East Kent Hospitals University NHS Foundation Trust

Queen Elizabeth The Queen Mother Hospital

Quality Report

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Date of inspection visit: 6, 19 and 20 March 2014
Date of publication: 13/08/2014

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Accident and emergency	Inadequate
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and family planning	Requires improvement
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Queen Elizabeth The Queen Mother Hospital in Margate is an acute hospital. It is one of three hospitals that form the East Kent University NHS Foundation trust. It has a total of 388 beds, providing a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric services. The hospital dates back to the 1930s when the original building was constructed. Between 1996 and 1998 most services were relocated and expanded into a new main hospital building linked to the original facilities. The hospital has a specialist centre for gynaecological cancer and modern operating theatres, Intensive Therapy Unit (ITU) facilities, children's inpatient and outpatient facilities, a new Cardiac Catheter Laboratory and Cancer Unit.

We inspected services at The Queen Elizabeth The Queen Mother Hospital, namely the accident and emergency, medical care, surgery, critical care, maternity and family planning, children and young people, end of life care and outpatients.

Overall this hospital was rated as 'requires improvement'. The hospital was rated as 'requires improvement' for safety, effectiveness and responsiveness. Caring was 'good' and well-led was 'inadequate'. The Accident and Emergency services were rated as 'inadequate'.

Our key findings were as follows:

- The A&E department did not have sufficient levels of staffing to ensure a safe service was provided. There was an over-reliance on locum staff which created risks to safety.
- Safety in the A&E department was not a sufficient priority.
- The hospital was not well-led.
- Many patients experienced delays in leaving hospital because they were waiting for their medications. One patient we met had waited five hours.
- We were told that staff were reluctant to fill in the staff surveys as they did not believe it was confidential and did not trust the organisation not to penalise them for making adverse comments.
- Patients who attended pre-assessment before undergoing surgery experienced long waits before seeing the doctor. We met two patients who had waited over two hours and staff told us this was not unusual.
- There was not enough staff to provide a safe service to women during their pregnancy. The midwife to birth ratio was up to beyond 1:33. This was above the national recommended ratio of midwives to births of 1:28.
- Services for children and young people were not effective.
- Not all 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms documented the involvement of patients and their relatives. Some were not signed by a senior health professional.
- Staff were disempowered to make changes in the outpatients service. They were aware of the issues but they felt unable to make improvements to the service.

We saw several areas of outstanding practice including:

- Staff were caring
- There were good clinical outcomes for patients who had a stroke. The length of stay for stroke patients was 13.2 days with an expected rate of 17.5 days compared to similar trust's (January to December 2013 data).
- The critical care unit monitored its performance and data from Intensive Care National Audit and Research Centre (ICNARC) and showed that patient outcomes were good.
- Staff had learnt and changed practices as the result of 'Never Events' in the maternity services.
- Incident reporting was leading to learning and changes in the outpatients' service.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

Summary of findings

- Ensure there are appropriate levels and skills mix of staffing to meet the needs of all patients.
- Ensure safety is a priority in A&E.
- Ensure patients leave hospital when they are well enough with their medications.
- Ensure that maintaining flow through the hospital and discharge planning is effective and responsive. Patients must not be moved numerous times, and not during the night. When patients are well enough they must leave hospital.
- Ensure that staff are aware that at a board level there is an identified lead with the responsibility for services for children and young people.
- Ensure staff are fulfilling their roles in accordance with current clinical guidance.
- Ensure medications are stored safely.
- Ensure the administration of all controlled drugs is recorded.
- Ensure that procedures for documenting the involvement of patients, relatives and the multi-disciplinary team 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times. All forms must be signed by a senior health professional.
- Ensure patients are not experiencing unnecessary waits for follow up appointments at outpatients and when waiting in outpatients for appointments.
- Ensure there is adequate administrative support for outpatients. On the day of our inspection one medical secretary was responsible for sending out 1,660 GP appointment letters and had not met the within 72 hour target.

In addition the trust should:

- Ensure quicker response time to prevent escalation of Grade 2 pressure ulcers to Grade 3.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Inadequate 	We found that there were not enough appropriately skilled staff in A&E, which put patients at risk of receiving unsafe care. There was an over-reliance on locum staff. The lack of appropriately trained children's staff could affect the treatment and care delivered to children attending A&E. Staff were not always able to access the mandatory and specialist training they needed to deliver safe, effective care. Safety was not a sufficient priority. There was an up-to-date major incident policy, however we found staff were not aware of it and referred to an out of date policy. Staff told us they rarely practiced what they would do in an emergency. Overall the care we observed during our visit was effective. Staff were caring and responsive to patients' needs, although they did not always maintain the documentation to show that patients' needs were being met and monitored. We saw examples of good individual leadership within the department, such as the new training programme, but there was evidence that ongoing safety issues, for example around the shortages of staff, had not been resolved at a higher level.
Medical care	Requires improvement 	Patients told us that they felt safe, and cared for by kind and caring staff. However we saw that an increasing number of patients were being admitted as medical emergencies and not always transferred to the appropriate specialist medical ward. There were not always enough nurses to staff the extra beds that had been opened during the winter months. There were not enough doctors (40% vacancy of medical registrars) to maintain rotas at nights and weekends. We saw that patients were experiencing delays in their assessment, treatment and discharge and some patients were moved several times between wards. This could lead to inconsistent care and treatment. Overall patients received care according to national guidelines, although this could vary. The trust took part in national audits, for example, they had worse than expected standards for caring for older patients who had falls but performed better than expected in

Summary of findings

			caring for patients who had experienced a stroke. There was evidence of effective practice across the medical division, but it was inconsistent and not embedded in practice.
Surgery	**Requires improvement**		Patients had long waits when they were pre-assessed for their surgery. During their stay patients experienced care and treatment provided by a multi-disciplinary team who worked together to meet their needs. The day surgery unit did not comply with national guidelines and posed an infection control risk to patients. Due to the pressures on beds, patients were moved several times during their inpatient stay, sometimes during the night. Staff could not always provide the care and treatment needed as they had to look after additional patients when extra beds were opened with no increase in staffing numbers. Patients were cared for by appropriately trained staff as they were up-to-date with their mandatory training and had completed their appraisals.
Critical care	**Good**		Patients admitted to the unit received care that was safe, compassionate and focused on their individual needs. The unit had a ward vision that encompassed the importance of evidenced-based practice, collaboration and multidisciplinary communication and working, and understanding the needs of patients and their families. There was an induction process and training for both junior medical and nursing staff. There was a clinical nurse educator available to develop staffs' competencies. Staff reported issues in accessing online training modules. Around 14 nurses had not updated their yearly resuscitation training. The number of qualified nursing staff who have a post registration critical care course fell below the recommended 50% of their nursing establishment. Of the 14 anaesthetic consultants who covered the unit out of hours, only four were trained in Intensive Care Medicine (ICM). The consultants made themselves available outside of their normal hours to provide support either by phone or in person.

Summary of findings

Maternity and family planning

Requires improvement

There was not enough staff to always provide a safe service to women and their babies. Some of the environment did not facilitate safe care and some essential equipment was not always available.
The service investigated serious incidents and 'Never Events' and learning was shared with all staff and led to improvements in practice. Staff were focused on providing a caring experience for women and their babies but due to staff shortages and interim arrangements clinical guidelines were not up to date. The effectiveness of specialist services had not been measured for example the reduction in teenage pregnancies may have been attributed to the specialist team that was created to support teenage pregnancies.
Some decisions taken at a senior level did not appear to relate to the experience of staff at a ward level. The Chief Executive told us the maternity strategy consultation had been completed and the reconfiguration implemented successfully. However, we found that there was a disconnect between the strategy and the organisation in general and the maternity services at an operational level.

Services for children and young people

Requires improvement

The children's ward, special care baby unit and day surgery unit provided a safe and suitable environment to care and treat children. Parents told us they were happy with the care and support that was provided in these areas. There were suitable numbers of appropriately trained nursing staff and the skill mix reflected current guidelines within the children's services. However children being seen in other areas of the hospital did not experience the same level of care. In A&E children were not always seen by a specialist children's nurse and the children's waiting area was isolated and not always appropriately staffed and was not often used. In outpatients there was not a child friendly waiting area or specialist staff available to care for the needs of children.
Care was not effective. Best practice guidelines or national standards were not followed and most of the information relating to the safe care of children was out of date and did not reference national standards.
Staff in the children's services were providing caring treatment and were supported by their immediate

Summary of findings

managers. However there was no person at board level with overall responsibility for ensuring the voice of the child was heard and children's issues promoted and taken into consideration. This led to the children's service being fragmented and not taken into consideration during service redevelopment.

End of life care — **Requires improvement**

The Specialist Palliative Care service provides specialist advice and guidance for individual patients and family members. However the work performed by the SPC team cannot reach all patients receiving end of life care. In the wards we visited we saw little evidence of obvious strategic trust-wide leadership and support for end of life care. Although individual staff were committed, the result is an ad-hoc reactive response since the removal of the Liverpool Care Pathway. Nursing and medical staff we spoke with highlighted gaps in their end of life training, no increased staff levels to support wards with patients nearing the end of their lives, and poor documentation resulting in a disjointed approach to end of life care.
Not all 'Do Not Attempt Cardiopulmonary Resuscitation' forms documented the involvement of patients and their relatives. Some were not signed by a senior health professional.
Effective care was being delivered by specialist teams across the trust including the SPC team, ITU, CCU and Fordwich Ward, with input from multi-disciplinary teams who meet regularly to collaborate and consolidate knowledge. This ensures that patient received specialist end of life care receive the best planned care possible.

Outpatients — **Requires improvement**

All the patients we spoke with told us they felt they had been treated with dignity, and that they had found staff in the department polite and caring. They were kept informed of any delays in waiting for their appointments.
We found that some clinics were very busy and that staff outside of the department routinely overbooked patients for clinics because the number of appointment slots did not always reflect patient requirements. Patients therefore were experiencing long waiting times.
Staff used the incident reporting system and there were examples of changes as a result of learning

Summary of findings

from incidents. We found that staff were collecting data on waiting times and overbooked clinics, but, while they were aware of the issues, they felt unable to make improvements to this area of the service. Patients who required follow-up appointments told us that they often had these appointments cancelled and moved to a later date. They also complained that they had to wait too long for follow-up appointments. Staff told us that, when appointments needed to be cancelled, it was generally follow-up appointments that were cancelled because this did not affect the trust's targets for 2- and 18-week referral to appointment. We noted that the department was led by a manager and matron who were respected and liked by their staff. The staff were aware of their responsibilities and had all passed competency assessments to ensure that they were able to perform their roles to the required standard.

Queen Elizabeth The Queen Mother Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; and Outpatients

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Detailed findings

Background to Queen Elizabeth The Queen Mother Hospital

The Queen Elizabeth The Queen Mother Hospital, Margate is an acute hospital with around 388 beds, providing a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric services. The hospital dates back to the 1930s when the original building was constructed. Between 1996 and 1998 most services were relocated and expanded into a new main hospital building linked to the original facilities.

The hospital has a specialist centre for gynaecological cancer and modern operating theatres, Intensive Therapy Unit (ITU) facilities, children's inpatient and outpatient facilities, a new Cardiac Catheter Laboratory and Cancer Unit.

Our inspection team

Chair: Diane Wake Chief Executive Barnsley Hospital NHS Foundation Trust.

Head of Hospital Inspections: Siobhan Jordan, Care Quality Commission

The team included CQC inspectors and a variety of specialists and members of the public.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital.

We carried out an announced visit on 4 and 7 March 2014. During our visit we held focus groups with a range of staff in the hospital this included Consultants, Junior Doctors, nurses in training, matrons and administrative staff. We talked with patients and staff from all areas of both hospitals including the wards, theatre, outpatient departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

We held listening events where patients and members of the public shared their views and experiences of the location.

An unannounced visit was carried out on the 19th and 20th March 2014.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Inadequate	Not rated	Good	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Good	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Notes

1. We do not give a rating for A&E/Effective and Outpatients/Effective.

Accident and emergency

Safe	Inadequate
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

The Accident and Emergency (A&E) department sees approximately up to 230 patients a day of which 25 % -57 were children. It provides a 24 hour service seven days a week and consists of a triage area, majors and minors areas, a resuscitation area, and a paediatric treatment area.

When people enter A&E a 'navigator' nurse assesses their medical condition and directs them to the appropriate area. Patients attending in an ambulance had a dedicated entrance. They were assessed and directed through to an appropriate area. The 'Majors' area consisted of 11 cubicles and one side room for gynaecological patients. The resuscitation area had four bays' one of which was designated as a paediatrics bay, and one designated for acute strokes- those who were suitable for the stroke pathway. However if four traumas or cardiac patients arrived, all bays were utilised. The 'minors' area had three trolleys and four chairs. We saw a dedicated paediatric treatment area with two cubicles, waiting room and toilet. There was also a psychiatric assessment room which had two exits and alarms and one relative's room. Once the hospital has made a decision to admit a patient they would be moved as soon as possible from the A&E to the main hospital wards.

We talked to patients, relatives and staff, including nurses, doctors, consultants, managers, support staff and paramedics. We observed care and treatment and looked at care records.

Summary of findings

We found that there were not enough appropriately skilled staff in A&E, which put patients at risk of receiving unsafe care. There was an over-reliance on locum staff. The lack of appropriately trained children's staff could affect the treatment and care delivered to children attending A&E. Staff were not always able to access the mandatory and specialist training they needed to deliver safe, effective care.

Safety was not a sufficient priority. There was an up-to-date major incident policy, however we found staff were not aware of it and referred to an out of date policy. Staff told us they rarely practiced what they would do in an emergency.

Overall the care we observed during our visit was effective. Staff were caring and responsive to patients' needs, although they did not always maintain the documentation to show that patients' needs were being met and monitored. We saw examples of good individual leadership within the department, such as the new training programme, but there was evidence that ongoing safety issues, for example around the shortages of staff, had not been resolved at a higher level.

Accident and emergency

Are accident and emergency services safe?

Inadequate

Incidents

- Staff used an online system to report incidents. Some staff, both medical and nursing told us they would not use this system to report when the unit was very busy and unsafe.
- We gathered from all the feedback that there was an inconsistency of both reporting incidents and of the feedback received.
- We received information that the supervision of doctors was not always carried out, in particular the paediatric area. This was not reported as an incident from 1 November 2012 to 28 February 2014.
- Junior doctors did not have appropriate supervision. We were told, "Everyone has their own patients with no oversight by a supervisor, and patients are shipped out, far too early with incomplete care."
- This was reflected in the incident reporting, for example, premature discharge home with incomplete or inaccurate diagnosis. This meant that patients were potentially placed at risk.
- We reviewed the incidents reported from September to January 2014. A common reported incident was staff being subjected to abusive and aggressive visitors. Staff told us they were not trained in managing violence and aggressive behaviour as part of their training.

Cleanliness, infection control and hygiene

- The A&E department was visibly clean and uncluttered on the day of our inspection visit.
- There were no cleaning schedules in place that staff signed that ensured the environment it had been cleaned to the standards required.
- We saw by direct observation that all staff were bare below the elbow and used appropriate protective equipment designed to reduce the risk of cross infection.
- There was a supply of hand washing materials and hand gel dispensers. We noted that all bays and cubicles had fabric curtains that had no dates on to identify when last cleaned or changed. We asked staff how often they were changed and were told, "Not unless stains were noticed." This means patients were at risk of avoidable infection. There was no policy in place for staff to follow.
- At the time of our inspection there was no identified infection control lead, but we were told that a band 7 registered nurse would be taking up the lead for infection control.
- Trolleys were stripped after each patient had moved on, but staff did not wipe down the trolley or equipment with a cleaning agent before the next patient was treated. On one occasion a patient had no pillow and was given a used pillow from another trolley. This meant that patients were not always protected from the risk of cross infection.

Environment and equipment

- We were told by the senior nurse that staff checked equipment such as the cardiac arrest trolley, suction equipment and piped oxygen and suction every day.
- We checked the resuscitation trolleys and found that all the necessary equipment was in place, such as oxygen bottles, defibrillation and suction machines and the emergency drugs were in date. However there was no documented check list that assured staff that all the equipment had been checked and was working.
- Feedback from medical staff told us that on two separate occasions the piped oxygen and suction had not been working and had put patients at risk. This was not found in the incident report data seen.
- The resuscitation room was well equipped and organised.
- There were no checklists of dates and equipment in place that staff had replaced the medication or equipment following usage.
- The environmental layout of majors and minors allowed staff to monitor patients; there was a monitor at the nurses' station that displayed all the cardiac monitors in use in majors.
- All equipment had a portable appliance testing label that was in date.

Medicines

- We found that medicines were stored correctly including in locked cupboards or fridges where necessary. Fridge temperatures were checked daily.

Accident and emergency

Records

- A&E had a paper pro-forma that had recently been reviewed. Staff told us that they didn't use the pro-forma anymore but used a number of inserts such as the Critically ill Patient Escalation Plan and 'rounding tool' which evidenced patients comfort and well-being were checked at least two hourly . However we found that not all were completed.
- Nursing assessments and risk assessments were not always completed as there was more than one system that had to be completed. The staff had introduced their own 'patient rounding' checklist that was completed two hourly and asked six questions, are you in pain, do you need the toilet, are you comfortable, can you reach your call bell and do you need a drink. This however was not used consistently.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients we spoke with told us that all staff asked for their consent before examination and undertaking tests.
- Staff told us that they understood about the Mental Capacity Act 2005, but had not received training recently and two staff said they had never received any training.
- Deprivation of Liberty safeguards were known by senior staff we spoke with but again they told us that they had not received specific training. One member of staff referred to on-line guidance that was available to all staff.

Safeguarding Children

- We were told that if there were concerns regarding a child's welfare the A&E consultant would discuss with the on call paediatric registrar. If they had significant concerns then the paediatric consultant would be contacted and would review the child.
- All skull and long bone fractures in infants under one year old were discussed with the paediatric consultant.
- All children attending the department were checked on the child protection register. If the patient is on the register then they were automatically referred to the paediatric registrar on call. Children on the register cannot be discharged without being reviewed by the consultant on call.
- If a child attended the department more than three times in one year, the local Safeguarding Children Services and school nurses would be contacted.

Mandatory training

- We were told that due to staff shortages that mandatory training and appraisals were routinely cancelled. We looked at the training records and saw that training for staff was not up to date and current.
- Staff knew what action to take about safeguarding vulnerable people and children from abuse and 95% of staff had received this training. However the training rota identified that 15% of staff had not received training/refresher in the timescale set. One staff member had not received training in level 3 safeguarding children since 2008 and safeguarding adults since 2007. Staff spoken with knew how to recognise the signs of abuse, when to report and who to report to.
- The safeguarding policies and procedures were up to date and had been reviewed in September 2013.
- We spoke with staff about the training they received. They told us that access to training was difficult due to insufficient staffing levels. Staff told us that their mandatory training was not up to date and staff were not always able to access further training for their professional development. An education practice development nurse had recently been assigned to the department. We were told that all staff had completed specific A&E training, such as cannulation, plastering, wound gluing and suturing, but were not able to access evidence to support this.
- The matron told us that they had identified training issues and that there were plans to develop training and competency books for all levels of staff. For example a band 5 nursing development framework devised on the 28th February 2014. A practice development nurse had recently been employed and had identified training needs and planned training.
- All staff have access to computers with a card, this facility was not given to agency staff. We were told that there was not a short induction programme agency staff or locum doctors.

Initial assessment of patients

- The trust had introduced a 'navigator' formerly known as a triage nurse.
- This meant that patients who walked in to the A&E department were triaged by an appropriately trained member of staff. This system was designed to relieve some of the pressures on the A&E department and to

provide appropriate safe treatment to patients. The prioritising of patients by staff is an acceptable practice, called streaming, and guidelines are in place for staff to move patients into the correct area of the service.
- Patients brought in by ambulance arrived in the assessment area and were mainly assessed by the A&E staff within the national guideline time of 15 minutes.
- We saw that when the department was busy, patients could be queuing down the corridor waiting to be admitted to the assessment area. Once admitted to the assessment area, a system called the triage system was used to manage patients in a methodical way.

Management of deteriorating patients

- The resuscitation room had the equipment and medication required for expected trauma, cardiac patients and for stroke patients. For example, the staff described to us the acute stroke treatment pathway. Ambulance crews alerted staff of an incoming suspected stroke patient. There was a dedicated bay that had all the medication and equipment needed to commence the treatment. The stroke unit would be informed by the nurse in A&E of the expected time of arrival so the specialist nurse and medical doctor could be in A&E on their arrival.
- The staff used a white board and had developed a code for dependency that alerted staff as to the patient's condition. We saw that staff had updated and changed this regularly. We saw that the staff used a 'Critically Ill Patient Escalation Plan. This gave a flow chart with actions for staff to follow.
- Staff planned patient transfers. Some patients would if necessary be fast tracked to the high dependency unit or intensive care unit once stabilised. Staff told us that all patients transferred to other parts of the hospital including wards were accompanied by a nurse if critically ill or technician (healthcare assistant) if stable.
- Staff were not aware that A&E had a written escalation plan for when the department was unable to treat any more patients due to no capacity.
- Staff said they were unclear if there was a plan to follow that ensured patients were safe. One senior staff member said, "Ambulance staff wait in the corridor with new patients until a trolley becomes available." We were also told that the observation unit would be used and the patients from the observation unit moved to escalation beds on the main wards.

Nursing and Medical Handover

- We observed a medical and nursing handover during our inspection. This happened at shift changes and when the department was full.
- We were told that nursing handovers occurred twice a day on shift changes and was attended by all staff commencing their shift. Staffing for the shift was discussed as well as any high risk patients or potential issues.
- Medical handover occurred twice a day and was led by the consultant on the emergency floor

Nursing staffing

- On the day of our inspection the nursing team were short by two registered nurses to meet the needs of patients.
- The new practice development nurse was treating patients and not working in a supervisory role as planned during that shift.
- We were told by both the medical and nursing team that the staffing levels within A&E were insufficient to meet the department's needs and that it felt unsafe.
- Staffing level reviews were undertaken regularly using a recognised staffing tool to decide the actual number of staff required on each shift. As a result a twilight service (4pm to 12) had been commenced but had not resolved the low staffing numbers.
- There was a designated paediatric area that was open 24/7 and there were no paediatric nurses in A&E.
- In March 2013 a serious incident occurred involving a very young child who was not given the care and treatment they required. The service sees approximately 50 children a day and in March 2014 the service still did not have the appropriately paediatric trained staff.
- We were told that recruitment for a paediatric nurse had been successful but was not enough to cover 24 hours, seven days a week service.

