main waiting area. At triage a decision would be made about the patient's treatment. For example, whether they needed to wait for tests or be directed to the majors A or B areas.

Paediatric patients would be checked in via the main ED reception desk and then directed to the paediatric ED. Patients and their families would wait in the paediatric ED waiting room before being triaged by a paediatric registered triage nurse. During the inspection we observed a child and their parent queuing to be streamed and then queuing again to be checked in at the main reception, a total of 25 minutes. We asked why paediatric patients were not taken straight to the paediatric ED once they had been streamed as this could potentially reduce time to initial assessment and treatment. We were told there was no reception staff employed in the paediatric ED to check patients in.

Patients directed to the GP streaming service would be checked in at the main ED reception and then taken to wait in the GP streaming waiting room to be seen by a GP.

When the GP streaming doctors came on shift at 8am they would go to the front door to assist with streaming, and to help identify patients whose clinical need could be seen in the primary care setting rather than the ED setting. This helped redistribute patients away from the ED and freed up space for patients with a greater clinical need.

The GP streaming service had established itself as an integral part of the ED service. The service saw approximately 20 patients daily. This was helping to decongest majors A and B and maintain patient flow.

The department used a mixture of carer's, do'ers and volunteers in the waiting room. These helpers would show patients the way if they had been signposted to other areas of the ED or other services in the hospital. They also assisted with issuing personal protective equipment and non-clinical enquiries. The carer's and do'ers were paid roles instrumented as part of the department's COVID-19 response to assist patients. The do'ers were easily identified as they wore tops with "Here to help" on them.

The current ED status was displayed and monitored by a dedicated team member in each area of the department. This was a database showing the status of the department at that point in time. The tool provided a RAG rating for the department and was used to track compliance with internal and external standards. This meant the department could provide clarity on whether the department was green, amber, red or black in terms of key ED measures, such as capacity, the patients' time in the department, the average time to triage and longest patient stay. By displaying this information, it gave the whole team the complete picture of what was happening in their department and actions could be put in place to improve performance.

ED had a flow co-ordinator seven days a week 24-hours a day. This was a dedicated member of the team who was responsible for the overall movement of patients through ED in a safe and efficient manner. They told us the role involved, coordinating patient care activities such as arranging and getting results of blood samples and diagnostic tests, liaising with clinical staff and admitting teams on the wards and keeping an eye on potential ED patient breaches. Staff we spoke with in the department told us the patient flow coordinators had freed up time for doctors and nurses for clinical duties and patient flow had improved.

Urgent and emergency services

ED staff carried out their assessments in a timely manner. National guidance states that following streaming, triage should be delivered within 15 minutes of the arrival in the department. We observed triage and there was a clear process for this. During this inspection we tracked the time of arrival (which was the time the patient was booked in) to time of initial assessment for five patients and saw each of these were assessed within 15 minutes. In addition to this we looked at triage times on nine sets of patient records, three records showed patients waited more than 15 minutes for an initial assessment, 25 minutes, 27 minutes and 34 minutes respectively.

The hospital recorded ambulance arrival times and handovers on patient paper records which were scanned and kept in the patient files. Therefore, the hospital did not keep an electronic record of handover times as it was regarded as increasing the burden on the department to individually record these measures. The ambulance trusts that served Darent Valley emergency department kept their own records of handover times categorised into 15 to 30 minutes, 30 to 60 minutes and over 60-minute handover waits. If issues arose regarding handover waits the trust would liaise with the ambulance trusts to decide on a course of action. During the inspection patients arriving by ambulance were taken straight into the ESAT without needing to wait for a space to become available. Paramedics told us they very rarely had to queue at the hospital, and it was a smooth offload from the ambulance to the ED department. Between February 2021 and March 2022, 6% of handovers were over 30 minutes.

From February 2021 to January 2022, the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was 38% which was better than the England average. Over the same period, one patient waited over 12 hours from the decision to admit until being admitted.