Medical staffing

- There was only one consultant on call for both of the trust's A&E departments at night which were approximately 40 minutes apart by road.
- There were 7.5 consultants that worked across two hospitals. For the size of trust and number of patients treated the College of Emergency Medicine would recommend 13 consultants should be in place.
- There was a consultant on duty in the department between 8am and 7pm Monday through to Friday, and

outside of those hours a consultant could be contacted by telephone. We were told that the consultants were working additional hours to cover one of the vacant consultant posts.
- For the weekend of the 1st and 2nd March 2014 the rota evidenced that 80% (four out of five) middle grade doctors were locums.
- Records confirmed that vacant middle grade doctors' shifts were being filled by locum doctors and the trust was recruiting permanent middle grade numbers, by advertising in England and overseas.
- Junior doctors told us the use of a large number of locums was impacting on the support they received.
- Junior doctors were in the main positive about the support they received from the consultants but were less positive about the staff grade support from the locum doctors.

Major incident awareness and training
- There was an up-to-date major incident policy, however we found staff were not aware of it and referred to an out of date policy.
- All the staff we spoke with in A&E during our inspection could not recall practicing what they would do in an emergency.

Are accident and emergency services effective?
(for example, treatment is effective)

Not sufficient evidence to rate

Use of National Guidelines
- We were told that a combination of NICE and College of Emergency Medicine guidelines to determine the treatment they provided. Staff told us that the trust policies were written in line with this and were updated if national guidance changed. We found that some policies had not been reviewed since 2008, for example the pain management guidance and protocols.
- A consultant told us that the A&E was managed in accordance with the principles in 'Clinical Standards for Emergency Departments'.
- We asked staff how they were kept informed on changes to resuscitation guidelines as 90% of staff had not received any training updates or refreshers since 2010 and 80% had not undertaken their practical resuscitation course in the past year. We were told that they learnt from peers and doctors. However this was not documented.
- Changes to guidance and the impact that it would have on their practice was discussed and recorded at clinical team meetings.
- We were told that clinical audits of documentation and clinical pathways were carried out, we received the overarching results of audits for clinical pathways such as stroke but not for the specific A&E documentation. We were told that the A&E documentation had recently changed as a result of an internal audit.

Outcomes for the department
- The national average for unplanned re-admittance of a previous attendance at A&E was 7% and trust was at 9% -9.5% continuously. Staff were aware of this, some staff reported that they felt pressure to discharge patients form the department to prevent breaches to the 4 hour target and that this was seen as more important than the overall quality of care. This could have contributed in patients returning.

Care plans and pathways
- We spoke with eight patients and looked at records about the care and treatment provided. The majority of patients told us that they had received the care and treatment they required and were kept informed about the treatment plan. One patient said the treatment was "Excellent." Another said, "I wasn't told why I had to wait but the treatment was spot on." Patients were supported to make decisions about their care and treatment. One patient told us they had asked him, "This is what we need to do, but another option is to wait and see, I chose to be treated immediately."
- Staff were knowledgeable about the stroke pathway, cardiac and the management for fractured neck of femur.
- We found however that the assessment and management of patients' pain was not consistent. We looked at eight records and saw that a pain score was not recorded for five patients on arrival in the department. For one patient they had been given paracetamol by the ambulance crew but nothing else had been offered in three hours, this patient was visibly in discomfort. We saw a child considerable pain and emotionally distressed. They had been in over an hour before receiving analgesia, once given the child was

able to be examined more easily and tell the nurses where the pain was. The records for two other patients demonstrated that analgesia was given within 30 minutes. We also saw that not all patients' pain levels had been reassessed after analgesia was given as per the trust protocol seen. This meant that not all patients' pain was assessed, managed and recorded effectively.

- We were told by that all patients would be assessed for risk of developing pressure sores within six hours and this included a visual check of all pressure areas. This did not reflect current good practice guidelines. We did not see this undertaken as there were no patients in the department for more than five hours during our inspection. We were also told was access to specialist mattresses and beds for patients who were assessed as at risk.
- We observed patients being treated in the resuscitation area. There were clear lines of responsibility for each member of staff involved and staff communicated effectively with each other. In the minor and major injuries area we saw that most patients were seen and assessed in a timely manner. Staff knew which patients they were responsible for and about the patient's needs.

Multidisciplinary Team working and working with others

- We observed staff worked with the psychiatric team when required. Staff told us that they worked with the care homes and families who are carers when discharging them back in to their care. We saw that discharge letters went with the patient if further treatment and care was required.
- The medical and nursing team in the department both acknowledged that at times they were not working effectively together due to lack of staff. One doctor said, "It is hard sometimes to find staff to carry out treatment, because they are busy elsewhere. This does cause stress and delays in treatment. Nursing staff said that the lack of their own doctors was frustrating as "When locum staff are here valuable time is spent showing them the ropes and facilities."

Hydration

- There was no water fountain or beverage machine available for patients or their relatives to help themselves to. Staff said that there was no dedicated domestic member of staff available for this service. One nurse told us, "If someone asks then I will try to get one for them."

7 day services

- A consultant was available either on the unit or by telephone from 8am to 6pm at the weekend. After 6pm they were available by telephone. They were supported by a senior registrar and a senior house officer level doctor.
- Pharmacists were in the hospital from 8am until 1pm on both Saturday and Sunday. Out of those hours there was an on-call pharmacist available by telephone.

Are accident and emergency services caring?

Good

National Survey

- Data from the A&E Friends and Family test (FFT) for the period October –December 2013 was not disaggregated to location. The A&E did not display its own departmental score. Overall the trust performed lower than other A&E department, with a score of 38 in December 2013 compared with the national average of 56.

Compassionate Care

- We spoke with a small number patients and relatives in the department and the majority reported that staff were caring and kind.
- We saw staff communicated with patients' relatives effectively and in a kind and compassionate way.
- A play therapist was available; we saw her interacting positively with the children and their parents.
- We saw that patients dignity was maintained whilst being treated, staff ensured that curtains were drawn whilst undertaking tests and taking blood. Patients were given a hospital gown if necessary and were provided with a blanket to promote their dignity.
- Staff and doctors talked to patients in a low voice in an effort to maintain patients' privacy.
- The white board used by staff to track patients identified patients name and trolley bay number but only contained basic information such as tests undertaken, and dependency code. Diagnosis or symptoms were not on the white board for other people to see and the board was not on clear view to people passing through the department.

Accident and emergency

Patient involvement in care

- The majority of patients told us they were very satisfied with the care and treatment they received. They praised the staff and said they had been kept well informed and included in the decision making process. One patient was unhappy and told us they did not know the treatment plan or what was going to happen next. We alerted staff to this and they quickly responded and asked the attending doctor to speak with the patient.
- We observed that staff kept individual patients in the resuscitation area and majors informed about their plan of care and treatment. For example, we saw one nurse inform a patient and their relatives of the planned time of a specific test being carried out by another department.
- We also saw that patients were involved in making follow up appointments that fitted in with them.
- Staff carried out 'patient rounding' checklists (also known as comfort rounds or round-the-clock care) to ensure that patients were comfortable and safe. However these were not completed consistently when we were observing and the care provided to each patient was not always documented. This evidenced that this process was not yet fully embedded.

Are accident and emergency services responsive to people's needs?
(for example, to feedback?)

Inadequate

Access

- Since April 2013 the performance against the A&E waiting target which is a maximum of four hours to be treated of a decision to admit varied from 84% to 100%. In November 2013, December 2013 and January 2014 the trust achieved 90%, 91% and 92% respective. This is trust level data therefore we are unable to comment on individual site's performance. However at William Harvey Hospital we saw that the recording of waiting times of patients was inconsistent.
- We saw that there was a system that ensured patients both adults and children could be referred to psychiatric services 24 hours each day. However, staff told us that patients sometimes endured a wait of several hours sometimes overnight before a member of the psychiatric services teams attended the department to assess them.
- We observed board rounds where doctors reviewed patients' assessments and treatment plans. We observed that the most senior A&E doctor on duty led these board rounds, where advice was given to other staff to help streamline and prioritise patient care in the whole department.

Maintaining flow through the department

- The initial waiting time was not clear in the department unless the receptionist was specifically asked by a patient. There was no announcement or a board indicating the waiting time to be seen.
- The matron told us that the trust implemented a number of strategies to manage the flow of patients through A&E. There was an internal policy which outlined reporting mechanisms to senior managers. There were two or three bed management meetings held each day, designed to improve the management of patient flow and identify available beds in the trust. Where possible the site manager joined the board round with the A&E consultants and nurse in charge to discuss possible discharges and referrals.
- We saw that when certain areas of the department became busy, staff were redeployed in order to meet the needs of the patients there. For example, following a board round one nurse was redeployed from the majors' area to the children's area to meet the increased needs there.
- However, staff told us that this practice did not take place for patients with minor injuries, as patients with more serious conditions could not be left by staff. This redeployment of staff meant that the staffing levels were decreased in majors for over one hour until the paediatric patient was admitted to the paediatric ward. This was only possible because the resuscitation area was empty. The staffing levels would have been critical if a trauma or critically ill patient had arrived.

Meeting the needs of all patients

- The training records did not provide evidence that staff had received training in caring for patients with a dementia type illness and some staff confirmed that they had not received training.

- Mental health nurses were not based in the department and staff told us that the psychiatric team would be contacted immediately and their medical needs treated. Staff reported that this process could be frustrating because the single contact telephone number often resulted in waiting on hold for lengthy periods.
- Once seen by the crisis team and a decision to admit to a psychiatric ward was made, there was no further input from the crisis team. This meant that patients with a mental health need could be waiting in the unit for a long time for a psychiatric bed to become available. Staff reported that this was a frequent occurrence. This meant that people who may be experiencing a mental health crisis were being cared for, for long periods of time, by general nurses. This was impacted by ongoing staff shortages and unsuitable accommodation.
- The trust provided a service to a diverse population that included 5.33% of non-white minority, which was lower than their other locations. The area was significantly rural. Staff had access to a telephone interpreter service (language line) and that some staff were bi-lingual and could be used to interpret.
- We noted that that there was not a hearing loop service in the reception area for those patients who had a hearing deficit. Staff therefore had to speak loudly which impacted on patients' privacy.
- There were multiple information leaflets available for many different minor complaints. These were available in all of the main languages spoken in the community.
- Patients received information and follow-up advice when they left the department. There were a range of information leaflets available for patients.

Communication with GP's, other providers and other departments within the trust

- Patients ready for discharge were supplied with the appropriate follow up information and where required discharge letters, for example discharge to a care home. A discharge summary was also sent to the GP by email automatically on discharge from the department. This detailed the reason for admission and any investigation results and treatment undertaken.
- One patient was waiting for hospital transport to go home and said, "They have given me pills and advice, very good service."
- We saw that some patients returned to the waiting area following treatment whilst waiting for transport. This meant that the waiting area at busy times became crowded.
- The department had struggled with encouraging other departments to visit patients in A&E, especially orthopaedic and surgical services. This had led to delays in some patients being reviewed.

Complaints handling (for this service) and learning from feedback

- A list of complaints from July to December 2013 was seen. However there was no process in place to monitor and review these complaints and the complaints were not audited in order to identify trends and take appropriate action, where necessary.
- Concerns were raised that proper procedures had not been followed when a patient was admitted with history of loss of consciousness. There was no recorded action or outcome documented.
- Another complaint received on the 14 January 2014 was a delay in treating asthmatic patient and patient safety, again no action or outcome documented.
- There was no evidence of either departmental or trust wide learning from these complaints.

Are accident and emergency services well-led?

Inadequate

Governance, risk management and quality measurement

- There was no evidence of learning from incidents across the trust. The incident reporting system did allow for the identification of the trust's A&E services.
- The incident reporting system showed that a very limited number of staff reported incidents.
- Monthly governance meetings were held within the directorate and all staff were encouraged to attend including junior members of staff.
- Complaints, incidents, audits and quality improvement projects were discussed at staff meetings.
- Staff did not feel that risks were escalated quickly enough in regard to lack of staff both nurses and doctors to A&E department.

Accident and emergency

Leadership of service

- We were told that staff morale was improving and all the staff we spoke with were positive about the fairly new management structure in A&E which consisted of a new matron and new senior nurses.
- Senior nurses said that the prospective additional nursing staff especially paediatric nurses and the introduction of a practice development nurse had significantly raised moral within the team.
- One member of staff said, "We really need protected training times or extra staff on when training is booked, hopefully this will happen."
- A staff nurse told us "We have a fairly new manager that listen to what we have to say, they know what's going on and know what to do. They are recruiting more staff which will help".
- Staff felt supported by their immediate line managers. We were told that the matron was supportive and approachable. They all worked as a team and supported each other. There were opportunities to learn lessons at debriefing sessions following a difficult trauma or a failed resuscitation.

Culture within the service

- Staff had access to a counselling service if they needed further support. The senior nurse or matron would access the counselling through occupational health or the clergy team.
- Staff told us that although they felt stressed when the department was busy they were supported by their matron. We were told that due to staff shortages which had been highlighted that they could not attend training as often as they should be. They did not feel that the senior management listened to their concerns. One staff member said, "It does not get better, we have put a case forward for more staff, especially paediatric trained nurses but we are still waiting."
- The medical staff were concerned about the hours of junior doctors which were stretched as it was not sustainable over a period of time.
- Staff told us that there was at times a difficult relationship with some locum doctors as they did not always follow the trusts pathway policies and procedures. One staff member said, "It's difficult at busy times when the doctor does not know the department and where things are kept."

Innovation, improvement and sustainability

- We saw that the senior charge nurse had been encouraged to develop and design the resuscitation rooms to improve efficiency and safety.
- The management team of the A&E service worked across all three sites of the trust. We were told of a change following a complaint involving a young person with learning disabilities. This complaint related to a lack of care and in response to this the unit introduced "comfort rounds" every 2 hours to check if patients needed a drink, the toilet or pain relief, the managers had not taken this opportunity for organisational learning and had not introduced this initiative across all three emergency care services.
- This had improved staff confidence in working across two sites if the need arose, as the layout mirrored their normal working environment.
- One nurse told us, "I recently worked at the William Harvey Hospital and felt confident to work in resus and felt I was contributing to the team, rather than feeling lost and in the way."
- The lack of supervision and training for both doctors, nurses and technicians impacted on learning and improvement.

Medical care (including older people's care)

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

Information about the service

The hospital has acute medical units, general medical wards, care of frail and older people and stroke and cardiac services. Medicine has a team approach to managing medical services across the three hospitals which incorporates a frailty model on this hospital and 45% of patients admitted would be identified as being frail.

We talked with 33 patients, five relatives, and 75 staff including nurses, doctors, consultants and senior managers, therapists and support staff. We observed care and treatment and looked at care records. We received comments from our Listening Event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust and this hospital.

Summary of findings

Patients told us that they felt safe, and cared for by kind and caring staff. However we saw that an increasing number of patients were being admitted as medical emergencies and not always transferred to the appropriate specialist medical ward. There were not always enough nurses to staff the extra beds that had been opened during the winter months. There were not enough doctors (40% vacancy of medical registrars) to maintain rotas at nights and weekends. We saw that patients were experiencing delays in their assessment, treatment and discharge and some patients were moved several times between wards. This could lead to inconsistent care and treatment.

Overall patients received care according to national guidelines, although this could vary. The trust took part in national audits, for example, they had worse than expected standards for caring for older patients who had falls but performed better than expected in caring for patients who had experienced a stroke. There was evidence of effective practice across the medical division, but it was inconsistent and not embedded in practice.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Incidents

- We observed in all of the areas we visited that patients' care plans showed that risk assessments of patients developing blood clots, pressure ulcers, catheter and urinary tract infections and falls had been completed.
- We noted that some ward areas had higher numbers of falls and pressure ulcers than others. Staff told us that intentional rounding (where nurses check patients every two hours for pain, nutrition, hydration, skin, falls and anxieties) was being implemented and we saw examples of this on three of the wards we visited. For example, we noted on two wards they had received 100 days without a new pressure ulcer developing and had received a certificate of good practice from the trust. A ward sister on Minster ward said, "The implementation of intentional rounding had improved the continuity of care for patients on Minster ward".
- Staff told us they reported most incidents and were familiar with the electronic incident reporting process. Staff did not always receive feedback which could discourage incident reporting as staff did not know what actions had been taken. The sister thought there had been less falls than when the ward was open to support winter pressures last year. However, there was no way that this information could be substantiated.
- We spoke with 10 nurses who raised concerns about the prevalence of pressure ulcers. Whilst the prevalence of pressure ulcers is within the comparable averages for similar trust's, nurses expressed concerns that the number in the past 12 months were fluctuating but not decreasing.
- There were two tissue viability nurses who were part of a trust-wide team of six. It was noted that Grade 2 pressure ulcers have a national implementation plan against them. There was no improvement plan against Grade 3 or 4 (more serious) pressure ulcers but an organisational target of a 50% reduction had been set. We were told by the Tissue Viability Lead Nurse that a root cause analysis was completed for all Grade 3 and 4 pressure ulcers. The tissue viability team reviewed the reported pressure ulcer within three days of receiving the diagnosis and ensured the root cause analysis was completed and the care plan was appropriate. The trust may wish to note a quicker response time to prevent escalation of Grade 2 pressure ulcers to Grade 3.

Safety thermometer

- The trust used the national tool the Patient Safety Thermometer system. The system measures the incidents of new pressure ulcers, catheter and urinary tract infections, falls with harm to patients over 70 and Venous Thromboembolism (VTE). We observed that eight risk assessment forms had been completed in patients care records. We observed that monitoring information was available which was clearly displayed on all wards and specialist units we visited. We observed that falls resulting in harm to patients over 70, patients developing pressure ulcers and catheter and urinary tract infections were higher than expected to comparable trusts.

Cleanliness, infection control and hygiene

- Medical wards and specialist units were clean and tidy and safe.
- Clostridium difficile (C Diff) and Meticillin-resistant staphylococcus aureas (MRSA) for the trust were within expected statistical limits.
- Patients with spreadable infections were treated in side rooms.
- Ward sisters told us about the actions the trust had taken to reduce the level of catheters and urinary tract infections which was higher than expected. For example, increased hand washing and monitoring through hand washing audits was observed in ward areas. This demonstrated that the recent actions to reduce infections had been effective.

Environment and equipment

- We reviewed the testing and maintenance of equipment across wards and specialist medical units. For example, resuscitation trolleys, hoists and slings, medication trolleys and fridges, and the hand held clinical monitoring system. The majority of equipment was cleaned and maintained in a timely fashion on wards and in the medical specialist units. There were delays in uploading the patient information to the system. Nurses told us that they had repeatedly raised concerns with the information department over the past two years and this still had not been addressed.

- Staff told us pressure relieving equipment was often difficult to obtain when it was required for patients who were at risk from developing pressure ulcers. We were told that there was no coordinated system in place and it was not uncommon for patients to have to wait (from 24 hours upwards) or for other patients who were at less of a risk of developing a pressure ulcer to have the equipment relocated to a higher risk patient. We observed in patients care plans where the pressure relieving equipment had been unavailable, appropriate nursing interventions had been documented. For example, frequent turns to relieve pressure and use of pillows etc.

Medicines

- The handling, administration and storage of medicines were reviewed across wards and specialist medical units. Pharmacy staff told us there were not enough staff to cover the wards and departments. We observed that the electronic management of medicines on wards and in specialist medical units was reliant on doctors completing the discharge medication process.
- We saw examples of delays and staff told us that patients became very frustrated at the time they had to wait for the dispensing of their medication. For example on Minster ward and in the Discharge Lounge.

Records

- All records were in paper format and all health care professionals documented the care they provided in one record. The notes on two wards were well maintained and of a high standard. We noted that all patient records were kept safe across the medical division.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The nurses we spoke with had an understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. However they had limited experience of completing mental capacity assessments for patients who lacked capacity.

Mandatory training

- Ward sisters on all wards and in acute medical units told us that the mandatory training of staff was up to date. We were told that it was a challenge to ensure that all staff attended their training courses and it was a shared responsibility between the ward manager and the staff member.
- The complexities of the electronic mandatory training system meant that it was not always easy for staff to navigate around the system. Staff were concerned about the reliability or their IT (Swipe) cards to access the system. This was a problem across the hospital and had yet to be resolved.
- Staff had appropriate skills and training and three ward sisters told us that staff competency was monitored through staff appraisals and mandatory training.
- We saw staff were professional and competent in their interactions with patients and colleagues.
- Formal staff appraisals were clearly documented and up to date.
- We saw evidence that staff had attended training programmes to help improve patient outcomes. For example there were dementia champions on some medical wards.

Management of deteriorating patients

- Staff told us how they would escalate concerns around the management of a deteriorating patient. We saw policies and procedures that supported the use of a hand held clinical monitoring system. This is a bedside monitoring tool to capture real time patient information and support the clinical risk assessment of each patient.
- The Critical Care Outreach Team closely supported all wards and departments and there was an automatic escalation in place for patients who were flagged on clinical monitoring system as being high risk.
- We saw evidence that equipment that was used in emergency situations was easily accessible on medical wards and specialist units. We noted the equipment was checked daily and was within its expiry date. This meant that staff were able to deal with emergency situations when they occurred in the medical division.

Nursing and Medical Handover

- We observed both medical and nursing handover, in and out of hours that clearly identified what was required for each patient. Nursing handovers occurred throughout the day, and staffing for the shift was discussed as well as any high risk patients or potential issues.

Nursing staffing

- Nurses told us that they often experienced shortages of staff. One patient said" The nurses are wonderful but there is not enough of them particularly at night".

Medical care (including older people's care)

- A nursing review (Francis 2013) had been undertaken in April 2013. £2.9m had been agreed as an investment in nurse staffing across the trust. Increased staffing levels were in place in the Fordwich Stroke Unit to support the release of the thrombolysis nurse to care for stroke patients on their admission to A&E.
- There had recently been a recruitment of new nurses.
- We observed that staffing levels on St Augustine ward (the winter pressures ward) were at a minimum. The ward sister told us there was no cover for her and she worked long days without days off.
- A patient acuity tool which was completed each month. This enabled the sisters and ward managers to anticipate the number of staff that would be required to staff the medical ward or acute specialist department area safely. We noted that despite the acuity planning some wards and specialist areas were understaffed. This was particularly relevant to wards where extra beds had been opened in response to winter pressures where establishments were unclear and staff were not aware that the appropriate planning had taken place to ensure that patients were cared for in a safe and planned way.
- Staff had appropriate skills and training and three ward sisters told us that staff competency was monitored through staff appraisals and mandatory training. There were difficulties with the monitoring of mandatory training as the system was not 'user' friendly and did not always register the training that staff had completed. For example, staff had attended infection control training and had received their certificates of attendance. However, the system would not register that staff had completed the training.
- On the wards and medical specialist departments we visited staff were professional and competent in their interactions with patients and colleagues. We saw evidence that formal staff appraisals which were clearly documented and up to date. We saw evidence that staff had attended training programmes to help improve patient outcomes. For example, we saw evidence that staff had attended dementia awareness training and we saw there were dementia champions on some medical wards.

Medical staffing

- We were advised by doctors and ward sisters of a shortage of medical staff. Eight junior doctors raised concerns about the inconsistency of the medical rota. The doctors told us they had concerns about the length of time patients had to wait to be seen in the A&E Department and the Clinical Decisions Unit.
- The doctors said "The team approach to medical care creates significant risks and it is hard to get sub-speciality help. Neurology is only available Monday to Friday and renal is only available once a week".
- A senior medical clinician said "The junior doctor's rota is stretched and is probably not viable in the future. There are issues with maintaining general medicines role for cardiologists and gastroenterologists. Currently 40% of medical registrar posts are vacant as no one wants to work here.

Are medical care services effective?

Good

Use of National Guidelines

- Staff told us about the best practice guidelines in relation to stroke and dementia and we saw examples of best practice in the Fordwich Stroke Unit. For example, use of the Skins Bundle, falls risk assessments and the management of swallow and patient nutrition. A patient told us "I was really frightened after having a stroke but the staff really knew how to care for me and I am making good progress ".
- Staff on the wards and in the specialist medical units had little knowledge and understanding about clinical audit plans including the monitoring of National Institute for Health and Care Excellence (NICE) and other professional guidelines.

Consultant input

- Consultants and senior manager in the medical division told us that although participated in the national audit programme, local audits had only been in place for the last 18 months, therefore it was too early to measure the implementation of changes or effectiveness.
- We spoke with three consultants who told us, "We do comply with the national audit programmes but we need to turn the national audit outcomes into local action. We have a new Quality Assurance Board (December 2013) in place which is attended by all key professionals and this will help us to manage audit in a planned and structured way".

Medical care (including older people's care)

Outcomes for the department

- The hospital was found to be performing worse than expected for two of the Myocardial Ischaemia National Audit Project indicators - The proportion of eligible patients with a discharge diagnosis of non-ST segment elevation myocardial infarction (nSTEMI) who were referred for or had angiography and the proportion of eligible patients with a discharge diagnosis of nSTEMI who were seen by a cardiologist or member of their team.
- The stroke unit contributed to the Sentinel Stroke National Audit Programme which allows comparison of key indicators that contribute to better outcomes for stroke patients. Overall performance is rated from A the highest to E which no service achieved. It is acknowledged by the audit that very stringent standards are set, the hospital achieved grade C.
- Number of patients readmitted following a stroke was lower than at comparable trust's. The length of stay for stroke patients was 13.2 days with an expected rate of 17.5 days compared to similar trust's (January to December 2013 data).

Care Plans and Pathway

- Care records contained evidence that patients had been involved in planning their own care. Patients told us they had been able to discuss their care preferences when they were admitted to the ward or specialist medical unit. Comments included "I know what is in my care plan as it was shared with me when I was admitted to the ward". One patient told us "I don't always know what is happening to me each day but I do get answers when I ask the nurses what is going to happen to me next".
- Some relatives told us they were very happy with care that their relative was receiving. One relative said, "I was involved in the discussions around end of life care for my relative which was really helpful to the family". This demonstrated that patients and these close to them were involved in planning to meet their future needs.

Multidisciplinary Team working and working with others

- We saw evidence at the daily bed planning meeting of a multi- disciplinary and collaborative approach to care and treatment. We were told that a pilot programme was in place to support the more effective and timely discharge of patients who required Continuing Health Care which could lead to delayed discharges of care. The lead manager told us that the early findings of the pilot had demonstrated that performance had improved and communications processes were more effective for patients and staff.

Seven day services

- The service was working towards a seven day services and the risk register recorded there was a requirement for a seven day consultant presence across all divisions.
- Seven day working was in place for services that support the medical division to ensure continuity of care. For example, Critical Care Outreach, pathology and radiology. Services currently being developed were pharmacy and therapies.
- Staff on Fordwich Stroke Unit told us they were anxious about the development of Seven day working for the therapy service. The staff (who were based on the unit) were already very stretched and concerns had been expressed by the stroke team around the effectiveness of Seven day working within the current staffing constraints.

Are medical care services caring?

Compassionate Care and emotional support

- Patients, relatives and visitors we talked with commented on the kindness of staff involved in their care. Comments included "You cannot fault the staff, there is just not enough of them" and "They are always prompt when I call them". Another patient said "I always feel safe and well cared for here".
- We saw the interactions between care staff and patients were kind and courteous and staff responded compassionately to patients when they requested information or rang their call bell. Staff assisted patients in a discreet and dignified manner. Patients told us they were treated with respect and were never made to feel uncomfortable or embarrassed when assisted with personal care.
- The majority of wards and specialist medical units had dedicated private areas for patients and relatives.
- Visiting times (where it was applicable) were clearly displayed at the entrance to all wards and specialist clinical units across the medical division. One patient told us "My relatives visit when they can and have asked the ward sister if they can visit outside of visiting times

as they live a long way away. I was told this was not a problem which made me feel very relieved as I worry about my family while I am in hospital". This demonstrated that the patient's emotional needs and welfare were being taken into account by the ward sister.
- Patients told us the communication from the doctors and nurses was good and they felt they could trust them
- Staff were sensitive and met patients' needs. For example a close relationship was formed with a visually impaired older patient who was unfamiliar with a hospital setting to ensure they were put at ease and felt comfortable.

Patient understanding and involvement

- Patients told us they were very happy with the care and their overall experience. The adult inpatient survey in December 2013 showed that wards and acute specialist units in the medical division scored between 82% and 94% for respect, privacy, dignity and cleanliness, worries and fears, care and control of pain.
- Lower scores were achieved on Deal ward. However six patients on Deal ward told us they had experienced 'high levels of care' by compassionate staff, and their privacy and dignity was maintained throughout their stay. Two patients told us there were difficulties with staffing at night.
- The ward sister told us that generally staffing on the ward was adequate and there was a good response when patient acuity requires extra resources. However, the ward sister expressed concerns that staffing requests could not always be covered by the agency as many agency staff did not want to work on the more highly dependent wards. On the day of the inspection there were vacant shifts that had not been filled for that day.

Are medical care services responsive?

Requires improvement

Access

- Patients told us they were well cared for and staff responded to their needs and requests in a timely manner. One patient who had been admitted to Minster ward told us they had been "speedily dealt with which included tests and x rays". They were awaiting discharge and praised the care they had received.
- The number of patients spending 90% of their time on a stroke unit in the trust was 96% (January 2014). On the Fordwich Stroke Unit, there had been 13 breaches of the 90% target. This suggests that patients who had undergone a stroke were receiving care in an environment appropriate to their needs.

Maintaining flow through the hospital and discharge planning

- We observed that medical services were variable in their level of responsive to patients needs across the wards and clinical specialist units in the medical division.
- We observed that clear admission processes and ward rounds were in place in the Coronary Care Unit. There was often patients who did not require care and treatment from coronary care staff on the unit due to a lack of available of beds in other areas of the hospital.
- Endoscopy services and the care pathway for patients with heart failure were well managed and responsive to patient's needs.
- Three patients told us they had experienced up to four bed moves during their stay. One patient said "I recognise the need to move me to another ward during my stay and just put it down to being one of those things". Another patient said, "I wish the move had not happened in the middle of the night". This demonstrated that patients were not able to access a hospital bed that was appropriate to their needs.
- Mixed sex breaches happened most days and every attempt was made to ensure that patients' privacy and dignity needs were met. We were told that mixed sex breaches were reported but we did not see any evidence of this.
- Four patients told us they had experienced long delays (up to five hours) waiting for their medication so they could leave hospital. One person said "Everything else has been fine but I am really unhappy that I have had to wait so long for my medication to be dispensed".
- The Discharge Lounge had three patients when we visited at mid-morning. We spoke with one patient who had been waiting for over an hour and was going to another hospital. We revisited the Discharge Lounge later in the day and identified that the patient had left the department after a wait of two hours.

Medical care (including older people's care)

- We attended a bed planning meeting, there were 60 patients who were well enough to leave hospital but their discharges were being delayed due to various reasons. Twenty patients had been attributed to infection control issues as there were patient's experiencing diarrhoea and vomiting virus from the previous weekend. The remaining 40 patients were well enough to leave hospital but were delayed because of waiting for care home and social care beds, medical review, and/or discharge medication.
- There was evidence on the day of the inspection of the pressure staff were experiencing to ensure that patients were discharged in a safe and timely manner.
- Patients told us that although they were involved in planning their care they were not as involved in planning their discharge. Patients told us that they felt 'rushed' and were not always clear about what was happening to them.
- Staff told us that patients discharge medication would not be written and ordered from the pharmacy until all the ward rounds had been completed.
- Patients and relatives often had to return to the ward to collect their medication after they had been discharged. This demonstrated that discharge arrangements were not responsive to patients' needs.

Meeting the needs of patients

- A core group of staff had attended the dementia training and disseminated this across the wards.
- We saw evidence of dementia care pathways and the use of 'This Is Me' (individual care plan for vulnerable adults). We saw evidence of the dementia care pathway in operation on the Fordwich Stroke Unit. However, we saw few examples of the completed dementia care plans in patients' notes. This demonstrated that although the trust was aware of the implications for patients with dementia the changes to practice had yet to be embedded across the service.
- Support was available for patients with dementia and learning disabilities. Most wards had a dementia champion and were supported by the Learning Disabilities lead nurse. Staff were able to access on line safeguarding and learning disabilities open learning materials.
- Interpretation services were easily available.

Communication with GP's and other departments within the trust

- Four ward sisters told us that managing patient flow was a top priority for all staff and relationships with social services and the continuing health care team were excellent. They felt supported when placing patients in long term care settings.

Complaints handling (for this service)

- Staff spoken with were aware of the complaints policy and procedures in the trust. They were aware of current and ongoing complaints/concerns raised in their area.
- One sister said "If a patient wanted to raise concerns or make a formal complaint I would do everything I could to resolve the issue at the earliest opportunity. I encourage my staff to listen to patient's concerns and to make every effort to discuss any worries the patient might have in a private area to protect the patient's privacy".
- Patients told us "Staff were caring and supportive and I know if I had a complaint I would be listened to".
- Staff told us the ward sister shared any complaints with the care team. We noted on the Fordwich Stroke Unit that governance meetings included discussions around complaints and we saw evidence in the form of action plans and minutes of governance meetings where concerns had been addressed and action to prevent further complaints had been put in place.

Are medical care services well-led?

Requires improvement

Vision and strategy for this service

- Wards sisters told us that they were aware of what was expected of them as clinical leaders at ward level. For example, responsibility and accountability for safe care of patients in their care, staff recruitment, appraisal, and clinical supervision.
- The ward sisters told us they were aware of the trust board initiatives to engage staff in the wider organisation. For example, Dragons Den and the Chief Executive Forum, but many of the ward sisters had not been involved as either they did not see it as being important or relevant to their roles.
- We spoke with junior doctors who told us they did not feel supported by their consultants. The doctors

recognised the limitations of the medical cover the consultants could provide but felt there was a lack of ownership of the patients who were admitted out of hours. The doctors felt that this put patients at risk of unplanned and uncoordinated care.
- We were told by the staff in CCU that there was a good team spirit and senior doctors were very supportive to the junior doctors who felt they were able to escalate issues and concerns out of hours and across all the rotations.

Governance, risk management and quality measurement

- We spoke with staff about their understanding of clinical governance in relation to their roles and responsibilities
- Consultants told us there were monthly clinical governance surgeries which were held on each on the three sites. Representatives attended from the medical division including senior nurses to review findings, identify key risks and identify trends, review the learning from complaints and any failures of the governance process. The stroke risk register identified limited space between the beds on Fordwich Stroke Unit due to the unplanned use of extra beds. This was impacting on the delivery of therapies to stroke patients and compromising infection control and manual handling guidelines.
- Medical staff were asked to support a reduced length of stay by half a day per patient to enable better use of space and to reduce the levels of risk to both patients and staff.
- To date the actions that have been taken were: purchase of more equipment for rehabilitation of stroke patients, implementation of trust-wide winter plan to negate the use of extra beds, re provision of storage for non-essential equipment and consultants working towards a reduced length of stay.

Leadership of service

- There was a multidisciplinary team approach to managing medical services within the hospital and across the trust.
- We observed two telephone calls requesting the ward sister to open the six extra beds that the ward was not staffed to manage. The ward sister refused to open the extra beds on the grounds of insufficient staff. This demonstrated that the ward sister was aware of the need to ensure that patients received safe, effective and compassionate patient care.

Culture within the service

- Some ward sisters told us they were well supported by their matrons and knew they could raise concerns with them at any time.
- A sister told us they had escalated concerns about the poor staffing on their ward. The Chief Nurse who was also the Director of Quality and Operations had visited the ward and the sister felt that she had been listened to and supported by the wider organisation.
- Ward sisters did not have protected time to dedicate to leadership due to staff shortages.
- Nurses told us they were well supported by their senior colleagues and knew they could always escalate risks and concerns and would be listened too.
- Some student nurses told us they were really enjoying their placements and felt there was an open culture of learning and support.
- We spoke with a range of staff in the medical division about the lower than expected staff survey results. Staff told us they were either unaware of the results or were surprised "bullying and harassment or abuse from other staff" had occurred.
- During our inspection we were told of an example where a member of staff felt bullied and verbally abused in front of witnesses when they were putting the safety and quality of care for patients first. The member of staff was comfortable reporting the incident and it was being investigated by the Chief Nurse, who was also the Director of Quality and Operations.

Innovation, learning and improvement

- Consultants were concerned that there was a lack of investment by the organisation in clinical leadership.
- Junior doctors, registrars and nurses all expressed concerns about the pressures of working too many hours and the difficulties they experienced in having sufficient time to learn from incidents and complaints to ensure the future sustainability of high quality care.
- A structured appraisal process was in place and noted that most wards and clinical specialist units were up to date with their appraisals and had been able to access training and development opportunities.
- There was evidence in the monthly governance reports for stroke (January and February 2014) and in the weekly incident reports for each area that continued to be a high prevalence of falls and issues associated with insufficient nurses.

Medical care (including older people's care)

- Rapid response services had been put in place including Social Services and whole health economy monitoring and alert systems to highlight performance against targets. Staff were unclear about the local arrangements concerning additional support from Social Services.

Surgery

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

Information about the service

There are five surgical wards, a pre admission unit, a fracture clinic, a central admission lounge, a day surgery unit and a main theatre suite. The hospital currently provided emergency, general, trauma and elective surgery.

During our inspection we spent some time in all of these areas. We spoke with 37 patients and 30 members of staff and with four relatives. We looked at the records both in theatre and on the wards we visited and saw 15 sets of patient records in total. We also attended a listening event to gather the views of people who had used the hospital and lived in the local area.

Summary of findings

Patients had long waits when they were pre-assessed for their surgery. During their stay patients experienced care and treatment provided by a multi-disciplinary team who worked together to meet their needs.

The day surgery unit did not comply with national guidelines and posed an infection control risk to patients.

Due to the pressures on beds, patients were moved several times during their inpatient stay, sometimes during the night. Staff could not always provide the care and treatment needed as they had to look after additional patients when extra beds were opened with no increase in staffing numbers. Patients were cared for by appropriately trained staff as they were up-to-date with their mandatory training and had completed their appraisals.

Surgery

Are surgery services safe?

Requires improvement

Incidents

- Serious incidents were reported through the hospitals electronic system.
- Theatre staff told us that all incidents were discussed at senior nurse meetings and cascaded down to other staff to ensure everyone had the opportunity to learn from events that occurred.

World Health Organisation Safety Checklist

- The 15 patient records we looked at showed that the WHO surgical safety checklist was completed.

Safety thermometer

- The data was displayed on all wards and in theatres, with the exception of Quex ward. This showed their rates of falls, pressure ulcers and urinary tract infection (UTI) was now being well managed. This was because staff were aware of any fall or developing pressure ulcer and taking preventative or remedial action straight away.
- Staff were aware of the need to ensure that people were not at risk of developing pressure ulcers and any risk of falls was minimised.
- Risk assessments were completed to ensure that anyone at risk of malnutrition was assessed and measures in place. When talking with seven patients we reviewed their documents and saw the risk assessments had been accurately completed.

Cleanliness, infection control and hygiene

- The rates for Clostridium difficile (C Diff), Meticillin-resistant staphylococcus aureas (MRSA) and Meticillin-sensitive staphylococcus aureas (MSSA) infections were within an expected range for a hospital of this size.
- All areas of the hospital were clean on the day we carried out our inspection and staff were wearing appropriate protective gloves and aprons when they carried out any personal care with a patient.
- People who had a possible infection were treated in side rooms. During our inspection we saw that there were clear instructions and hand gel available at the entrance of every ward we visited.
- Infection control information was displayed.
- The trust operated a zero tolerance policy in regard to hospital acquired infections, and investigated any infection reported. We saw a record of the infection control audits carried out and resulting actions taken in relation to identified infections.
- However, we did not see detailed or effective infection control audits on the wards that we inspected or in theatres. Cleaning and environmental audits were in place but these did not include infection control risks.
- The day surgery unit had exposed pipe work, old ceramic sinks in the dirty utility area and a condemned autoclave in the clean utility area. Although there was a dedicated cleaner in post for this unit and a weekly cleaning audit, there were significant infection control risks and the area did not meet current national guidance.
- Four of the ten theatres on site had ultra clean air facilities to reduce the risk of infection.

Environment and equipment

- We found that facilities within the day care unit were poor. The facilities were dated, with no segregation between male and female patients; there was insufficient toilet and washing facilities, and significant overcrowding. The unit held 14 beds but we were told by staff that on an average day catered for 35 patients. The trust's information systems showed that an average of 18 day case patients were seen per day.
- The day surgery unit also managed up to ten ophthalmic patients two or three times per week and while able to walk to and from theatre, they were cared for until discharge in a small waiting room. They accessed the two toilets available to other day surgery patients.

Medicines

- Medicines were stored correctly including in locked cupboards or fridges where necessary. Fridge temperatures were checked.

Records

- We examined 15 sets of patient records during the inspection. These contained integrated pathway documents specifically designed for the type of surgery, for example adult surgery, fractured neck of femur surgery and Hip and knee replacement. The documents showed a clear pathway from admission through the

procedure itself, recovery and ward stay. The document contained both medical details and notes, anaesthesia detail and nursing notes. Any other multidisciplinary notes were also within this document.
- The records we examined were stored securely and clearly showed the input of the various specialisms.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. We saw examples of patients who did not have capacity to consent to their procedure. The Mental Capacity Act 2005 was adhered to appropriately and we saw that deprivation of liberty safeguarding was applied.
- We examined 15 sets of patient records. These included signed consent forms. The integrated care pathway documentation showed that consent had been reaffirmed before entering theatre.

Mandatory training

- We looked at staff mandatory training records and spoke with staff on the wards and in theatre. Staff confirmed to us that they had regular mandatory training throughout the year.
- Staff were up to date with their training required to carry out their roles.
- Staff had an annual appraisal and regular meetings with their manager to assess discuss their day to day work.

Management of deteriorating patients

- Patients who were at risk of developing pressure ulcers were risk assessed and appropriate measures including aids and equipment put into place.

Nursing staffing

- Staff were working in a flexible manner and cover was arranged where required through their internal bank or by agency staff. However, the day surgery unit had significant staffing shortages.
- The day care theatre was fully staffed, staffing in the day care unit was not adjusted to the additional number of procedures taking place within the day surgery, which in the last full year totalled 833. Staffing levels had not been changed to accommodate the increased use of the day surgery unit.
- The pre assessment unit and surgical admissions unit had similar staffing concerns. A senior nurse told us that they had 1.5 whole time equivalent nurses per day which they felt was potentially unsafe.
- Two of the three patients we spoke with in the pre-assessment unit complained they had waited over two hours to be seen by the consultant.
- Overall for the trust spend on agency staff was lower than other trust's in the same region (£15.9 in the year 2012/2103). All agency staff underwent appropriate local induction on arrival for their shift.

Medical staffing

- Although planned changes were under discussion, the emergency general surgery cover at this hospital currently involved the use of non-accredited associate specialists to cover on the Consultant rota.

Are surgery services effective?

Requires improvement

Use of National Guidelines

- The trust's contribution to national audits was variable. National Bowel Cancer audit was 59% (262 of anticipated 447) of cases, and the data was inadequate, with 14 cases of major surgery recorded. Data completeness was 0%.
- We looked at the theatre utilisation data and staff told us that although the information was provided monthly, there was no analysis made or actions taken to address persistent overrunning in theatres.