Staff in the ED were working together to reach the Department of Health's standard of 95% of patients being admitted, transferred or discharged within four hours. Between February 2021 and January 2022, the trust had an average of 81%. Although below the Department of Health's standard the performance was better than the England average and considered good in the context of the current high pressure, high demand climate. ED staff told us they had good relationships with speciality doctors who would come to the ED to review patients. However, we were told delays still occurred as patients could not always be admitted to wards due to lack of bed space. We saw this occurring during the inspection.

Part of the inspection included a review of the medical care pathway to understand its impact on the department. We visited the 33 bedded acute medical unit (AMU) which operated as a gateway between the ED and the wards of the hospital, and the 20 bedded Nightingale ward which was an escalation ward.

The AMU, which was supposed to operate as a short-stay department before patients were transferred to their medical speciality wards, had patients who had been waiting for a long time for a bed on the designated wards. When we visited the AMU, the unit was busy with several seriously ill patients which included cardiac and frailty patients who needed intensive support and care. We were told 70% of patients on the AMU were elderly.

The hospital had set up an escalation ward in part of the outpatient department during the COVID-19 pandemic when demand for inpatient beds had outstripped the hospital's bed capacity. The remit of the ward was to care for patients who were deemed to require minimal medical intervention. However, we were told by senior staff working on the ward that it was not just used for this purpose and was also used by patients who were waiting to be transferred to their speciality wards. At the time of our inspection, the ward was full and there were patients who had come from ED and were waiting to be transferred to other wards in the hospital.

Urgent and emergency services

The hospital had a frailty team who were based on the Evergreen Unit. The Frailty Assessment Unit provided nursing and support to the ED to facilitate admission of frail and older patients to the hospital wards a discharge to a community hospital or to the patient's own home.

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

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients could make complaints in various ways, verbally, by telephone and in writing by letter or email. The department clearly displayed information about how to raise a concern in patient areas. The hospital had a complaints leaflet which patients could take away and read at home. The hospital website had a detailed page explaining the complaint procedure and how to make a complaint. The complaint leaflet could also be downloaded from there.

Staff we spoke with told us they always tried to address complaints or concerns as soon as possible. The team attempted to resolve any issues before concerns escalated to become formal complaints. Conflict resolution training was part of the mandatory training. If the problem could not be resolved by the team, patients would be given contact details of the Patient Advice and Liaison Service (PALS). The PALS office had a visible presence within the main entrance of the hospital. Information regarding PALS, the services they offered and how to contact them was displayed in prominent areas in ED and on the hospital website.

The department had received 61 formal complaints between March 2021 and February 2022 and there were approximately 125,000 attendances to ED during that same time period.The main themes were the care given, staff attitude and clinical treatment. Complaints would be discussed in clinical governance meetings and any complaint themes or trends were analysed and actions put in place to stop issues occurring again. Post-inspection we were given a breakdown of the complaints and any outcomes and learning resulting from the complaint.

Staff said learning from complaints and concerns would be communicated to them mainly at handovers, team meetings and through emails.

Is the service well-led?

Good 

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

Leadership

Urgent and emergency services

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

The trust was split into divisions with each division having a management structure and clear lines of responsibility and accountability. The emergency department (ED) was part of the medicine, cancer and emergency care division. The division was led by a divisional medical director, divisional director of nursing and a divisional director of operations. This leadership style is referred to as a triumvirate.

At the local ED level, the department had its own triumvirate. The ED clinical director, the ED head of nursing and the ED operational manager were responsible for the running of the department. At the time of inspection, the head of nursing and operational managers positions were vacant, but appointments had been made. The department had two matrons who were responsible for the nursing aspects of the ED at the time of our inspection. The triumvirate were supported by a governance lead, audit lead and the children and young person lead.

The ED leadership team understood and could describe the challenges to quality and sustainability within the department and had pro-active on-going plans in place to address them. They were aware of the challenges to meet ED targets and had plans to improve service delivery. They were working to create better patient facilities, patient flow and increase capacity. For example, with the introduction of the emergency streaming and treatment area and the new paediatric ED.

There was a clinical leadership presence in ED. We were told by staff it was easy to access and locate the consultant in charge of the shift. Each shift had a nurse in charge who was supernumerary and not rostered to deliver direct patient care. This meant they could provide leadership and support the staff on duty. The paediatric ED had its own nurse in charge. During the inspection we found these nurses to be knowledgeable, approachable and passionate about the team and the patients they cared for.