Care Plans and Pathway

- Integrated care pathways were in use. These were documents that covered both the medical and nursing notes from admission to discharge. This gave an easily accessible record of the procedures undertaken.
- The pathway documents formed a multi-disciplinary record of all interventions including medical, anaesthetists, recovery and nursing care in one document. This meant that there was a clear audit trail to show the procedure undertaken and the recovery from it.

Multidisciplinary Team working and working with others

- We saw multi-disciplinary teams included members of the medical team, anaesthetists, physiotherapy, occupational therapy, speech and language, pharmacy and dieticians.

- It was recorded at both ward and theatre level that decisions about patient care were made in a multi-disciplinary forum. This was recorded in individual integrated care pathway documents which combined both medical and nursing notes and tracked the treatment from pre admission through the procedures undertaken to the recovery and post-operative care.
- The multi-disciplinary team on general surgery met to discuss all patients who remained in the hospital over the weekend to ensure that information was available for weekend staff. This ensured that the necessary information was available to staff at all times.

Equipment and facilities

- There was appropriate equipment to ensure effective care could be delivered. However, instrument trays and equipment were decontaminated under contract and off site. This caused delays due to missing equipment or torn tray wraps.
- Similar arrangements were in place for laundry functions. This was a five day a week service and staff we spoke with told this was causing some shortages of bed linen at weekends.
- Facilities in the day surgery were poor, with a far larger number of patients treated than the unit was designed for and ophthalmic patients recovering from their surgery in a waiting room. This meant that the service was running in excess of its capacity and facilities were inadequate for that number of patients. We were concerned that additional staffing had not been recruited into post to cover the additional number of people receiving treatment and this meant that they could not offer a safe or effective service.

Pain relief

- Patients were assessed pre-operatively for their preferred pain relief post-operatively.
- There was a dedicated pain team who undertook a consultant ward round weekly. Pain nurses saw patients daily including during the weekend.

Seven day services

- A move towards more seven day services was planned by the hospital but had not yet been implemented. However, better use of theatre facilities was being made during weekdays with an earlier start time.
- Emergency surgical cover was available at night and at weekends. However plans were in place to move general surgery away from the hospital. These were currently being evaluated along with the effect this may have on call rotas.

Are surgery services caring?

Compassionate Care and emotional support

- 16 patients were extremely likely to recommend the surgical ward.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect.
- We saw that call bells were answered quickly both at day on an evening visit to Cheerful Sparrows ward.
- One person told us that they had, "Received very good care since I have been here and they have already checked that I have support at home." Another person told us that, "I have had a really good experience here."
- Two relatives we spoke with told us that the dementia nurse was actively engaging with their family member. Another patient told us that they had some personal worries about their home environment. The staff had already arranged to visit her home to see whether it was suitable for her to return to which they told us had eased their concerns.
- Two patients, who were Roman Catholic, told us that they had been supported to attend a Mass and another said that the hospital chaplain regularly visited them. However we did not see any other direct evidence that other faiths and cultures were supported.
- During observations on four wards, we saw that comfort rounds (intentional rounding) were undertaken and recorded within the risk assessment folder kept by the patient's bed. We looked at five of these folders whilst talking with patients. All contained completed 'rounding' documentation where required.
- We watched a ward round on Bishopstone ward and saw that doctors introduced them appropriately and that curtains were drawn to maintain patient dignity during any conversations or examinations. We also noted that they explained what was happening to the patient at all times.
- We looked at 15 sets of patient records and found they were completed sensitively and detailed discussions that had been had with patients and relatives

- Although set visiting times were in place, all of the wards we inspected told us that they would be flexible when necessary to ensure relatives could spend appropriate time with their family member.
- We spoke with patients on three wards. One person told us that they had, "Received very good care since I have been here and they have already checked that I have support at home." Another person told us that, "I have had a really good experience here." Two relatives we spoke with told us that the dementia nurse was actively engaging with their family member. Another patient told us that they had some personal worries about their home environment. The staff had already arranged to visit her home to see whether it was suitable for her to return to which they told us had eased their concerns.
- Records showed that people's emotional needs were being considered both during their hospital stay and in terms of future support needs. Occupational therapy assessments were undertaken to assess their needs when they returned home and two people told us that the additional equipment that they had been assessed as requiring had already been delivered to their home. One person told us, "This makes me feel more settled because I know I will have what I need when I go home."

Patient Involvement in Care

- Patients and relatives we spoke to stated they felt involved in their care. Details of the consultant responsible for each patient were on a board above their bed.
- One person we spoke with on that ward told us, "It is wonderful here, I feel that I have been included, involved in everything and empowered, it's the best experience I have had in a hospital." Two other people we spoke with on the same ward also commented on how involved they felt with their treatment. We were also able to observe a detailed conversation between a consultant and their patient and noted how detailed their explanations were to ensure that their patient knew what to expect in the days following their operation.
- Records showed evidence that the patient had been involved in pre and post-operative discussions about their treatment and that they had been asked to compete a consent from which was reaffirmed throughout the procedure.
- Several patients that we spoke with were aware of their care plans, but told us that they were happy to leave it with the nurses to deal with. One person said, "I know that they record everything in their folder but I am happy with the care I receive and leave them to do their job." They added, "I am sure that I could read it all if I wanted to but I have never felt the need."
- Plans were in place on all of the records we examined on the wards in terms of people's discharge, although exact dates had not always been discussed with patients pending a decision by their doctor or consultant.

Are surgery services responsive?

Good

Access

- We spoke with staff and patients about the access to services. On a planned surgery ward a pre-operation joint school was in place providing information to people before their operation and access to additional equipment and services should this be required. Patents we spoke with spoke very highly of this service.
- In other areas of the department, we saw access to specialist therapists including physiotherapy and occupational therapy and records we examined showed that people's needs on discharge had been assessed in terms of their home environment and ongoing access to services.
- Data available to us showed that there were no concerns at this hospital around referral to treatment times which should be less than 18 weeks.

Maintaining flow through the hospital and discharge planning

- The hospital currently had a waiting list of around 400 cases which was described by a senior member of the management team as, “Going up.” They added that their internal capacity overall was about 550 cases per month with a demand of about 800 cases. Additional resources were being provided by the board and 70 – 90 cases per month were being treated in the private sector. This meant their waiting list continued to increase.
- Patients we spoke with during our inspection told us that they had been assessed for treatment prior to the operation, other than those admitted through A&E, and were told what to expect.

Surgery

- Patients attending for elective surgery on Quex ward were invited to a pre-operative joint school where they were given information about their operations, assessed for any aids and adaptations they needed to return home and given exercises to aid their recovery. Three patients we spoke with on that ward told us that this had been invaluable in preparing and planning for their treatment.
- We looked at the hospital's 'Seasonal Pressures/ Capacity plan for 2013/2104. this involved the use of four escalation beds on one ward (Cheerful sparrows, female) However, it was clear that the use of these beds had been agreed at a corporate level and had not taken into account the pressure their use caused on the ward. Staff we spoke with told us that they had been in use for much of the winter and because there were no additional staff in place, this left them with less time to manage their own patients on the ward.
- Although we were told by staff on wards that they attempted to restrict bed moves to a minimum and to reasonable hours, we were told that at time moves happened late at night and between wards. However, staff on Cheerful sparrows ward told us that they often had to open the escalation ward during the night to relieve bed pressures elsewhere.
- Another patient we spoke with on the same ward told us how they had been moved from A&E to Seabathing ward, and then transferred to Cheerful Sparrows. They were expecting to be discharged but had not been told what was happening and were feeling isolated as they were in the escalation section and the only person there.
- Ward rounds were undertaken five days a week on all surgical wards. Physiotherapists, Occupational therapists and nursing staff attended.
- Discharge planning was in place on every ward soon as patients were admitted to the ward. Evidence of this was seen on the ten sets of records examined on the wards we inspected.
- Radiology requests could be prioritised for patients who needed scans prior to discharge.

Meeting the needs of patients

- The trust employed a dementia nurse specialist at each hospital who was involved in the care and treatment of people within the surgical unit with a diagnosis of dementia
- A learning disability liaison nurse was employed to assist in managing the needs of people with a learning disability who required surgery.
- Staff we spoke with had all received training in the Mental Capacity Act (2005) as part of their annual mandatory training and were familiar with the requirements of the legislation in that any decisions made for someone who lacked capacity must be in that person's best interests.
- We did not see any records on the day of our inspection that showed that anyone receiving treatment at that time lacked capacity but were satisfied that appropriate steps measures were in place when the occasion arose.
- On the wards we inspected we saw information available to patients and relatives about a range of conditions and how to seek support if they were unhappy. These were available in all of the main languages spoken in the community.

Communication with GP's and other departments within the trust

- We noted on the ten sets of ward records we looked at that GP details were included within the discharge pack. We also saw that where patients were readmitted following a previous time at the hospital, the discharge information was also recorded on file.
- Close links were noted with the A&E, Intensive care unit and recovery units to ensure that information was passed from each department. Copies of admission documentation from the A&E were seen on the records we examined during our inspection.

Complaints handling (for this service)

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint then they would speak to the ward manager.

Are surgery services well-led?

Inadequate

Vision and strategy for this service

- At a trust level, there appeared to be a clear vision and statement of values. However, this did not appear to be clear at individual ward level. Staff we spoke with during our inspection were unclear on the overall vision of the trust or the values represented.

Surgery

- We were told by more than one senior ward staff member that there was something of a blame culture within the hospital. We were told that, “If something went well then management took the credit, if something went wrong, the individual is pilloried."
- This was reflected in the 2013 NHS staff survey, where the trust as a whole was seen to be performing in the bottom 20% of trusts in nine of the 28 areas including near misses, accidents, violence at work and bullying and harassment. Individual data for this hospital was not available.
- We were told of initiatives including a version of 'dragons den' to encourage staff ideas, but when asked, senior divisional staff were not able to provide examples where progress had been made as a result of the initiative.

Governance and measurement of quality

- A monthly governance meeting was chaired by either a divisional director of surgery or divisional medical director. This meeting looked at surgical issues but it was unclear how this was cascaded down to ward level. We were told that an ‘unexplained death’ report was provided weekly but this was information purposes only. When asked who would act on that information, we were told it was the responsibility of the clinical lead for trauma and orthopaedics, a post it transpired had been vacant since late 2013.
- Staffing issues had been identified at board level as a major concern. However, although funding was agreed in April 2013 delays in recruiting into vacant posts and continued recruitment difficulties were affecting the delivery of care across all of the hospital sites.
- We were told the complaints process could, “be slicker.” They described how the turnover to respond to the CEO’s office did not allow time for a full investigation

Leadership of service

- During our inspection we spoke with staff at all levels. We found that from the ward manager down staff felt supported and encouraged to carry out their day to day duties. Most of the staff we spoke with were dedicated to the role they filled and showed great enthusiasm.
- During our inspection we found that there were significant recruitment issues within the department.
- Ward mangers were not always able to fulfil their super nummery role and although there were plans to recruit more qualified nursing staff, this had yet to have any significant effect on staffing levels within the service.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients.
- Quality and patient experience was seen as a priority and everyone’s responsibility.
- Staff we spoke with during our inspection were open and transparent, telling us about both the positive and negative aspects of their role and the impact on patients. They felt well supported at a ward level.
- There were clear multi-disciplinary decisions being made for the benefit of the patients.
- We observed staff working together and supporting each other.

Innovation, improvement and sustainability

- During our inspection we noted that improvements in theatre utilisation had been made following an analysis, with the introduction of the dawn bookings scheme. This meant that the theatre was in use for a longer part of the day and reduced waiting times.
- We asked for a copy of the surgical risk register which identified potential risks, but the latest copy made available to us was dated August 2013. This meant that we could not be assured that any potential current risks to the department had been identified and steps taken to mitigate the risk.
- We saw that improvements had been made in the neck of femur replacement service, with an integrated pathway document specifically for this type of procedure which tracked and logged the patient’s time at the hospital.

Critical care

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

Information about the service

The critical care unit (CCU) at the Queen Elizabeth The Queen Mother Hospital (QEQM) has eight mixed level intensive care and high dependency care beds, if capacity is exceeded a ninth bed can be utilised. Patients of all ages who have a potentially life threatening illness can be admitted to an intensive care bed, or those patients too ill to be cared for on a general ward can be admitted to a high dependency bed. There was an outreach team of 5.5 whole time equivalent nurses that covered the hospital and provided a 24 hour service.

There was an outreach team of 5.5 equivalent nurses that covered the hospital and provided cover 24 hours a day, and utilised the clinical monitoring system to monitor and support deteriorating patients. In 2012-2013 there were 25 admissions of patients aged 16 and under, usually for stabilisation prior to transfer. There were a relatively low number of admissions in the above 80 age group – at 30 medical admissions and 50 surgical admissions out of a total of 630 admissions in 2012-2013.

We spoke with one patient, three relatives, twelve staff including, nurses, doctors, consultants, senior managers and support staff. During the inspection we looked at care and treatment, we also reviewed care records. We received comments from our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Patients admitted to the unit received care that was safe, compassionate and focused on their individual needs. The unit had a ward vision that encompassed the importance of evidenced-based practice, collaboration and multidisciplinary communication and working, and understanding the needs of patients and their families.

There was an induction process and training for both junior medical and nursing staff. There was a clinical nurse educator available to develop staffs' competencies. Staff reported issues in accessing online training modules. Around 14 nurses had not updated their yearly resuscitation training. The number of qualified nursing staff who have a post registration critical care course fell below the recommended 50% of their nursing establishment. Of the 14 anaesthetic consultants who covered the unit out of hours, only four were trained in Intensive Care Medicine (ICM). The consultants made themselves available outside of their normal hours to provide support either by phone or in person however there were no formal Consultant wards at weekends.

Critical care

Are critical care services safe?

Good

Incidents

- The most recent serious incident led to a root cause analysis. The results of this were shared with staff and the relatives of the affected patient had been involved.
- Staff were aware of the process of how complaints were dealt with both the investigation and resolution.
- We were told about two incidents that had occurred in February, we spoke with a senior member of staff who had responsibility to follow up and monitor the progress of the complaints. They were able to demonstrate a transparent process both in the reporting of and the following up of complaints.
- We were told that one incident had been resolved; the second more serious incident was currently being investigated. A senior member of the nursing team would conduct a root cause analysis as part of the investigation process.

Safety thermometer

- Some of the audit results were displayed on the notice board outside of the units for all to see. The results included falls with harm, new pressure ulcers, new blood clots (VTE) and new urinary infections associated with catheters. 100% of patients were assessed for the risks in February 2014.
- There was a family satisfaction survey displayed outside of the unit, there was a high level of satisfaction from family and friends. A quote from one patient recorded and displayed said “Everyone 100%. I can’t thank you all enough.”

Cleanliness, infection control and hygiene

- The unit was visibly clean and tidy with bed areas laid out to ensure staff could appropriate monitor patients.
- We saw staff regularly washing their hands and using hand gel between patients.
- A microbiologist visited the unit daily

Environment and equipment

- Daily checks of the environment and equipment were carried out and recorded
- The environment on the unit was safe. Staff said that equipment was maintained and serviced as required and was quickly repaired.
- Equipment on the unit was serviced and maintained, we were informed that there had been a problem with the reliability of a hemofiltration device; this issue also impacted on the other two units’ within the trust and was recorded on the critical care risk register.
- Both the critical care steering group and procurement had worked together to resolve the issue.
- Equipment had been standardised and was clean and well maintained.

Medicines

- Medicines and equipment were safely stored.
- The pharmacist visited the unit each day and reviewed the medicines and drug charts.

Records

- Records were completed. They included risk assessment for patients considered to be at risk of falling, skin bundle daily checklist to monitor skin integrity and the use of aids.
- There was a structured approach at staff handover and from feedback in the main consultant rounds, the focus centred on management of each patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- On the day of the inspection there were no patients on the unit who required care under the Deprivation of Liberty Safeguards.

Mandatory training

- All staff were up-to-date with their appraisals
- Not all staff (fourteen) on the training matrix had evidence of completion of their yearly resuscitation training update.
- We saw that safeguarding for children and young people was recorded, but we could not see safeguarding for vulnerable adults.
- We were told that the electronic system for training had been problematic and had created delays for staff undertaking their mandatory training through online learning modules.

Management of deteriorating patients

- The outreach team were present on site 24 hours a day seven days a week. They provided care and treatment to patients whose health was deteriorating in line with the

prevention and management of the deteriorating patient policy. The team used an electronic trigger system which provided a recording mechanism for patient's vital signs and essential screening tools.
- The trust had implemented the national early warning score for patients; the system standardises the assessment of acute illness severity, and indicated when senior staff should be contacted.
- All discharged patients who were admitted to the units were followed up by the outreach team.
- Patients who were stable with tracheostomies were only transferred and cared for on a specific ward.

Nursing staffing
- There were enough nurses to meet their needs of patients
- The unit did not use agency nursing staff, occasionally staff were moved from the other units within the trust to help support and maintain levels of care.
- There was not always a supernumerary clinical coordinator on the unit 24/7 as recommended by the national guidelines.
- We saw that there were 52 staff on the rota, nurses and health care assistants – 42.5% of the registered nurses had a post registration course in critical care. This falls below the recommendation of 50% of nurses with specialist critical care knowledge.
- We spoke with the education lead who confirmed that new staff members had a structured four week induction programme and were supported throughout this period.

Medical staffing
- Of the 14 anaesthetic consultants who covered unit out of hours, only four were trained in Intensive Care Medicine (ICM) and had predominant 50% unit sessions embedded in their job plans.
- There were dedicated weekend ward rounds in place and took place each morning on Saturday and Sunday. There was a formal hand over on Monday morning led by consultants.
- Consultants were available to cover the unit 24 hours which in accordance with national guidelines.
- Trainee cover is junior on the unit and those trainees that we spoke with were positive about the support they received from the consultants. Consultants were available by telephone.

Are critical care services effective?

Good

Use of National Guidelines
- The unit used a combination of NICE, Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment they provided.
- Governance meetings were held for the service to discuss national guidelines, which then fed into the trust-wide forum.

Outcomes for the unit
- The unit monitored its performance and data from Intensive Care National Audit and Research Centre (ICNARC) showed that patient outcomes were within the normal range.
- Meetings were held monthly using the patient safety template, information of findings or outcomes go to the safety board and an end of year report is written.
- The length of the stay for the unit was four days.

Care Plans and Pathway
- The unit used a daily ward round pre-printed daily sheets that prompted staff to following the patient's pathway which was completed during the morning ward round.
- Care bundles were in place for specific situations, we reviewed one ventilated patients observation chart who was receiving one to one nursing care. The staff member showed awareness of guidelines and protocols and was able to demonstrate knowledge about tracheostomy and ventilator acquired pneumonia (VAP) care bundles.

Consultant Input
- Consultants undertook ward rounds twice daily.
- All potential patients were discussed with a consultant and were reviewed in person by them within 12 hours of admission but not at the weekends.

Multidisciplinary Team working
- A multidisciplinary team reviewed patients. Including pharmacists, physiotherapists and dieticians.
- We spoke with a dietician who told us about the Malnutrition Universal Screening Tool (MUST) that is used to assess patient's nutritional requirements.
- A physiotherapist visited patients on a daily basis.

Critical care

Seven day services

- Pharmacists were available on the unit five days a week.
- Out of hours in hospital cover was provided by the specialist registrar who covered theatres and maternity.

Are critical care services caring?

Good

Compassionate care

- Due to patients being very unwell we were unable to speak with any patients directly, we saw that relatives either sat with the patients when observations were being taken or moved away from the bed area.
- We looked at patient records and found they were completed sensitively and detailed discussions that had been had with relatives were clearly documented.
- The staff and relatives we spoke with demonstrated that communication and keeping the patient, family and friends updated and informed was important.

Patient understanding and involvement

- We spoke with three relatives who were new to the unit. They told us that staff had been very kind and good; they had been kept fully informed about what had been happening with their relative and had been seen on time.
- The decision making process was clear and they were fully informed about the plan of care.
- Patient diaries were kept. The purpose of the diaries was to allow patients to understand what happened to them during their stay on the unit.

Emotional support

- We saw from records and observation, the consultant responsible for the patient or a member of their team met with the patient or their relatives if they were on the unit. If the patient was not conscious the consultant discussed the care with the team and the responsible nursing staff.
- Staff that we spoke with and observed interacting with both their patients and relatives demonstrated that they empathised with them. We saw staff spending time talking to their patients who were sedated and ventilated, explaining what they were doing and why.

Are critical care services responsive?

Good

Maintaining flow through the department

- The service was working with pre-assessment to develop processes to identify which patients should be admitted to critical care and for the information to be passed through the system to book a critical care bed on a timely basis.
- If a high dependency unit was not available then there was a direct consultant to consultant discussion.
- The number of planned admissions to the unit, from January 2013 – December 2013 was 62 admissions.
- During the same period there were 206 delayed transfers.
- We were told that there had been issues raised when the provider of the ambulances transferring patients from the unit had been changed.
- An interim agreement had been reached about provision for the transfer of critically ill patients. This had impacted on the time scale of patient transfer and also impacted on the time away from the service/ delivering patient care.

Discharge and handover to other wards

- The patient admissions form booklet had an ICU nursing discharge/transfer form. Relevant information regarding admission details, assessment of body systems and recommendations for discharge needs were recorded and signed by both the transferring and receiving nurses signatures. There was also an intra-hospital transfer checklist for critical care transfers and discharge to the ward.
- The outreach team follow discharged critical care patients on the ward.
- Nurses from the outreach team followed up all patients within five days of leaving the unit.

Complaints handling (for this service)

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint then they would speak to the shift coordinator. If this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). This process was outlined in leaflets available in the relatives waiting area.

Critical care

- On the day of the inspection we were told about the process of how complaints are dealt with both the investigation and resolution. The unit staff used the incident reporting system to report any incidents.
- We were told about two complaints that had occurred in February, we spoke with a senior member of staff who had responsibility to follow up and monitor the progress of the complaints. They were able to demonstrate a transparent process a transparent process both in the reporting of and the following up of complaints. We were told that one complaint had been resolved; the second more serious complaint was currently being investigated. A senior member of the nursing team would conduct a root cause analysis as part of the investigation process.

Are critical care services well-led?

Governance, risk management and quality measurement

- The unit had frameworks for monitoring the quality of its service. The unit was within the division of surgery.
- The department held monthly surgical governance meetings.
- There was a critical care steering group that met monthly across all three sites: there was a video-link option available.
- We saw that there was a critical care risk register; the recent problems with haemofiltration equipment had been recorded on the register.
- A safety thermometer showing the number of patients who received harm free care for February 2014 was presented so that all levels of staff understood what the unit: harm free care had achieved.

Leadership of service

- There was a designated clinical lead consultant
- There was an identified nurse who was formally recognised with overall responsibilities for the nursing element of the service.
- Most staff worked more than their contracted hours to ensure they provided a good quality service.
- All staff told us and we saw that communication in the service and with other services was effective and that important issues were discussed
- Formal, organised nurse and consultant meetings were not regularly held rare.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients.
- Openness and honesty was the expectation for the department and was encouraged at all levels.
- Staff worked well together and respected each other's roles and responsibilities.

Innovation, improvement and sustainability

- In addition to an induction programme, the unit offered opportunities for applying to do a post registration critical care course.
- Clinical competencies were assessed and tested following completion of the course.

Maternity and family planning

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

Information about the service

Approximately 3000 births occurred at the hospital. The trust had a single maternity service shared across East Kent operating out of several locations.

At this location there was a:

- High risk consultant-led antenatal (before birth) clinic which included foetal medicine, day care, labour and in-patient postnatal services (Kingsgate Ward)
- Low risk midwife led unit (MLU) for antenatal, intrapartum and immediate postnatal care. The MLU had four multifunctional rooms that were used for labour, delivery and postnatal care. Two of these rooms had a birthing pool.
- Special care baby unit (SCBU) providing care to babies born after 28 weeks gestation
- Consultant led labour suite, Kingston Ward with one co-located maternity specific operating theatre.
- Recently re-furbished midwife-led birthing unit, (St Peters unit) with two birthing pools, for women with uncomplicated pregnancies who wanted to give birth naturally and in a less clinical hospital environment.
- There was an antenatal and postnatal service for women co located with the delivery suite.

Summary of findings

There was not enough staff to always provide a safe service to women and their babies. Some of the environment did not facilitate safe care and some essential equipment was not always available.

The service investigated serious incidents and 'Never Events' and learning was shared with all staff and led to improvements in practice. Staff were focused on providing a caring experience for women and their babies but due to staff shortages and interim arrangements, a number of clinical guidelines, policies and patient information leaflets were out of date, some in excess of two years. The effectiveness of specialist services had not been measured. For example the reduction in teenage pregnancies may have been attributed to the specialist team that was created to support teenage pregnancies. However, no audit of this service had been undertaken to demonstrate improvements since the team was implemented in 2008.

Some decisions taken at a senior level did not appear to relate to the experience of staff at a ward level. The Chief Executive told us the maternity strategy consultation had been completed and the reconfiguration implemented successfully. However, we found that there was a disconnect between the strategy and the organisation in general and the maternity services at an operational level.

Maternity and family planning

Are maternity and family planning services safe?

Requires improvement

Performance data

- Performance data showed that a number of caesarean sections performed, both elective numbers and emergency, was within the standard range.
- The trust's rate for normal deliveries was slightly above the England average.
- Maternity related infections, such as puerperal sepsis, were within the expected levels. The number of serious incidents reported and 'never events' (incidents that should never occur) were all within or below expected levels when compared to other trust's.
- Between 01 December 2012 and 30 November 2013, five Serious Incidents occurred which were reported on Strategic Executive Information System (STEIS).
- We saw the NHS Safety Thermometer for monitoring pressure ulcers, catheter associated urinary infections, venous thrombo-embolism (VTE) and patient falls for the postnatal service and saw that 100% of patients received 'harm free care' for the last 12 months. This information was visibly displayed in the ward area.

Incidents

- Staff knew how to report incidents. On average the service reported 80 incidents per month across the maternity service.
- Staff spoken with reported that they did not always report incidents through the online incident reporting system due to pressure of work.
- There was no mechanism to ensure that all clinical incidents were reported as there was no systematic checking that a form had been submitted for every clinical incident. This identifies a potential for under-reporting harms and near misses within the service as reporting an incident allows the trust to understand the risks and improve safety for patients.
- There was a comprehensive policy for the management of incidents, including serious incidents for investigation and external notification. Staff were working in accordance with this policy and were investigating incidents that were reported.
- The risk management report for the service highlighted delays in receiving reports and updates from staff enabling action plans to be completed in a timely way. This meant it was taking a long time to identify the root cause and embed the learning from some incidents. We saw a number of completed root cause analysis indicating that an investigation had been undertaken to establish the facts, identify learning and take action to change practice where appropriate. This level of monitoring, reporting and action planning would contribute to the safety of patients.
- There had been two maternal deaths in 2012/13.Staff were able to articulate the investigation and learning that had resulted from these two cases. It was clear that learning and changes in practice had occurred, with staff demonstrating the improvements in documentation and information for mothers having home births and the development of multidisciplinary training specific to catastrophic haemorrhage.
- Learning was shared. A newsletter entitled 'Risk Wise' was written and circulated to 'inform, educate and enhance safety and quality, taken from best practice and lessons shared from adverse events locally'. Staff were keen to learn from serious and untoward incidents and to share the learning to avoid repetition in the future and to improve safety for patients.
- Staff spoken with were not aware of any complaints across the units so not involved in learning the lessons from these.

Monitoring safety and responding to risk

- Everyone we spoke with was committed to providing high levels of individual care and treatment and to ensuring the 'safety of both mother and baby'. Risk management and complaints were coordinated through the service risk manager recently appointed in January 2014.

Cleanliness, infection control and hygiene

- There were infection prevention and control leaflets on the wards but a number of them were out-of-date.
- The overall infection control precautions policy was current having been issued in September 2013. We found that it was comprehensive and thorough but we found, in practice, there was limited personal protective equipment available, such as disposal gloves and goggles, thereby reducing staff safety in relation to exposure to blood and body fluids.

Maternity and family planning

- The new midwife-led unit on this site had been in use for 18 months and was painted with brighter colours, with sufficient space, modern equipment and en-suite facilities. These rooms were easier to clean, although it was noted in one room that plaster was exposed on one wall and when asked staff had not reported this.
- Overall, the trust scored as well as other trusts for cleanliness in the 2013 survey of women's experiences of maternity services.

Environment and equipment

- The environment and fabric of the buildings forming the consultant-led Kingsgate ward and delivery suite was in a poor state of repair, poorly lit and staff reported difficult to maintain from a cleaning and estates perspective. We found chipped paint work with exposed wood visible on the doors and doorways. The walls had scuffed paint with large areas where bare plaster could be seen. This posed an infection control risk but staff we spoke with said that they had not reported these problems to facilities.
- The area for storing waste disposal was adjacent to Kingsgate ward and it was observed that there was water leaking from the ceiling. This was considered a hazard for staff and had been reported but no action taken.
- The delivery rooms and ward areas were small, cluttered and cleaning was not up to the standard expected. We found badly stained toilets and dust on trolleys and other surfaces.
- The delivery rooms did not have en-suite facilities.
- Obstetric theatres occupied one half of the ward area and at the end of the delivery suite was an unsecured staff area and storage.
- The postnatal ward cleanliness had been checked in the morning and afternoon, but in one room we found a chair stained with dried fluid, a dirty floor, evidence of patches of damp flaking paint, coffee type stains on the bedside cabinet and the base boards of the bed were scratched and visibly dirty.
- Some patients on the postnatal ward commented in writing on the facilities: 'not happy with mould and mildew in the room' and 'maybe some more baths in bathrooms and mirrors in toilets' and 'would prefer better toilet and bathroom facilities' The antenatal consulting rooms were clean and in good decorative order but the patient toilet facilities were old, in a poor state of repair showing significant staining.
- We also found a sluice room in the antenatal clinic with the fire door propped open and three large sharps bins on the worktop containing infection controlled equipment and materials left in sight. We observed a member of staff testing a urine sample and noticed that they applied hand gel only after the test and left the sample in the room that was open to the public.
- Access to the sink in the sluice room for handwashing was blocked by a trolley.
- We found that equipment was generally available although there were insufficient foetal monitoring machines available on the labour ward for one to be in each delivery room. Three across the service had been 'condemned' but not replaced. This was because the availability of spare parts could not be guaranteed and until such time the monitors needed obsolete parts replacing they were safe to use. Replacement monitors had been ordered but it was reported that there had been a delay in delivery.
- Lack of equipment was not on the risk register, and it did appear not to be of concern to the staff we spoke with. It appeared to be custom and practice not to have a full range of equipment for each delivery room, and staff managed this within their day-to-day practice and did not question or challenge the need to change.

Medicines

- Staff we spoke with knew about how to store and manage medicines management but we found several cupboards and clinical fridges unlocked. There were also gaps in the records including signatures in the controlled drug book. Fridge temperatures were recorded daily.

Records

- Patient notes were well written and clear. As is common nationwide, following booking, women carried their own maternity notes. Good governance processes were observed to ensure notes were entered into the maternity information system as soon as possible after booking.

Nursing and medical staffing

- There was 60 hours of consultant cover per week.
- Not all staff posts were currently filled. There were vacancies due to secondments and maternity leave. We were informed of extended 'acting' arrangements to cover vacant posts. A 'midwife vacancy freeze' had been implemented from July 2013, in response to a fall in the

number of women booking for delivery. The ratios were recalculated using an estimate of the number of predicted births based on the bookings. This had the effect of the trust holding up to 16 midwifery vacancies since July 2013. We saw a recent report written by the Head of Midwifery in January highlighting that there were 16 vacancies in the maternity services across the trust at this time. This, along with a short-term increase in sickness absence, had driven the midwife to birth ratio up to beyond 1:33. This was above the national recommended ratio of midwives to births of 1:28.

- The staff we spoke with were passionate about their work but said that the staffing levels had an impact on morale at times
- One midwife said “we can be very busy and some days I really struggle to offer the one-to-one care I want because I just can't get round to everyone”
- Another midwife said that when “bookings [for births] went down they were very quick to put us on a job freeze, but when bookings went up again, they were not so quick to react.”
- One patient said, “I have not got a bad word to say about them, but I am reluctant to use my buzzer because I can see how busy they are.” However, when we heard the sound of an emergency buzzer we saw the staff reacted very quickly to what was, in the event, 'a false alarm'.
- A member of staff said, “there have been days recently when we have been run off our feet and the care has been safe but a bit basic.”
- Changes to staffing in the antenatal clinic were causing concern for staff we spoke with. The ward clerk had resigned and the replacement process had not begun, even though concerns about the post being left vacant had been raised with the senior midwifery team. It was reported that the staffing resources had been 'stripped' from the team at Margate with resource being focused on the William Harvey Hospital, Ashford, without regard to the demographic profile of women living in the Margate area where there were additional issues such as high levels of teenage pregnancy, mothers from eastern Europe, smoking in pregnancy and growing levels of maternal obesity.

Mandatory Training

- Attendance at mandatory training was planned through the e-roster system with and monitored through the use of a trust-wide database. Compliance with training was at 75%, and using the roster system attendance had improved in the last year and the number of staff not turning up has decreased significantly.
- Midwives were expected to attend four training days each year which included trust and midwifery specific mandatory sessions. Joint ‘skills and drills’ training with medical obstetric colleagues was evidenced.
- Some of the staff we spoke with were overdue their appraisals and some managers confirmed that they were struggling to fit these in. We saw an appraisal list for midwives and saw that approximately 30% were overdue. The results for the 2012 staff survey also indicated that the trust overall was falling behind the national average for the 'percentage of staff having well-structured appraisals in the last 12 months'.

Are maternity and family planning services effective?

Requires improvement

Use of national guidelines

- Most of the clinical guidelines for maternity were out of date. This included guidance on reducing the risk of group B streptococcal infection, and the birthing centre/ home birth criteria, both had expired in September 2011. The guidelines for clinical practice for amniotic fluid embolism expired in December 2011, the guidance for water birth expired in February 2012, guidance on Antepartum Haemorrhage expired in October 2012 and for Breech presentation in November 2013. We found some up-to-date documents still within the expiry dates including guidance for homebirths and an operational policy for newborn security.
- Plans were in place to ensure clinical guidelines were up-to-date. However due to the lack of staff there was not a timely process of review and revision for clinical guidance and standards and that 'women and babies came first'.
- Most of the guidance leaflets displayed on the wards associated with women's' health were out of date. One leaflet 'Monitoring your baby's heart beat in labour' had been produced in March 2010 and referred to out of date guidance and to facilities, such as the Canterbury Birth Centre, which was no longer in existence.

Maternity and family planning

- The leaflets on the website, such as 'Neonatal death' and 'Help for the bereaved ', were up-to-date and informative.

Monitoring and improvement of outcomes

- The Acting Head of Midwifery was working on a new maternity dashboard and showed us an early version of the data. We saw from this that there were 2,227 births in the consultant led ward and 670 births in the midwife-led unit between February 2013 and January 2014.
- This dashboard, including birth data by unit and location, was described as a 'work in progress' but was already being used as a useful tool in benchmarking patient outcomes and would, we were told, be used in the future for improving patient outcomes. It was not currently shared with staff.
- We saw that a number of audits had been completed across the different sites in 2013. These audits and the findings were for discussed at the midwifery management team and across women's health services. We saw audits for newborn feeding, shoulder dystocia, intermittent auscultation of the foetal heart and thromboprophylaxis. All of these included a set of recommendations for improving best practice with a target date for completion. However at the time of our inspection the action and outcomes of the audits were not known and were due to be followed up.
- Maternity services are monitored on their ability to book women by 12 weeks and 6 days into their pregnancy. Data across the service demonstrated that East Kent achieves 85%. The trust have set a target range of 80% (red) to 90% (green). This benchmark is lower than other maternity services.

Multidisciplinary working and support

- Community midwives met regularly with the hospital midwives and co-operated well to provide continuity of care for patients. There was also good communication between medical and midwifery staff.
- Daily audits of all caesarean sections took place on the labour ward where all of the previous day's work was examined by a multidisciplinary team. Other examples of good multidisciplinary working included working between pathology, HIV and screening coordinators and between the antenatal screening coordinator and gastro-enterology.
- Staff within the maternity services worked flexibly between the midwife-led unit and the labour ward and sometimes the community midwives could offer cover, although there was no formal rotation.
- It was reported that there was little engagement with the obstetric team with guideline development. This, we were told, was seen as a midwife function and the team was aware that many of the guidelines and policies were out of date. This was not seen as a service priority.

Are maternity and family planning services caring?

Good

Compassion, dignity and empathy

- We observed staff caring for patients with compassion, dignity and empathy
- There were privacy notices on doors and midwives and assistants knocked before entering.
- On the postnatal ward the patients were asked if they would like the curtain pulled around the bed and their wishes were respected. A midwife care assistant explained that they would usually avoid positioning a patient, who had a caesarean section and could not move around, in the middle of three beds as they would be left without a view of the ward if the two patients either side had their curtains pulled around. They said that they tended to position these patients by the window if possible. This was thoughtful and caring. One patient wrote 'it felt like I was in a hotel - was treated with dignity and respect.'
- We saw written comments from patients on the post natal ward and they were all positive. Comments included 'very helpful and caring and made me feel comfortable. Everything explained in full. Looked after very well'.
- Patients appreciated the care given to them by the staff and one said: 'The specialist care for post C-section mothers was excellent. Very supportive, kind and understanding. Felt treated as an individual with my individual needs and experience taken into consideration. Staff from the midwives to docs to consultants and caring support workers have been great.'

Maternity and family planning

Patient understanding and involvement

- The trust score in the CQC 2013 survey of women's experiences of maternity services demonstrates that East Kent is performing better than other trust's for care during labour and birth. It had also been improving considerably since the last survey in two areas: 'were you spoken to in a way you could understand?' 'did you have confidence and trust in the staff caring for you during your labour and birth?'
- These responses were repeated by the patients we spoke with on the wards and in their written feedback. One patient who gave birth on the midwife-led unit said: 'Our post birth care was such a lovely experience. We had a lot of time for myself, partner and baby to enjoy those first precious moments together.' We were told that partners were involved and were made to feel very welcome: 'There was a private room where my husband could stay with me and baby - sofa bed very handy'.
- The trust also scored well, and better than other trust's, in response to the question: 'At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?' The patients we spoke with said that they felt 'involved in decisions every step of the way'.
- One patient wrote 'I was kept informed of what was happening throughout the day. All the questions I asked were answered fully so I understood'. Another written comment was 'Great supportive midwives! Relaxing setting, really helped. Midwife talked through every stage as it was happening so really put my mind at ease that all was in good hands.'

Trust and respect

- The patients we spoke with were very grateful for the support they had received from staff. They mentioned staff by name. Patients told us they received important information and advice on feeding and caring for their new babies and they appreciated that the staff did not seek to impose their own views and opinions on breast or bottle feeding for example. One new mother said 'they answer my questions when I ask but they are not overbearing or pushy'.
- Interpreters were available.
- We observed midwives responding to patients, answering inquiries and buzzers. We also observed one of the support staff dealing with a confidential inquiry over the 'phone. This was handled with discretion.

Emotional support

- Patients were appreciative of the continuity of carer. One patient wrote in her feedback: 'Familiar faces - members of staff from the labour ward working across both wards enabled supportive yet patient led care. Opportunities to discuss and practice breast feeding guided by supportive midwives and assistants'. At one of the listening events a young mother told us how the midwife had stayed with her throughout the delivery and this was 'exactly what I needed.'
- Staff showed us the facilities they used for patients requiring higher levels of emotional support following the birth of a stillborn baby, for example. They showed us the facilities they had available and guided us through the plans they had for developing these facilities for the future. They had a lead for developing new services for bereavement and they said 'it needs to be quiet and calm, a little away from the noise of crying babies but not isolated'.
- There were contact details for counselling services on the postnatal ward and early pregnancy unit and a birth after thoughts service was available to all women, either through direct contact or via the community midwife.
- Four members of staff, three midwives and an obstetrician had received specialist counselling training to assist women in need of additional emotional support.

Are maternity and family planning services responsive?

Requires improvement 

Meeting people's needs

- We observed that antenatal and gynaecology clinics were running concurrently on the day of the inspection. This, we were informed, occurred on two days per week. Staff confirmed that patients experiencing fertility issues could be seated in the same area as women in late pregnancy. Staff were not aware of any complaints associated with this arrangement but understood that this may be upsetting for some women.
- There was evidence that the trust was providing services to meet the needs of different ethnic and vulnerable groups, although there were also concerns expressed by staff about a reduction in those services.

Maternity and family planning

- A specialist team had been created in response to the high rate of teenage pregnancy, however the team had been reduced from four to two midwives and the funding for an attached maternity care assistant had stopped. The team were by their own admission 'victims of their own successes as local teenage pregnancy rates had dropped. However they did feel that any expansion of the service to offer new initiatives in parenting had needed to be put on hold due to the reduction in staff. Actual figures were not articulated, and the team had not performed any audit or review of the service since its inception in 2008.
- There had been an increase in the number of eastern European migrants accessing services over recent years. A positive move had been the employment of midwives and maternity care assistants from eastern Europe and Russia to help in meeting the differing cultural and language needs for these families
- Throughout the service 'The Big Word' was widely used as a translation tool when English was not the first language of the mothers attending. This is the approved supplier of translation and interpreting services to the NHS, including 24 hour telephone interpreting. For more sensitive discussions and consultations pre-booked interpreters could be arranged and staff said this was not difficult to organise.
- There was a shortage of sonographers leading to a delay in the availability of timely ultrasound scans in pregnancy for women. This issue was raised with us by patients and staff on several occasions. We were informed by several members of staff that 15 sonographers had resigned and left the trust recently, primarily because of changes to their pay and conditions in relation to on call services in radiology. As staff left, locums were engaged and were paid more than the substantive staff. This resulted in some tension and subsequently more staff had left.

Maintaining patient flow

- Women from East Kent were offered a choice of care pathway based on their clinical need, either the consultant-led team or the midwife-led unit. It was evident from maternal notes that appropriate risk assessment was undertaken during pregnancy to ensure clinical complications/deviations from the 'norm' were highlighted and addressed before labour. There were processes in place for midwives to refer directly for consultant opinion at all stages of pregnancy and childbirth
- Births could be at home or in hospital, according to choice and clinical need. There was a flexible choice of location for antenatal appointments either in the community clinics, GP surgeries, children's centres, supermarkets or at the Dover and Canterbury hospitals or at the trust.
- There were good practices and processes for antenatal screening with two screening co-ordinators in post for all women across the trust. There was an antenatal screening offer and 85% of women booked before 12 weeks and 6 days and were eligible for first trimester screening.
- We reviewed some of the written feedback from patients about discharge. One said "Only downside was very long wait for discharge - gave birth at 10 pm and still waiting for paediatrician at 3pm the following day - ready to go home really. I think this was due to staffing levels." Another patient said, "It was a pity about the entire form filling."

Vulnerable patients and capacity

- The perinatal mental health guidelines provided practical information for maternity staff working with patients with an existing mental disorder and a range of conditions including depression, eating disorders and schizophrenia.
- The guidelines indicated that an interpreter should be provided for 'all non-English speaking women'. The guidelines were helpful but the details may be out of date as they had been written in August 2010 and expired in August 2013.
- We saw a copy of the discharge form and observed it being used with patients. Again this form was considerably out of date and overdue for review from July 2008. Two of the patients we spoke with were eager to go home and were waiting for various checks to be completed.

Complaints handling for this service

- Maternity complaints received were handled by the matron.
- Some staff did report receiving feedback following complaints, but the most commonly used feedback from patients was through the 'We Care' programme at ward level. Examples of comments from mothers and

their families were shared with the inspection team. However, there was also some poor examples of incident reporting when a senior member of the maternity team described how she only took action when a mother changed her mind about complaining about her care. Initially the mother did not want any action taken following a fall from a trolley in theatre but changed her mind and submitted a complaint. It was only then that the incident was investigated.

- On the whole we found staff were open and transparent and very happy to discuss what they saw as the positive and the negative aspects of the service. This open and transparent approach was allowing staff to learn from incidents and improve the effectiveness of the service.