We found an improved culture since the last inspection in 2019. Staff spoke highly of the ED leadership team, consultants and senior nursing staff, saying they found them supportive, approachable and collaborative. During the inspection we observed many interactions between staff and leaders, and it was evident there were close working relationships amongst staff of all disciplines.

Vision and Strategy

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

The trust's vision was "to be an outstanding hospital trust providing the best possible care for our patients that is safe, well-coordinated, in the right place and designed around the patient's needs."

This vision was underpinned by the trusts values and behaviours which provided a set of standards for how staff behaved towards others and how they conducted themselves as professionals. The values were:

- delivery high quality care with compassion to every patient;

- demonstrating respect and dignity for patients, their carers' and our colleagues;
- Striving to excel in everything we do;
- sustaining the highest professional standards, showing honesty, openness and integrity in all our actions; and
- working together to achieve the best outcomes for our patients.

Staff we spoke with knew how their work contributed to the vision of the trust, were aware of the trust values and behaviours and used them when interacting with patients and their families and when working with each other. We saw the trust values displayed throughout the department on posters.

Senior staff we spoke with in the department told us of their plans for delivering good quality sustainable care for now and in the future, and how they were working with the local healthcare community to ensure this would happen.

Culture

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

The ED leadership team had worked hard as a group to change and improve the culture of the department. During the inspection it became clear the emphasis was on making staff feel respected, valued and supported whilst delivering quality care to the patients.

We were told by staff working across ED there had been a change in culture since our last inspection in 2019. The culture was now one of positivity with a real sense the department was moving forward together. We were told of the good atmosphere in the team, even when staff were under pressure, and as a team, how they shared the stress.

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

Staff told us the managers looked after their wellbeing. One example of this was hiring security staff to work in the ED. This action had been taken by managers due to the rise in inappropriate behaviour, such as violence and aggression, towards staff from patients and visitors that had occurred during the COVID-19 pandemic.

As per NHS guidelines the trust had appointed a freedom to speak up guardian whom staff could talk to in confidence if they had concerns. Staff we spoke with were aware of the freedom to speak up guardian.

Governance

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

There were clear lines of accountability from the department to the board, through the trust's governance structure. All levels of governance and management functioned effectively and interacted cohesively with each other.

The ED had a dedicated governance lead who was supported by the ED leadership team. Clinical governance meetings were held monthly and were open to all staff who worked in ED. The meetings had a set agenda which included patient safety, patient experience, risks and clinical audit. An action plan was produced after every meeting and progress reviewed at the following meeting.

Senior ED staff told us information from these meetings was disseminated down to staff in various ways. For example, at staff meetings, during handovers and safety huddles.

Information was escalated up to the trust board via the monthly divisional governance meeting. The ED team was represented by the governance lead and the ED leadership team at this meeting.

Management of risk, issues and performance

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

Since our last inspection in 2019 there were clear and effective processes for identifying, recording, managing and mitigating risks in the department.

The hospital had a full capacity protocol which was used when the number of patients occupying the department was beyond the capacity for which it was designed and resourced to manage. This protocol was used alongside the escalation triggers when there was a surge in activity and when there was insufficient staffing to manage normal activity.

The department operated a local risk register which was reviewed at the clinical governance meeting and was a standing item on the agenda. New risks were added to the register and risks already on the register were monitored and managed. If the risk was determined to be a high, it would be added to the divisional risk register. We saw evidence the risk register was reviewed and updated.

At the time of the inspection there were five risks identified on the risk register and these reflected what staff had told us during the inspection. For example, the security of staff and the department's ability to meet the key safety targets.

There was a systematic corporate programme of clinical and internal audit to monitor quality, and operational processes in the department. This helped leaders understand and analyse performance issues and put measures in place to address them.

Information Management

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

Staff were required to complete information governance and data security training during their induction and then annually as part of their mandatory training. Staff were up to date with this training with records showing 95% compliance for the ED. However, when information governance and data security training was broken down by role, medical staff were 84%, which was below the trust target of 95%, nursing staff 99% and all other staff groups were 98% compliant.