Are maternity and family planning services well-led?

Requires improvement

Leadership of the service and culture within the service

- The Chief Executive told us the maternity strategy consultation had been completed and the reconfiguration implemented successfully. This involved concentrating maternity services on a fewer number of sites and the closure of the birthing units at the Canterbury and Dover sites. This clinical strategy was designed to make services safe and sustainable for the future.
- However, we found that there was some disconnect between the strategy and the organisation in general and the maternity services at an operational level.
- Feedback from midwives on e-rostering had not been acted upon and this had caused some disruption of the service.
- We saw evidence that the reconfiguration in the maternity services had not been completed and the focus had moved on to other clinical areas. The pace of change appeared to be a challenge and some of the infrastructure changes were lagging months behind. For example, whilst a birthing centre had been closed at Canterbury for 18 months, the signage still remained on the site and patient leaflets and even parts of the website still referred to this birthing centre.
- The reduced staffing levels in maternity overall were leading to the frequent closure of the midwife-led unit at Ashford and this was undermining the clinical strategy by reducing the choices for women.
- We found that the risk register for maternity was across all sites and the most recent version we saw had an entry for a moderate 'risk of harm to women as a result of inadequate midwife-patient ratio'. This was a risk that had been created by decisions taken at a divisional level not being fully informed by the experience at ward level and perhaps not reviewed in a timely way.
- There had been a high attrition rate of student midwives from the midwifery course. This may have been due in part to the recruitment freeze and the fact that no student midwives from East Kent had been offered posts on qualification in September 2013.
- We were informed that staffing levels were still based on levels set historically. The Birthrate+ formula was being used but was dependent on guidelines for staffing that had been written in 2009.
- Both were significantly out of date and included services in the formula calculation that no longer existed at Canterbury and Dover. Staffing levels had not been reviewed and some staff suggested that, whilst the ratio suggested that there were sufficient staff, they were actually in the wrong place.
- A full review of staffing levels was considerably overdue and this was undermining quality and performance and the delivery of the new clinical strategy.
- The post of Head of Midwifery had been advertised but had not been filled It was suggested that the new post holder would want to bring a new leadership, setting new priorities and a clear refreshed strategy. Developments were put on hold. The role and responsibilities of this post were considerable and the current acting Head was unable to attend to the full workload. We were told that the tasks had to be prioritised and some, including the review of policy and guidance, had not been completed.
- A new deputy post had been created (but not recruited too as yet) and this post would potentially absorb some of the workload.
- Leadership on the wards was effective.
- Some decisions taken at a senior level did not appear to relate to the experience of staff at a ward level. The

decision to 'freeze' vacancies for an extended period and beyond the point at which staff were finding it difficult to cope and were closing the midwife-led service at Ashford.

- Individual members of staff demonstrated good leadership. We also saw that staff were very professional and loyal to the service and committed to providing a good experience for women and their babies.
- East Kent overall had 21 appointed statutory supervisors of midwives. Supervision was described by staff in various ways ranging from supportive to passive. The current ratio of supervisors to midwives across East Kent was a little outside the recommended ratio of 1:15 at1:17 due to at least two supervisors taking a break from this role. This was significant for the service as supervisors conduct independent investigations outside the trust route cause analysis investigation and so provide a further check on the safety and effectiveness of the service.

Patient experiences and staff involvement and engagement

- The consultation processes were extensive throughout the trust, but members of the Board and Executive Team were disappointed by the results from the staff survey. The staff survey results for 2012 and 2013 indicated that communication between senior managers and staff was poor and worse than in other trust's.
- We spoke with a board members about this and they said that they were 'at a bit of loss' to understand it. They said that the patient experience results were improving but the indicators for staff involvement and engagement remained disappointing.

Learning, improvement, innovation and sustainability

- The Acting Head of Midwifery was developing a useful dashboard that will help the local management team identify priorities for the improvement of the service. This dashboard contained parameters and a range of key performance indicators that had been set by the maternity service rather than in collaboration with the commissioners of the service as would be best practice.
- In due course, the use of the staffing acuity tool will also allow the service to review and set the midwife to birth ratio and skill mix at an appropriate and sustainable level across the service.
- The leadership development opportunities were good at the trust and a number of midwives were participating in additional training.
- The team spirit was impressive and staff told us that they were happy to work extra hours and shifts to maintain the service.

Services for children and young people

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

Information about the service

The child health team provides 24 children's inpatient beds on Rainbow Ward for children between the ages of 0 – 16 years. The ward contains nine separate cubicles and a high dependency cubicle together with a 14 bedded bay. The hospital has a special care baby unit and has dedicated outpatient clinics for children (Broadstairs Suite). Children are seen in the main A&E and undergo surgery in the hospital's separate day surgery unit.

Summary of findings

The children's ward, special care baby unit and day surgery unit provided a safe and suitable environment to care and treat children. Parents told us they were happy with the care and support that was provided in these areas. There were suitable numbers of appropriately trained nursing staff and the skill mix reflected current guidelines within the children's services. However children being seen in other areas of the hospital did not experience the same level of care. In A&E children were not always seen by a specialist children's nurse and the children's waiting area was isolated and not always appropriately staffed and was not often used. In outpatients there was not a child friendly waiting area or specialist staff available to care for the needs of children.

Care was not effective. Best practice guidelines or national standards were not followed and most of the information relating to the safe care of children was out of date and did not reference national standards.

Staff in the children's services were providing caring treatment and were supported by their immediate managers. However there was no person at board level with overall responsibility for ensuring the voice of the child was heard and children's issues promoted and taken into consideration. This led to the children's service being fragmented and not taken into consideration during service redevelopment.

Services for children and young people

Are services for children and young people safe?

Good

Incidents

- Children's services used a national NHS framework for reporting serious incidents. We reviewed the past three months of incident reports relating to child health and found that staff were reporting incidents relating to children where ever the child was being treated for example A&E and Outpatients as well as on the children's ward.
- However we had concerns that not all incidents were being reported. No drug errors had been reported and discussed this with staff. They told us that medication errors had occurred however they had not been recorded. The staff we spoke with demonstrated awareness of the trust's reporting systems and could not explain the gaps in reporting. This demonstrated that although there were arrangements for reporting safety incidents and allegations of abuse, which were in line with national guidance they were not always effective.
- Investigations were undertaken in a timely manner with action plans being in place to help prevent further reoccurrence. The action plans were monitored and followed up through the clinical governance reporting systems however we saw that many actions remained outstanding for some time.
- Senior staff told us that various methods to feedback the outcomes of any investigation were used such as a newsletter, team meetings and clinical governance meetings. However front line staff told us they rarely received feedback following reporting any incident.
- We did not see any evidence that when a child had been involved in an incident that they and their families were included in the investigation or that the outcome was communicated to all those involved. This information was not included in the root cause analysis process or the details of the complaints we reviewed.

Safety thermometer

- The safety thermometer was not used across the child health division as it had never been adapted for children's services and did not monitor useful information. We were told that the data was only used to monitor single sex accommodation on a monthly basis.
- We saw that children's services used the NHS Balanced Scorecard to benchmark inpatient services against the national averages although much of this information was not relevant for the services they provided.
- There was a limited understanding of managing risks to children outside of the main children's wards. Staff had not received training in specifically managing the risks to children and did not show any understanding in managing the specialist risks associated with caring for children.

Cleanliness, infection control and hygiene

- Rainbow Ward was clean and tidy with cleaning schedules in place. We saw that checklists were kept to verify that the designated cleaning tasks had been completed.
- We noted that the cupboards and equipment were kept clean and tidy.
- Theatres were clean with processes in place to audit the cleanliness on a regular basis.
- Hand gels were readily available.
- Staff wore personal protective equipment and there were effective arrangements for the classification, segregation, storage, handling and disposal of clinical waste.
- Staff in outpatients told us that sometimes there was a problem in maintaining an acceptable level of cleanliness in the department for children. They gave an example where they waited for over one and a half hours for a cleaner to attend to a spillage of bodily fluids in the corridor.

Environment and equipment

- We saw that on the children's ward the general environment was safe and child friendly.
- Children were kept safe and secure through the use of security doors at the entrance to the wards. There were systems in place to monitor the general environment, medicines management, and cleanliness and infection control.
- We saw various checklists completed by staff to ensure that the ward was kept safe such as health and safety,

resuscitation trolley checks and cleaning audits. Oxygen was at every bed space there were no records available to confirm that this equipment had been checked and cleaned.

- The services for children outside of the main children's wards undertook general risk assessments and monitoring. However we did not see evidence that the general environment was risk assessed to ensure was a safe place to see and treat children. For example risk assessing the particular environmental concerns relating to children such as accessible plug sockets, cross infection from toys, accessing dangerous medical equipment and the security risks where children were cared for. When we spoke with staff we found these issues had not been assessed, monitored or documented.
- Staff told us that across the trust different equipment was being used for the same procedure. They told us they often worked between the different hospital sites and worked with equipment they were not familiar with. They told us this was a potential risk to children's safety. This acknowledged risk was not on the risk register.
- Other directorates were using a technology based system for keeping patient records however this was not in place on Rainbow Ward or outpatients where staff were using a paper based system. This was not best practice as there was a risk of losing information and a risk of miscommunication as the different clinical teams kept separate records. .
- The staff told us they were working towards a paperless system however they did not have the IT support to do this. This meant that there were long delays in patients receiving discharge letters. The medical staff we spoke with told us that there was no time to achieve sending them within the required time frame.

Medicines

- On the children's ward and special care baby unit we saw that there were arrangements to check medication safety and that staff were checked to make sure they remained competent to administer children's medications.
- Medicine fridge checks and controlled drug checks were undertaken on a daily basis.
- The pharmacist attended the special care baby unit and ward weekly to advise on medicines management.
- On the day surgery unit we found that the controlled drugs and emergency trolley were checked on a regular basis.
- We found that children and young people were kept safe on Rainbow Ward, the special care baby unit, theatres and the day surgery unit as there were systems for the safe management of medicines.

Records

- We looked at the care pathway records used for children's surgery and saw that these documented the child's care and treatment from pre-assessment, the surgery, recovery and through to discharge.
- The documentation used included prompts for staff to ensure multidisciplinary working between nursing and medical staff and information sharing with the child's parents.
- We looked at a sample of records and saw that the medical and nursing records were dated, timed and appropriately completed. We saw results of an audit which demonstrated that records on Rainbow Ward were completed appropriately.
- We saw evidence that safeguarding procedures were followed and those children were referred to other services such a mental health teams and social services. We looked at the care pathway records used for children's surgery and saw that these documented the child's care and treatment from pre-assessment, the surgery, recovery and through to discharge.
- The documentation used nationally recognised surgical safety checklists and included prompts for staff to ensure multidisciplinary working between nursing and medical staff and information sharing with the child's parents.
- We saw that the documentation used on the day surgery unit was the same as used on the children's ward and throughout the trust. This was meant that there was good continuity of documentation which reduced the risk of errors being made.

Consent

- Consent forms were completed with guidance for parents and children.
- The guidance referenced best practice and legal considerations when obtaining consent from children and young people under the age of 18.

Services for children and young people

Safeguarding

- There were systems in place to safeguard and promote the safety of children and young people. We saw there were child protection policies and procedures available which referred to best practice and local safeguarding protocols.
- The safeguarding leads monitored staff child protection training across the trust. We looked at minutes from the children's safeguarding and multi-disciplinary safeguarding meeting, which demonstrated that local and national child protection issues were discussed within the child health team. There was a lack of medical input in these meetings; although clinicians were invited they often did not attend.
- The safeguarding team told us of the strong working relationship they had with the local authorities to manage child protection in the local area. They told us they attended the local authority safeguarding committees and worked closely with community teams to ensure the safety of vulnerable children and their families.

Mandatory training

- Staff across the trust told us that in general they felt well supported with appraisals, training and development. They told us that they had regular supervision and appraisals which was supported by the documentation we reviewed.
- Staff told us mandatory training was effective and included safeguarding and intermediate life support training.
- However the senior managers could not provide assurance that national standards and best practice guidelines were being met with respect of staff suitably trained in paediatric life support. There was not a member of staff with advanced paediatric life support skills available on every shift where children received surgical or emergency treatment.
- We found in other areas of the hospital that not all staff caring for children had appropriate training in life support and resuscitation. In A&E and outpatients few staff had received any paediatric life support training.
- We spoke with the resuscitation lead who told us that although staff on the children's ward and special care baby unit were prioritised for paediatric resuscitation training, in other areas of the hospital where children were treated the uptake was poor. This meant that if a child became suddenly acutely unwell the staff caring for them may not have the knowledge and training to deal with the emergency.
- We found the uptake of children's safeguarding training was variable. Staff on the children's ward and in A&E told us they received good safeguarding support and demonstrated an awareness and understanding of safeguarding children. However in other areas of the hospital where children were seen and treated staff were less confident and couldn't tell us when they had last received child protection training.
- We spoke with some of the nursing students working on the ward. They told us they had good support and enjoyed working on the unit.

Management of deteriorating patients

- On the wards we saw there were resuscitation trolleys with appropriate drugs and equipment to deal with emergencies. The trolleys were readily available. We saw that although the drawers on the trolley were not sealed the contents were checked daily to ensure the equipment was complete and drugs were in date.
- The trust used a paediatric early warning score systems (PEWS) to ensure the safety and wellbeing of children. This system enabled staff to monitor a number of indicators which identified if a child's clinical condition deteriorated and indicated when a higher level of care was required.
- The senior nursing staff had raised concerns that the PEWS system was not being implemented consistently across the trust and had conducted a trust-wide audit. However the audit identified and staff confirmed they were confident and competent in using PEWS and knew how to escalate concerns.
- We saw there were basic arrangements in place to deal with foreseeable emergencies. We were shown contingency plans which referred mainly to maternity services and relied heavily on the goodwill of staff. There were no child specific contingency plans in place.

Nursing and Medical Handover

- We spoke with staff who told us that there was a teaching session during every morning handover.

Nursing staffing

- The children's ward and special care baby unit had specialist children's nurses to support children and their parents/carers throughout their care.

Services for children and young people

- The ward team included play specialists who provided cover during the day Monday to Saturday. The skill mix in these areas reflected current professional guidance.
- We reviewed the past three months duty rota's and found that the numbers and skill mix were maintained throughout the week.
- In the day surgery unit we found that staffing was safe as there were two specialist children's nurses on the rota and that their off duty was planned around the children's operating lists. The day surgery unit was fully staffed with no vacancies.
- On the day surgery unit we spoke with senior staff who told us that children undergoing surgery on the day surgery unit were not seen or managed by the children's health team as the management of this unit was separate.
- Children always had a pre-assessment visit with a children's nurse if they were going to be admitted to the day care unit.

Medical staffing

- There was insufficient middle grade paediatric medical cover at night which contravened the British Association of Perinatal Medicine (BAPM) staffing guidelines. There was one paediatric registrar across the hospital, however because the hospital did not offer neonatal intensive care or paediatric trauma this was not such an issue as at other hospital's in the trust.
- The resuscitation lead could not provide assurance that all doctors and consultants caring for children across the trust had current life support training appropriate to their specialty.

Are services for children and young people effective?

Inadequate

Use of National Guidelines

- We found that most of the information relating to the care of children was out of date and did not reference best practice guidelines or national standards.
- There was only one standard operating procedure for the assessment unit, no overarching children's strategy or information about what key performance indicators were used to monitor the outcomes for child care. We had concerns that there were few key documents available on the trust's intranet and no reference to National Institute for Clinical Excellence (NICE) quality standards and other best practice guidelines for staff.
- The trust had various actions plans which discussed implementing standard operating procedures however these had been outstanding for several months. We were told that these were being developed but were not in place.
- This impacted on the care of children because there were no systems in place to monitor if care was being delivered in line with national standards and best practice guidelines.
- We saw that the wards and departments had developed local protocols to assist them in providing care for children. There was a surgeon specific care plan protocol for children undergoing tonsillectomy or removal of adenoids.
- We saw copies of guidance on the wards and departments but much of this information was out of date. In the day surgery unit we found that children were fasted according to the hospitals guidelines which met the best practise peri-operative guidelines. The guidance for this was included in the paediatric care pathway but not in any paediatric surgical standard operating procedure.

Pain Management

- We looked at the pain management of children and saw that the care plan documentation included a standardised child friendly pain assessment tool. However there was no guidance for staff on implementing the tool or the recognition and assessment of pain in children.
- We saw an audit which raised concerns that in February 2013 the pain tool was not being used effectively and saw there were recommendations in place to address this. However on the day of our inspection we spoke with a parent of a child in A&E who had returned to the hospital following surgery the previous day as their child was in pain. They told us that they felt their child had been sent home although they were in pain at the time of discharge. They told us they felt that this had not been managed well. This demonstrated that pain management in children was not always managed satisfactorily.

Services for children and young people

Outcomes for the unit

- The children's services did not use other key performance indicators such as patient feedback or staffing levels to review their performance alongside of other information. This meant that children's services could not demonstrate they used comparative information to benchmark their performance.
- We saw that the child health division had participated in most of the clinical audits they were eligible for.
- However on the ward we saw limited evidence that the results of these audits had been fed back to staff and were being used to improve outcomes for children. For example a re-audit of the Paediatric Early Warning (PEW) Charts undertaken in February 2013 because of senior staff concerns about its implementation gave a number of recommendations which had not been actioned over a year later.
- We saw details of three audits undertaken in 2013 but not a planned programme of regular audits undertaken at a local level across children's services to monitor the quality of care provided. For example there had been no auditing of key performance indicators or monitoring of compliance against national standards such as the British Association of Paediatric Surgeons Standards for Children's Surgery.
- At a local level the safety and effectiveness of the treatment offered to children was not monitored or assessed for example undertaking auditing of medical and nursing records on a regular basis to ensure they contained all the required information on consent and adhered to best practise in record keeping.
- We saw that health and safety audits were undertaken with feedback to staff where action was required to be taken. For example in August 2013 the health and safety audit identified that not all staff had received training in reporting incidents. Although this was identified as an action we did not see that staff training concerns had been addressed.
- The audits did not include safety monitoring of the environment for hazards particular to children.

Care Plans and Pathway

- During our inspection we followed the care pathway of children who were admitted for surgery or were admitted through A&E.
- We spoke with the staff about the child's journey through their departments from admission to discharge. In particular we asked staff from theatres and the day surgery unit about how they made sure children were appropriately cared for during their care and treatment within their department.
- Theatre staff told us that children were always operated on at the beginning of the surgical lists.
- Parents accompanied their child into the anaesthetic room and then met them again after the procedure in recovery. They told us that if there was a problem it was possible for parents to wait in recovery for the child.
- We were told that all children were admitted and discharged by the specialist children's nurses
- The nurses we spoke with on the day surgery unit were committed to safe patient focussed care. They spoke passionately about the care they provided and were knowledgeable about caring for unwell children.

Multidisciplinary Team working

- Care for children with complex conditions was shared with other specialist hospitals. They told us that there was good joint working and coordinated care. They gave examples of the care for children with cancer which was shared with the Royal Marsden hospital NHS Foundation Trust who offered a specialist oncology service for children.
- The team from the Royal Marsden hospital sent specialist consultants to the trust and offered some training for staff in caring for children with cancer.
- The hospital did not undertake surgery on children under the age of one year or 15kg. The trust coordinated care with London hospitals to provide treatment for these patients.

Seven day services

- Senior nursing staff confirmed that the inpatient units offered a consistent nursing service for seven days a week.
- However we found that across the trust there was insufficient middle grade paediatric medical cover at night which contravened the British Association of Perinatal Medicine (BAPM) staffing guidelines. There was only one paediatric registrar across the hospital, however because the Queen Elizabeth the Queen Mother Hospital did not offer neonatal intensive care or paediatric trauma this was not such an issue as at other hospital's in the trust.

Services for children and young people

Are services for children and young people caring?

Good

Compassionate care

- We observed the care being given and saw that on the ward and on the day surgery unit staff responded appropriately to the needs of the children and provided reassurance to their parents.
- The children and families we spoke with on the wards and in day surgery told us that they were happy with the care provided. They told us that the staff were caring and passionate about the service they offered. Medical staff were praised for their commitment and we were told that children's services provided good care.
- This was in contrast to A&E where the children and their parents we spoke with had a different experience.
- A child and their parents told us they had been waiting for over four and a half hours. Staff had not updated them on the reason for the delay. The parents told us they had been 'Put in the play area' and they felt forgotten. They told us that in the children's area there wasn't a vending machine. They told us their experience in A&E was totally different to their experience of care elsewhere in the hospital which they told us was 'Brilliant'.
- Children requiring treatment in A&E may not always have access to specialist children's nurses.
- We found that staff were considerate when communicating with parents and their children and were mindful of respecting their confidentiality. Parents spoke highly of their trust and confidence in the staff. However in A&E we spoke with one parent who was upset that the receptionist had been short with them and that their child's history had been taken in front of other people.
- On Rainbow Ward we saw that children's full names were easily visible on a ward information board. This did not respect the child's privacy and meant that their confidentiality could not be assured.
- One parent told us that although the nursing and support staff were very good they found the medical staff were less approachable and did not communicate so well. They gave examples of lack of communication between the various hospitals their child was receiving care at.

Patient understanding and involvement

- On the wards we saw that there were questionnaires available for parents and children to give feedback on the care they had received. However we did not see that the individual wards and departments had received feedback on the information provided or used this to improve the service.
- We spoke with children and parents receiving care across the hospital on the day of the inspection. They told us that they were very pleased with the care and support they received.
- Parents told us how the staff had gone out of their way to reassure them. They told us they really appreciated being able to stay with their child until they were asleep under anaesthetic and then being able to go with the nurse to collect them from outside the recovery room.
- In the special care baby unit parents told us of the exceptional care they received from the nursing staff. They told us staff were approachable and communicated any issues with care and concern.
- However one parent raised a concern that they rarely saw the same doctor twice and didn't feel they always knew what the baby's care plan was.
- We saw children and their families were supported to make choices with information leaflets that were readily available on the hospital and various conditions. We saw there were many booklets for children available to explain what it was like to stay in hospital and giving information on various conditions.
- Over 5% of the local population was from a diverse ethnic group. Staff told us the leaflets could be translated if required.
- We spoke with a child and their parent in A&E. The child told us they had been seen quite quickly and had no concerns about their treatment. The parent's first language was not English and there was little information readily available to support them. The parent relied heavily on their child to translate what was happening to them.

Emotional support

- We spoke with children and their parents across the hospital who told us that the care they received was usually very good. They told us that the nurses were

excellent supportive and very caring. One parent wanted to particularly praise the play specialist who they said went out of their way to provide care and support. Another told us that the staff always kept them well informed about what was happening.

- We saw that on the children's wards parents were encouraged and supported to visit their child. There were no fixed visiting hours although parents were expected to leave at a reasonable time in the evenings unless there was a problem. Parents told us they always felt engaged with the staff who kept them well informed.

Are services for children and young people responsive?

Requires improvement

Maintaining flow through the department

- The child's health division demonstrated joint working arrangements with other specialist services outside of the area.
- Staff told us that there was good joint working and coordinated care for children with complex conditions.
- We saw that there were appropriate arrangements in place to transfer children who had difficulty in breathing and needed artificial ventilation to another specialist service from outside of the area. Staff told us they received good support regarding this from with link consultants and training.
- We spoke with a child and their parents who were currently receiving joint care between the two hospitals. They told us that although the care was 'excellent' the communication between the medical staff could be improved.
- We saw a child ready for discharge home from the day surgery unit and a device was still attached to their arm. We saw that the paediatric procedure pathway included a discharge checklist which included ensuring that all intravenous devices were removed. The checklist also included ensuring that the parents had a supply of pain killers and if they had any questions about the care of their child. The checklist was not always followed which put children at risk of being discharged with intravenous devices not being removed.
- A child discharged the day before had returned to A&E as their pain management had not been addressed before discharge.

Meeting the needs of all children

- We found that staff made reasonable adjustments where possible for children and their parents to access the service.
- For example on the day surgery unit we spoke with parents whose child had had to cancel an appointment. They told us that there were no problems with changing the date to come back into hospital and that the staff had been very accommodating.
- We saw that the children's ward had taken into account guidance on providing care and treatment to adolescents.
- There were separate bays available with age appropriate activities available.
- Staff told us that if bed pressures dictated sharing facilities they asked the young people who they would rather share with and this was arranged. This demonstrated that the needs and wishes of young people were taken into account when responding to bed and cost pressures.
- In the main outpatients department staff told us that children were not always seen at the beginning of clinic lists and may wait for 90 minutes to be seen. We were told that toys were not provided in some of the clinics and alternative sources of keeping children engaged and entertained had not been explored. This meant that the service offered to children in outpatients did not always make reasonable adjustments to meet and support the needs of children.
- Staff told us that meeting the needs of looked after children in the local area was a challenge. We had concerns that strategies had not been put in place to address their particular needs. For example monitoring their attendance at outpatient clinics with a procedure to follow if they did not attend.

Environment

- We found the inpatient areas provided suitable environments to see and treat children.
- For example Rainbow Ward was appropriately decorated for children with picture, posters and murals.
- We saw that the main theatres were suitable for the care and treatment of children.
- The recovery area had two designated child bays with children's emergency equipment readily available.

Services for children and young people

- We saw that there was a separate area in the day surgery unit for children, which included four beds and a play area. This provided assurance that children receiving day surgery were cared for in a safe environment.
- However in A&E and outpatients there had been little consideration for the needs of children and their parents.
- In A&E we found there was a waiting area for children. However the staff we spoke with told us this was under used as it was too isolated for unwell or small children and there were insufficient staff to maintain a presence in the area.
- In the main outpatients we were told that there was not a suitable child friendly waiting area.
- Children's clinics were held in the same clinic area as the adults ear, nose and throat and eye clinics. Children were seen in outpatients in areas which were not child friendly and had not been adjusted to meet the needs of children.

Communication with GPs and other departments within the trust

- We reviewed the clinical governance reports including complaints for children receiving care at the hospital.
- We noted that a number of concerns raised were linked to outpatient appointment issues.
- We spoke to staff in outpatients who told us that there were issues with the I.T. technical support in the department.
- They told us there were problems with providing GP letters and some clinics did not meet the target for 72 hours and some were weeks behind.

Complaints handling (for this service)

- In February 2014 there were two complaints, in A&E and the ward.
- Staff on the wards told us they were encouraged to resolve all complaints at ward level. They told us this meant they could act quickly to intervene, address any issue quickly, which demonstrated that staff were proactive in dealing with concerns.
- We spoke with parents of children receiving care in the hospital and they told us they were aware of the complaints process but had not needed to use it.
- There was a leaflet titled 'Talk to us'. This was available in all areas throughout the hospital and on the trust's website. The leaflet gave contact details of the patient experience team and information about how to raise a concern. We saw that this leaflet had information in other languages about how to access further information, support and advice.

Are services for children and young people well-led?

Requires improvement

The trust did not have documented strategic objectives for the care and treatment of children. Frontline staff were unaware of the trust's vision and values regarding the provision of care for children.

Staff were not aware that there was a named board member with overall responsibilities for the care of children and young people within the trust. This meant that there was not a senior person at board level who understood the key risks associated with providing a paediatric service and had the responsibility for ensuring the child's voice was heard and their rights and issues were considered and promoted.

Although the childrens service was well led at ward level and in day surgery and theatres, we found the quality of care and treatment for children and young people varied across the hospital. This was because there was no person with strategic responsibilities for the care and welfare of all children in the hospital wherever they were seen and treated.

The trust had a clinical governance structure in place with processes for assessing, analysing and monitoring untoward incidents, complaints and clinical audits to build a picture of safety performance. However we found that the trust was slow to take action to rectify situations which put the care and welfare of children at risk.

Vision and strategy for this service

- The trust did not have documented strategic objectives for the care and treatment of children. Frontline staff were unaware of the trust's vision and values regarding the provision of care for children.
- The trust told us there were plans in place to review the provision of some of its surgical services looking at a single site for surgery across Kent.
- We were told that the changes would take place within six weeks.

- Many of the clinicians, nursing staff and members of the public expressed concerns about the safety of the re-configured surgical services.
- They told us the hospital chosen to be the new surgical hub did not have any children's inpatient beds and only offered a minor injury service between 9am and 4pm. There was no accident and emergency or trauma service at the chosen site.
- They told us the impact of the proposed changes did not take into account the needs of children who may be subject to several journeys across the county between the three hospitals in the trust in order to receive appropriate surgical care and treatment.
- Clinicians told us that they did not feel they had been involved in the decision making process and the risks to children had not been considered.

Governance, risk management and quality measurement

- There was a clinical governance structure in place to monitor data from various sources such as patient safety incident reports, complaints, health and safety incidents, inquests, claims and clinical audits to build a picture of safety performance.
- The hospital had systems in place to identify, analyse and review risks, adverse events, incidents errors and near misses.
- We saw that monthly meetings took place where this information was reviewed and then fed into quarterly trust Board meetings.
- We noted that several of the actions from the governance meetings had been outstanding for long lengths of time. For example updating policies, guidelines and developing standard operating protocols for child health had been outstanding for many months.
- This meant that although there was a governance structure in place the delay in implementing agreed actions put children and staff at risk.
- Front line staff told us about the areas they were concerned about and we saw that many of these issues were documented on the Child Health Risk Register and in action plans. We found that many of the issues the staff raised as risks and concerns were either not on the trust's risk register or had been removed without being resolved. For example the lack of middle grade medical cover and paediatric resuscitation training.
- We noted that little action had been taken to address the identified risks. For example in January 2010 staff raised a concern that the emergency care pathway did not meet the national service framework for children in A&E. The trust had set a target date for meeting the framework of July 2014, which meant that for four and a half years the hospital did not meet best practice guidelines for the safe care of children in A&E.
- Two other items on the Risk Register had been outstanding since 2009.
- We saw that in 2012 the trust had concerns that there was insufficient middle grade medical cover however this was removed from the risk register in September 2013. During our inspection we identified there were still concerns with the level of middle grade medical cover and this risk was added to the register again during our inspection.
- We also raised concerns about the safe care and treatment of children in areas outside of the main children's wards which was added to the risk register during the inspection. These issues did not give us confidence that the risks to children across the hospital were appropriately assessed, monitored and managed.
- The hospital could not demonstrate that there was a systematic process in place for implementing and monitoring best practise guidelines and standards or the impact on the care and treatment of children. For example the monitoring of paediatric key performance indicators.
- We saw that both the formal and informal complaints received fed into the hospital's clinical governance processes. On a monthly basis the individual complaints were reviewed and the statistical information fed into the quarterly report to the trust board.
- We saw that the trust continuously monitored the complaints information it received.
- However the monthly reports and complaints log did not provide assurance that the complaints had been handled in a timely way. The monthly reports did not include the action taken to resolve the complaints or demonstrate any learning had taken place.
- We found that the governance of child protection arrangements were strongly embedded and although there was a lack of medical input, the safeguarding team effectively worked hard to protect vulnerable children in the trust.

Services for children and young people

Leadership of service

- The National Service Framework for Children states that all trusts should have a named individual with responsibilities for the planning and delivering services for children.
- The responsibility for implementing the standard should sit in the trust's clinical governance framework for which the chief executive is responsible to the board.
- The trust did not have a named non- executive director with overall responsibilities for the care of children and young people within the trust.
- This meant that there was not a senior person at board level who understood the key risks associated with providing a paediatric service and had the responsibility for ensuring the child's voice was heard and their rights and issues were considered and promoted.
- For example the proposed reconfiguration of surgery placed children at risk from multiple transfers to receive appropriate care.
- We did not see an impact assessment relating to this issue and the senior medical staff we spoke to had grave concerns about its implementation.
- We spoke with senior managers who had responsibilities for different aspects of child care across the hospital.
- We found that the management of the care of children and young people across the hospital was not coordinated. For example the paediatric matron told us that they were responsible for the care of children admitted to the children's inpatient. The care of children in other areas such as A&E, outpatients and day surgery did not fall within their remit.
- However all the senior managers we spoke with were committed and passionate about the care of the children within their area of responsibility.
- We found there was effective leadership where front line staff provided direct care to children. For example both theatre suites had effective leadership with positive line management in place.

Culture within the service

- We spoke with senior nursing staff who told us that they felt well supported by the trust's divisional leads. They told us that their managers were visible and accessible.
- We found that senior staff worked hard in a complex environment to manage the needs of children over the three different sites.
- We spoke with frontline staff nursing, support and therapy staff that cared for children in the child health division. They told us they had the opportunity to contribute their views to the medical team and felt valued and listened to. We found the culture throughout the hospital to be open and honest with staff acknowledging where improvements could be made.
- This demonstrated a supportive team culture within the child health division.
- However across the hospital many of the frontline staff we spoke with told us that they had never seen senior members of the trust as they did not visit the wards and departments or speak with staff.
- Front line clinicians did not feel that the trust Board listened to their concerns about maintaining a safe paediatric service.
- We saw evidence that where clinicians had raised concerns about the care of children in the trust little action had been taken.
- For example serious risks to children had been brought to the chief executives attention in 2011 and at this inspection we were concerned to note that the same issues remained outstanding.
- The trust told us that they needed to reconfigure the surgical provision across East Kent to ensure its future sustainability.
- Concerns were raised by clinicians, nursing staff and the public that the proposed changes did not take into account what this would mean for the paediatric service.
- Clinicians told us they did not feel involved in the process and although they had an opportunity to state their concerns at the end of the week the overwhelming consensus was that the surgical reconfiguration would be taking place within six weeks and the clinicians would have to work round the implications for the child health division.
- The trust told us how they were disappointed with the results of the NHS staff survey. They told us they were taking action to address staff concerns and the areas highlighted as falling below the national average.
- We saw that the trust conducted an engagement survey in 2013, which involved all staff across the trust.
- The results from this survey indicated that there remained issues the trust needed to address. For

example the survey indicated that the child health division scored low on 'I am able to make improvements in my area of work' and 'I would recommend my organisation as a place to work'.
- We saw that the action plan prioritised developing the administration team to expand and consolidate their knowledge.
- We noted that the trust was concerned about the engagement of their staff but queried if the action plan would address the staff concerns.

Innovation, improvement and sustainability

- At ward level we found little evidence of innovation in dealing with issues and overcoming barriers to care.
- Although the staff we spoke with were dedicated to the care of the children in the trust they did not feel empowered to propose changes or make suggestions.
- For example senior members of the paediatric staff had not investigated, assessed or monitored the care of children throughout the hospital to ensure that the health and welfare of children were considered and promoted wherever they were seen and treated as this wasn't in their job description.
- We were told that there was a business case to increase staff for the paediatric admission unit, with plans to develop and train staff to fill the posts.
- However we noted that staffing on the children's wards has been an issue at the trust for many years and a business case to develop the assessment area and staff it adequately had been submitted several years ago and had still not been fully resolved.

End of life care

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

Information about the service

There is a specialist palliative care team (SPC) led by a nurse consultant in palliative care medicine that demonstrates a high level of specialist knowledge, service delivery and strategic planning. We saw evidence that systems were in place for the referral, assessment and review of end of life patients to the SPC team. The SPC team ensured patients received appropriate care and support with up-to date holistic symptom control advice for adults with advanced, progressive, incurable illness in their last year of life. We saw evidence that the SPC team supports and provide evidence based advice to other health and social care professionals and we were told by ward staff that they are highly regarded across the trust. We saw evidence that urgent referrals were seen on the same day.

We visited Fordwich, Minster, Deal, Coronary Care Unit, Viking Day unit (chemotherapy out), bereavement office, hospital mortuary, and the hospital chapel. We reviewed the care records of six patients at the end of life, observed the care provided by medical and nursing staff on the wards; spoke with three patients receiving end of life care and their relatives. We spoke with members of the hospital's SPC team, ward staff, relative support officers and mortuary staff. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

Summary of findings

The Specialist Palliative Care (SPC) service provides specialist advice and guidance for individual patients and family members. However the work performed by the SPC team cannot reach all patients receiving end of life care. In the wards we visited we saw little evidence of obvious strategic trust-wide leadership and support for end of life care. Although individual staff were committed, the result is an ad-hoc reactive response since the removal of the Liverpool Care Pathway. Nursing and medical staff we spoke with highlighted gaps in their end of life training, no increased staff levels to support wards with patients nearing the end of their lives, and poor documentation resulting in a disjointed approach to end of life care.

Not all 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms documented the involvement of patients and their relatives. Some were not signed by a senior health professional.

Effective care was being delivered by specialist teams across the trust including the SPC team, ITU, CCU and Fordwich Ward, with input from multi-disciplinary teams who meet regularly to collaborate and consolidate knowledge. This ensures that patient received specialist end of life care receive the best planned care possible.

End of life care

Are end of life care services safe?

Requires Improvement

Incidents

- Systems were in place to review and share good practise through departmental staff meetings.
- All staff we spoke with stated that they were encouraged to report incidents and received direct feedback from their ward manager. We were told that as a result of incident reporting chemotherapy was being delivered to the outpatients department in timely manner after problems with the late delivery of chemotherapy.
- We saw evidence that the hospital had responded to a Rapid Response report, National Patient Safety Agency (NPSA) /2010 RRR019 safer ambulatory syringe drivers. All syringe drivers had to be replaced by December 2014 due to a fatal error reported. The SPC nurse consultant put together a business case which resulted in new syringes arriving in February 2014 .A full training programme was set-up, but attendance from wards was poor, so subsequent on-line training was introduced and the SPC nurses support individual nurses on the ward when a patient requires drug therapy (often controlled drugs) through a syringe driver. There was a risk that inadequate numbers of staff have been trained to support a safe service 24/7.

Cleanliness, infection control and hygiene

- We observed a patient receiving end of life care. We saw that the patient was well groomed, clean, had good mouth care and was comfortable in bed. The bed linen, patient locker and chair were clean with a glass, water and nurse call bell close to the patient. This meant that systems were in place to deliver good patient centred care in a clean environment.
- We observed the mortuary viewing suite had easy to clean flooring and all areas were clean and dust free. Staff told us that there was suitable personal protective equipment, including gloves and aprons, available in the mortuary as well as hand washing facilities. Mortuary staff we spoke with were aware of the importance of good infection control procedures.

Medicines

- We spoke with three junior doctors who had different experiences of prescribing for end of life care.
- One junior doctor was able to identify easily the on line trust protocol for prescribing end of life medicines.
- However two other junior doctors didn't know what and when to prescribe and started the weekend “not knowing what to do” another said “very good palliative care is only available 9am to 5pm Monday to Friday and not at weekends.”
- All three junior doctors told us that they had not received training in end of life care over the past year or educational support for the phasing out of the Liverpool care pathway which meant patients safety was at risk.

Records

- We reviewed the personalised care plans of three patients who were receiving end of life care on Minster and Deal wards. The medical notes contained appropriate records about their medical and nursing care, communications with the patient and family and ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNA CPR) forms.
- We looked at three DNA CPR forms and found that all decisions were recorded filed at the front of the notes allowing easy access in an emergency.
- On visiting other wards in the trust that there were variations in the completeness of the DNA CPR forms with several not signed by a senior health professional or discussions having taken place with the members of the multidisciplinary team or family.
- We were told that patients undergoing chemotherapy, had separate chemotherapy medical notes and staff did not routinely have access to the main medical notes where DNA CPR forms would be kept. This meant that staff would not have access to this information in an emergency and could result in staff going against the patient’s wishes.
- We discussed with the senior staff how they managed situations where people lacked capacity to make decisions for themselves. We were shown how a different type of consent form was used and how family members and health professionals were involved in making decisions in the person's best interests. This included the use DNA CPR We looked at these on a range of records and in most cases it was clear that decisions not to resuscitate had been made either with the person or in consultation with their family and doctors. However we did note that on some of the DNA CPR forms we looked at, the counter signature by a senior health professional was missing.

End of life care

Staffing and training

- The End of life care strategy, published by the Department of Health in 2008, promotes high-quality care for all adults at the end of life in England. To deliver this vision, the trust had developed a specialist palliative team that could provide timely SPC and advice for people approaching the end of life (NICE, 2011 Manual for cancer services, 2004).
- SPC across the trust was provided by the SPC team. The team consisted of an SPC nurse consultant, who provided specialist support across all three trust sites, six clinical nurse specialists, three counsellors and two social workers. The SPC team was supported by a medical palliative care consultant from the Pilgrim's Hospice.
- Staff within the SPC team told us that, with the present staffing levels, it was not possible to support all patients receiving end of life care across the trust, so care was provided to those patients whose symptoms could not be managed in a timely way by their usual care team, but who might benefit from SPC.
- The Department for Work and Pensions (DWP) predicted an increase in people aged over 65 in Kent from 17.6% now to nearly 24% by 2013.Thanet and Dover were predicted to have the highest number of people aged over 65 by 2013 (DWP, 2013) Without investment in the SPC team, not all end of life patients would have been afforded the specialist care this team could deliver across the trust, and so meet the outcomes recommended in the End of life care strategy (2008).
- We were told by staff on one ward that there were concerns regarding the staffing levels on the medical wards and that there were often insufficient nurses to meet the needs of the ward and patients on end of life care.
- We were given an example from a member of staff that the medical ward been asked to give up a band five nurses post and replace it with a band four non-qualified post, we were told that this would leave the medical wards short of nurses to take charge and perform the medication round therefore placing extra pressures on a smaller cohorts of trained staff to deliver safe and effective care to patients.
- We observed that the atmosphere within the ward was rushed, staff remained composed, polite and professional under difficult circumstances but they did express they were worried about "the care dying patients were receiving."
- We were told that extra staff would not be allocated if patients were approaching their end of life which meant that staff did not have the time necessary to support patients that required extra nursing support or were distressed or anxious.
- Across the trust an e-learning module was available on end of life care but we were told that this was difficult to access and, in talking to staff; we did not find many who had undertaken the module, which was not mandatory. We therefore concluded that gaps existed across the end of life pathway because of the lack of training of the staff delivering the care

Are end of life care services effective?

Requires Improvement

Evidence-based guidance

- The latest figures from the Department of Work and Pensions for East Kent (2010) showed that 49.4% of people died in hospital. More people died in hospital than in any other setting. The national End of life care strategy (2008) aimed to improve end of life care for all.
- We saw that the trust had followed the National Institute of Health and Care Excellence's (NICE) quality standards for Improving supportive and palliative care for adults with cancer (2004) guidance reflected in the Manual for cancer services (2004) and had a specialist palliative care (SPC) team in place that was demonstrating a high level of specialist knowledge, service delivery and strategic planning and providing wards and departments across the trust with up-to-date holistic symptom control advice for patients in their last year of life.
- We saw evidence that the SPC team supported and provided evidence-based advice to other health and social care professionals by providing advice and training.
- The SPC team had an operational work plan in place, which demonstrated an integrated and equitable approach to SPC provision across the trust's three hospitals.
- We saw further evidence that the team had an integrated approach to end of life care as demonstrated through the 2012 peer review process and the successful launch of an end of life board.

End of life care

- National Policy directives required the development of acute oncology services to offer timely and appropriate advice to patients with problems associated with treatment or advancing cancer. This was implemented in April 2013.
- The acute oncology matrons facilitated the admission of acutely ill patients into the Clinical Decisions Unit which prevented patients having to wait in A&E.

Care Plans and Pathway

- On visiting wards and departments an overall impression was that staff did not recognise those patients who were at the end of their lives because there was no mechanism to identify patients since the withdrawal of the Liverpool care pathway.
- End of life care across the hospital was a developing service. Many of the wards we visited were providing it for patients and their relatives.
- We were told by one member of the SPC team that they do not necessarily know how many end of life patients were in the hospital at any one time, as they "do not see them all" as they review patients that have complex symptom's in the last 72 hours of life.
- Patients reviewed by the SPC team, have comprehensive care plans in the medical records and in their own SPC team notes which allows the SPC team to follow the patients in the ward and when they leave the ward.
- The chaplaincy service was audited. Records showed the number and type of consultation undertaken, but no indication of the quality and effectiveness of the service the chaplaincy provided.
- We spoke with staff in the mortuary about the arrangements for transporting patients to the mortuary. Porters had received training to ensure that they were able to carry out the necessary procedures in the mortuary at weekends and overnight. This meant that delays in the system would be prevented because night and weekend porters had been trained to ensure a streamlined consistent service was in place.
- The bereavement team carried out the administration of a deceased patient's documents and belongings, providing practical advice and signposting relatives to support services such as funeral directors. The office was open limited hours, Monday to Friday.
- Death certificates were produced within 24 hours, but this could be extended if the doctor was on nights and not returning to the hospital for two days.
- We were told that there was no training given in this role but support was available from the chaplain if needed.