The department used various IT systems to collect, analyse and share information within the department and the wider trust.

Patients were tracked through their ED journey by an electronic computer system.

The department could monitor its performance on a live basis through an electronic patient dashboard. For example, monitoring the four-hour targets, patient waits in the department, and the patient decision to admit status. The dashboard was constantly monitored by dedicated staff in the department who could see the department's live activity and operational performance. The information was also shared at the trust's bed management meetings which occurred throughout the day to monitor and coordinate patient flow through the hospital.

There were effective arrangements to ensure information was used to monitor, manage and report on quality and performance. Monthly reports were produced and discussed at the relevant governance meetings. We saw that action plans were created to monitor progress and were revisited at every meeting to ensure improvement in performance was embedded into practice and maintained.

The service collated and submitted data to a range of national audits. This allowed the comparison of data against national averages and standards to help facilitate continuous improvement.

There were effective arrangements to ensure data or notifications were submitted to external bodies as required.

Engagement

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

The trust had a website where the public could access information about the trust and its hospitals, including information about the ED at Darent Valley Hospital. There was information on the latest hospital news and the hospital's performance. The public could also find on the website details about how to contact the hospital, how to get involved with clinical research and how to find out about becoming a volunteer.

There were several ways patients and relatives could provide feedback on their ED experience. For example, by filling out specific patient surveys, making a comment, compliment or complaint or completing the Friends and Family survey (FFT). Patients could do this on paper forms found in the department, online, or by following the instructions on the FFT posters found in the department. The ED monitored the feedback monthly to look for challenges and celebrations; and for any trends and themes. This information was used to improve services and to feedback to staff positive comments.

The department's staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. Staff we spoke with felt informed and involved with the day-to-day running of the service and its strategic direction.

Urgent and emergency services

The hospital took part in the NHS staff survey which benchmarked against other NHS trusts in England. The hospital used the results to measure and respond to issues or themes raised by staff. The hospital was waiting for the results from the 2021 staff survey which were to be published in March 2022.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The service was engaging with local commissioning groups, the integrated care partnership and other local healthcare providers to specifically address local challenges. We saw and were told of various streams of work under development including redirecting patients to the correct services within the community.

Learning, continuous improvement and innovation

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

Since the last inspection in 2019 the hospital had developed and invested in a continuous quality improvement programme, and used it to support improvement and innovation work. The hospital and the department actively encouraged staff to find ways to improve quality of care and outcomes for patients.

We saw a number of initiatives aimed at improving performance and patient experience in the ED. This included a project to improve patient transfer times within the paediatric ED, and a sickle cell disease audit designed to increase awareness and find ways to improve the overall quality indicators for the management of sickle cell presentation in the department.

The research team at Dartford and Gravesham NHS trust had dedicated research nurses and was supported by the Kent & Medway Comprehensive Local Research Network and the Kent & Medway Cancer Research Network. Research work was being carried out in the trust and there were plans for the department to be involved in a national research programme once regulatory approval had been received.

Areas for improvement

Action the trust SHOULD take to improve:

- The service should ensure that medical staff complete their mandatory and safeguarding training (Regulation 12)
- The service should ensure they carry out and record daily safety checks on all equipment used in an emergency (Regulation 12)
- The service should ensure they carry out the re-audit of sepsis management in the department to see if improvements put in place have been effective (Regulation 17)
- The service should ensure computers are locked when left unattended to reduce risk of unauthorised access (Regulation 10)
- The service should consider relevant guidance and practice to determine if having nominated leads for safeguarding in the emergency department (ED) would improve liaison between the trust safeguarding team and the ED team.

Urgent and emergency services

- The trust should consider whether the security team would benefit from attending the trust's mental health and safeguarding training.
- The service should consider if the IT system used for displaying waiting times is effectively meeting the needs of people who use the service.
- The service should consider whether increasing the number of reception staff would improve access and flow.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC inspector and three specialist advisors with urgent and emergency care experience. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.