Multidisciplinary Team (MDT) working

- We saw evidence in patients' medical records that MDT discussions were taking place around patients towards the end of life in areas including the intensive therapy unit, the Fordwich Ward, coronary care unit and the SPC team.
- On visiting ITU, we observed practices, following national guidance, for the withdrawal of life-sustaining critical care treatment. The process could only begin after discussion had taken place with the relatives, patient and the MDT. The protocol gave direction to the medical team around the prescribing of medication and the removal of certain active treatments.
- After this process was completed, patients were transferred to wards and referred to the SPC team.
- All decisions made by the MDT had to be documented. With this system in place, continuity in care could be maintained and active treatment removed in a safe environment.
- As part of the national peer review, which was a national quality assurance programme, an MDT had been set up for the SPC team .This was a specialist multi professional team that made decisions together about how someone was to be cared for during the course of their EOL care. The team would consist of core members, such as the medical palliative care consultant, CNS, chaplain and other associate members.

Seven-day service

- We saw that systems were in place (such as shift patterns and on-call rotas) to provide timely SPC and advice at any time of day or night for people approaching the end of life who might benefit from specialist input.
- Patients could be referred to the SPC team via telephone or the hospital management system, Monday to Friday 9am–5pm.
- Families could ask to see the team through the ward staff.
- Out of hours and at the weekend, the local hospice would give advice and support.

Are end of life care services caring?

End of life care

Good

Compassionate care

- Three nursing care records on one ward showed evidence of good care, which included notes of regular discussions with patients and their families.
- We spoke with two patients and one relative receiving end of life care. Patients and relatives were positive about the quality of end of life care.
- One patient that we spoke with said that “they were very happy with the care they had received.” We were told that they had been seen by the SPC team today and “felt well supported by the palliative care nurse" and that as well as advising on medicine they would organise a hospice admission for the next day. Overall they had had a positive experience.
- Another patient told us that they had been admitted to the ward after a fall at home through A&E. They told us that "Sunday is not the best day to come to A&E as it was very noisy and chaotic" After being admitted the relative said that "they do the best they can on this ward but they do not have as many staff as there is at the hospice" and we were told that the relative had been asked if they could come in and help their relative at supper time." Although the relative was appreciative of the care his relative was receiving they felt it was evident that the staff could not deliver the extra care need to support this patient at the end of their life.
- We saw on the notice boards that compliment cards from relatives whose relatives had passed away on the ward. All cards we saw were complimentary of the care patients received.
- For relatives of patients approaching their end of life, staff told us that meals, tea and coffee was offered to relatives.
- Open visiting times allowed families to come and go as they wished.
- We were told by staff in the mortuary that viewing can take place the following day if no post mortem needed to be performed. The mortuary staff told us that viewings could be arranged through the relatives officer but they tried to discourage viewings at the hospital as the environment could be noisy due to machinery and telephones ringing.
- We were told that one hour slots were available for family to view their relatives and that during the viewing families were supported by the ward staff, relative’s officer or mortuary staff.
- Staff told us that they treated patients with respect and dignity while under their care by the careful movement and storage of the patient and until they left the hospital.
- We observed staff being kind and caring towards patients as well as being welcoming and reassuring.
- There were information leaflets, a supply of water and tissues and private areas allocated for private conversations to take place.

Emotional support

- We were told by the SPC team that emotional support for families was through the social workers in the team and the counsellor or psychologist who offered direct contact with patients and their families. We were told that one of the social workers was a ‘trusted assessor’ who could speed up the discharge process for those who wished to die at home so that their wishes and preferences could be met in a timely manner and prevent further distress.
- Emotional support was also delivered through the chaplain’s office. We saw leaflets advertising the service and how they offered to support patients and relatives whether religious or not. The chaplaincy could be contacted via the ward staff and patients could request to see a chaplain at any time because they provided a 24-hour service.

Are end of life care services responsive?

Requires Improvement

Access

- The trust provided timely specialist palliative care and advice at any time of day and night for people approaching the end of life who benefited from specialist input - the SPC team and hospice support.
- The Intensive Therapy Unit (ITU) provided support from midnight onwards to support frontline staff with patients with complex symptoms.
- Patients were referred to the SPC team via telephone or the hospital management system, Monday to Friday 9-5pm.

End of life care

- Out of hours and at the weekend the local hospice gave advice and support.
- The case load of the SPC team was 40% non-cancer patients and 60% cancer patients. .
- The team worked across two hospitals but all patients referred as urgent were seen within 24hours Monday to Friday. Patient records we reviewed confirmed this.
- Attempts were made for non urgent patients to be seen within 24 hour.
- Wards were advised to make referrals before 3.30pm on a Friday afternoon in order for patients to be reviewed before the weekend.
- The Palliative care medical consultant provided additional support to the wards over the weekends.

Discharge arrangements

- Patients under the SPC team who wished to return to their home, hospice or care home were put on the fast-track discharge pathway. We saw detailed evidence of the 'MDT Activity checklist summary pathway' which was developed to support staff in the necessary processes that needed to be completed for the safe discharge of end of life patients.
- Discharge checklists were available for all staff to access and were part of the hospital's discharge policy. Patients were discharged home or to a nursing home once suitable community packages of care had been put in place.
- Access to community packages of care varied, but the average time taken to arrange a package was 4–5 days with delays often occurring due to the many people involved in the process.
- The team aimed to achieve 100% of patients dying in their preferred location. Currently the SPC team were achieving 75% of their patients dying in their preferred location.
- Delays in viewing relatives occurred when a post mortem had to be performed. Hospital related post mortems sometimes required an independent pathologist and at present we were told it was difficult finding one available.
- Other delays occurred when death certificates were not signed within 24 hours. This meant that although staff were caring in their approach delays in the system meant relatives may have to wait several days to get there relatives released from the hospital.

Records

- The SPC team had undertaken an audit across the trust on end of life documentation in 2013. Of the 58 patient records audited all 58 had DNA CPR forms in place but 13 of the forms had no discussion documented with patient/relative/carer about DNA CPR status.

Meeting the needs of all patients

- We reviewed the end of life board minutes and saw that the SPC team had highlighted that conversations with patients and families were not always being documented, and we confirmed this when we reviewed medical records across the wards we visited. To respond to this, the SPC team had developed a proforma, "a record of end of life conversation", to gather the preferences and wishes of end of life patients irrespective of whether they had been referred to the palliative team or not.
- The proforma was having a phased introduction and would be launched on 20 March 2014. By introducing this conversation form, the SPC team were endeavouring to ensure patients had their wishes and preferences recorded in order that those can be fulfilled in the last weeks or days of their end of life care.
- The chaplaincy was the referral point for other faith leaders and organisations.
- Regular services were held in the chapels.
- Funerals and memorial services were performed. We saw records that confirmed that there had been an increase in the number of funerals performed by the chaplaincy in 2011/12 and 2012/13.
- A significant project was initiated and led by the Nurse Consultant, as a response to relative's needs, for a private space in the hospital, to maintain their dignity when upset and distressed. We were told by then Nurse Consultant that a successful bid to the kings Fund for funding was achieved; a suite has been designed and built, with extremely positive feed-back from relative.
- We were told the SPC Team that after listening to patients and staff about how to improve end of life care "project Invicta" was set up address the concerns about gaps in services provided to patients and their relatives 24/7. Staff told us this project was underway in the hope that patients and relatives could contact specialist knowledge and skills 24/7 if support was needed at any

time day or night. However the senior staff told us the project was a Hospice led initiative which was disbanded in 2013. The 24/7 call line was hosted and funded by Pilgrims Hospice.
- There was no viewing room available for relatives to see their loved one at this time and staff told us that they ensured the curtains were fully drawn and they could access a portable screen for further privacy if required.

Facilities for relatives

- There were no allocated relative's rooms on wards and relatives and families were taken to offices or staff rooms when they were upset or anxious which meant grieving families were not afforded dignity and respect when they were at their most vulnerable.
- A relative's suite was available 24/7 for relatives of patients receiving end of life care.

Communication with GP's and other departments within the trust

- We were told by the SPC team, and saw evidence to support this in the SPC annual report, that they were developing an electronic record system ('Share my care' to be implemented and linked to GPs). This would support a more robust activity and monitoring system, and real-time interventions. At present, the SPC and medical staff needed permission to access GP records, which meant consistencies in care might be lost.
- Other integrated pathways were in place around the fast-track discharge process along with the multidisciplinary team meeting and the end of life board all demonstrating strong collaborative partnership that was in place to ensure that patients received streamlined palliative care.

Complaints handling (for this service) and feedback mechanisms

- Complaints were handled in line with the trust policy. We were told by the SPC nurse consultant that complaints for end of life care is usually about communication and pain control. To address these issues that "record of end of life conversation" has been developed as mentioned and with regard to pain management training needs to be developed further to support the junior doctors.
- The SPC team, as discussed at the end of life care board in March 2014, were developing a pilot project to engage with relatives of recently bereaved to gain feedback. At present this is still in the planning stage. Presently it is only the ITU department that received feedback from relatives whose family have passed away in the trust.

Are end of life care services well-led?

Requires Improvement

We reviewed the minutes from the past nine months' end of life board meetings and saw that the attendees included a multi professional team.

The board was supported the implementation of palliative and supportive care practices and over the past nine months it had been actively involved in the development of the end of life pathway by initiating the "record of end of life conversation" and offering best practice advice.

Other initiatives included the 'end of life doing it right' quality standard and awareness programme, 'amber care bundles' pilot as an alternative to the Liverpool care pathway, release of a video statement regarding the LCP, panel discussion with junior doctors and the Invicta project (development of a single point of contact for patients and relatives for supportive care).

It was clear from documentation and talking with the SPC team that they were very knowledgably, patient centred and responsive to the palliative care needs of both the patients and relatives.

Staff across the hospital spoke very highly of the SPC team and the work they undertook led by the nurse consultant.

Nurses we spoke with on the wards felt comfortable about accessing hospice support during the evening if end of life patients developed complex management issues. We were told by ward staff that the intensive therapy unit outreach service was available to support them during the night.

Leadership and culture

- There was no obvious strategic trust-wide leadership, documented strategic direction and support for end of life care.
- Individual staff were committed.
- The lack of trust board direction was observed in a non-unified approach to end of life care across the wards and departments.

End of life care

- This was observed through different approaches to and methods of recording in medical records, different wards and services used different forms or obsolete forms still in use.
- The SPC team led on a trustwide project to implement one policy and procedure and training scheme. However we were told staff did not attend training as ward managers could not release them they daily roles.
- Within the SPC team felt the leadership was supportive and approachable.
- They worked closely as a team and that they were kept informed about what was happening within the team.
- They had access to counselling services through occupational health.
- We found a lack of evidence of support for the end of life care agenda above the ward level.
- There was no end of life care champion at trust board level to strategically lead to deliver the national End of life care strategy (2008) objectives.

Patient experiences and staff involvement and engagement

- Feedback from bereaved families was not collected except for in in the intensive therapy unit. There were plans to roll this out across the hospital but timescales were unknown.

Learning, improvement, innovation and sustainability

- We saw the innovative work that had been undertaken by the small SPC team which had enabled patients across the trust to benefit from a more patient-centred service. Innovative work included development of the relatives' suite.
- The team had introduced electronic palliative care records that allowed timely access to patients' records by all healthcare professionals, and enabled safe and consistent care to be delivered at all times.
- We observed the end of life board in practice. The board was unique to NHS hospitals and steered the clinical agenda to ensure that the palliative care agenda across the trust had a multi professional approach and was open and transparent.
- The integrated working with the Pilgrim's hospice had been enhanced by good leadership from the nurse consultant, which meant that patients benefitted from streamlined pathways of care across both the hospital and the community.
- The SPC team raised concerns about the sustainability of the service. Concerns included the rise in dementia patients and the implications of this for their own limited resources. These might mean that only a limited number of patients would have access to the service, which would be against national recommendations.
- The SPC team told us that they were experiencing difficulty in recruiting specialist staff due to the aging workforce and demographics of East Kent.
- The current model of SPC and end of life care was not sustainable; a review was under way, linking with local hospices, but tension with funding, especially to provide integrated health and social care, was a challenge and, because of the dissolution of the cancer networks, shared intelligence and expertise across Kent had been diminished.

Outpatients

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Outpatient services are located over two floors with three outpatient areas. They all share one reception desk which is located on the entrance to the department.

The trust offers outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up are required. The hospital offers clinics in haematology, colorectal, ear, nose and throat (ENT), urology, general surgery, rheumatology, respiratory, endocrinology, medicine, neurology, dermatology, diabetes, pain, vascular, and gastroenterology.

During our inspection we spoke with eleven patients, one relative, and thirteen members of staff. Staff spoken with included reception and booking staff, clerical and secretarial staff, nurses of all grades, doctors, and consultants. We observed care and treatment. We received comments from our listening events, and we reviewed performance information about the department and trust.

Summary of findings

All the patients we spoke with told us they felt they had been treated with dignity, and that they had found staff in the department polite and caring. They were kept informed of any delays in waiting for their appointments.

Staff used the incident reporting system and there was examples of changes as a result of learning from incidents. We found that staff were collecting data on waiting times and overbooked clinics, but, while they were aware of the issues, they felt unable to make improvements to this area of the service.

We found that some clinics were very busy and that staff outside of the department routinely overbooked patients for clinics because the number of appointment slots did not always reflect patient requirements. Patients could therefore experience long waiting times.

Patients who required follow-up appointments told us that they often had these appointments cancelled and moved to a later date. They also complained that they had to wait too long for follow-up appointments. Staff told us that, when appointments needed to be cancelled, it was generally follow-up appointments that were cancelled because this did not affect the trust's targets for 2- and 18-week referral to appointment.

We noted that the department was led by a manager and matron who were respected and liked by their staff.

Outpatients

The staff were aware of their responsibilities and had all passed competency assessments to ensure that they were able to perform their roles to the required standard.

Are outpatients services safe?

Good

Incidents

- Staff used an online incident reporting tool system to record any accidents, incidents or near misses that occurred. We were told that all staff had received training on this system, and had access to computers.
- We saw that staff had used the reporting system for a variety of incidents which included misfiled patient records, late starting clinics, and patient falls.
- Feedback from incidents and accidents to staff were shared daily during 'walkarounds' and formally at team meetings.
- Feedback from other divisions on their investigations into incidents were not always forthcoming. We were told that when asked they asked the staff responsible why they had not received feedback, "They generally say that they do not have time to complete the investigation".
- There was a link person for Health and Safety who had taken on extra training and responsibility in this area. The link person attended meetings every three months and fed any information from these meetings back to the team.
- We were told about two incidents where staff had encountered aggressive behaviour from patients attending the department. On one occasion security had been called and attended the incident. On another staff had been unable to contact security as they had been called to another area of the hospital and were unreachable. Staff were able to diffuse the situation without the assistance of security. However, as a result of this incident security staff now carried mobile phones to reduce the risk of this incident being repeated.
- We were shown policies and procedures for dealing with emergency situations. Staff that we spoke with were aware of their role in a medical emergency. We saw evidence that all nursing staff in the department had received resuscitation and life support training within the last year. This training had been delivered in line with the trust's policy.

Outpatients

Cleanliness, infection control and hygiene

- There were systems in place to reduce the risk and spread of infection. Patients told us that they felt that the department was cleaned to a good standard. One patient said, "Its clean here I have no complaints about that". Another said, “It looks relatively clean to me”.
- During this inspection we walked around the department looking at the cleanliness of the patient waiting areas, some clinic rooms, patient toilets, dirty utilities, and corridors. We observed that all of these areas were visibly clean, and free from unnecessary clutter.
- There was a lead for infection control in the department, and we were shown that all staff had received their mandatory annual infection control training.
- Staff demonstrated a good understanding of infection control and of their roles in preventing the spread of infection.
- Clinical staff were responsible for cleaning the clinic rooms and clinical equipment between uses. Checklists evidenced that this was being completed.
- The facilities team leaders completed cleaning audits every two weeks and that clinical staff were involved in the auditing process.
- The January 2014 outpatient’s survey results showed that 22% of responders felt that the toilets in the department were not clean during their visit. The department was cleaned by facilities staff during the evenings. With cleaning staff not being available in the department during the daytime this could mean that patient toilet facilities were not being inspected for cleanliness during clinic times. The manager told us that although the department did not have a dedicated cleaner during the day if they had any concerns or needed a cleaner they could ring a dedicated helpline number for the ‘Blitz Team’ who would attend the department. The manager said that cleaners always attended when asked.

Environment and equipment

- We were shown the Health and Safety risk assessments for the area. We were told by the manager that where things were considered a risk following assessment that they would be placed onto the trust’s risk register.
- An example of where a risk had been placed on the risk register was in one area of the department. There was no dirty utility room. This posed a risk for the spread of infectious disease as nurses were unable to dispose of urine specimens following testing. The manager told us that staff mitigated this risk by double bagging specimens and disposing of them in clinical waste. This issue was on the departments risk register but the manager was unable to give a date for when this issue would be resolved.
- Building maintenance was managed by the estates department for the hospital. The department kept a log of the work that they had reported to estates and kept track of when and how issues were resolved. We were shown the departments log book which showed that staff had reported and tracked maintenance issues.
- We were told that the department had enough essential equipment. The manager told us that when they required more equipment they would ask the division that the equipment was required for supply this.
- The Hospitals League of Friends was always supportive and had provided funding for equipment.
- We saw evidence that equipment stored in the department to assist staff during an emergency had been checked regularly by staff who had signed to say that the equipment had been checked and was available and within its expiry date. This meant that staff were able to deal with emergency situations when they occurred in the department.

Medicines

- Medicines were stored in locked cabinets within the department. All medicines were ordered by nursing staff through the hospitals pharmacy.
- The majority of medicines were administered by clinicians. Where nurses were required to administer medicines such as analgesia these would be prescribed by the clinician and recorded in medical records.
- The nurses would then sign and date the records to confirm that they had administered the medication.
- Prescription pads were stored in a locked cabinet. When clinicians wrote patient prescriptions the department kept a log which identified the patient, the doctor prescribing and the serial number of the prescription sheet used. This ensured the safe use of prescription pads.

Records

- Staff told us that there was an ongoing issue with misfiled notes had been improved since the manager had tightened up incident reporting and investigations in this area.

Outpatients

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All of the nursing staff with the exception of two new members of staff (who were booked to attend) had attended safeguarding training annually in line with the trust's policy.
- The trust's lead for safeguarding had also attended given staff additional training which related to their specific area of work.
- The manager gave us an example of where staff had highlighted a concern about a patient's capacity to make decisions about an examination required for their diagnosis. Staff had highlighted their concerns and had contacted the trust lead in safeguarding for guidance.
- Most patients with a learning disability bought with them a 'Healthcare passport' document. This outlined to staff how they should be supported with their care needs. The manager said that where patients attended the clinics without this information the department would contact their carers or family for advice on ways that the department could best support them with their care.

Mandatory training

- Staff in the department (with the exception of staff on long term sick/maternity leave) had all completed mandatory training requirements and the manager was able to demonstrate this using a database of staff training.
- Staff had completed competency assessments for the roles that they performed. Therefore staff that we spoke with were all clear about their responsibilities and roles within the department. Staff that we spoke with told us that although they were busy they felt that they were able deliver patients required care needs and support.
- 96% of staff in the D department had completed an annual appraisal. This meant that staff were supported and encouraged to develop within their roles.

Staffing

- Rotas showed that the department consistently ran on a sufficient number of staff to meet the needs of the service.
- We were told by the manager and staff that the department had at times run on the goodwill of staff that were willing to change their working patterns or work extra hours in order to meet the demands of the service.
- Nursing staff told us that although they were busy they felt that they were able to deliver good and safe patient care. They said that they felt supported and listened to by their manager.
- Staff needed a good understanding of their role and needed to be assessed for competencies in the areas that they were working. This meant that it was not always possible to use staff from outside of the department to cover shifts during staff absence. Where staff were absent they were therefore replaced either by staff within the department who would work extra hours or alternative shifts; or the department gave shifts to its three temporary staff who had been trained in the competencies required.
- The medical cover for clinics was arranged within the divisions, who agreed on the numbers of clinics and patient appointment numbers. The divisions had provided the appointment teams with templates which showed where appointment spaces were available.

Are outpatients services effective?

Not sufficient evidence to rate

Outcomes for the unit

- National Institute for Health and Care Excellence (NICE) guidance for Smoking cessation had been met within the department. The OPD assessed each patient who accessed the service to establish whether they would benefit from a referral to the Smoking Cessation service. Staff would refer patients to the service where a need was established. In order to ensure compliance with NICE guidelines the department had made this a part of the 'meet and greet' guidance for staff and had included this in staff competency assessments.

Use of national guidelines

- NHS England and Clinical Commissioning Groups in the responsibilities and standing rules regulations 2012 State that patients have the legal right to start their NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they wait longer.
- Patients also have the right to be seen by a specialist within a maximum of two weeks from GP referral for

urgent referrals where cancer is suspected. In order to manage the demands of this legislation the trust ran a central department booking system which opened between 8am and 8pm.
- The 'Choose and Book' system (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic) accounted for 20% of appointments booked by the department.

Care plans and pathways
- Patients that we spoke with told us that they had discussed their care plans with their doctors and felt that time had been taken to ensure that the care planned for them met with their needs.

Multidisciplinary team working
- We were told that the OPD made referrals to other disciplines where appropriate. We were shown referral to smoking cessation clinics, district nurses, the falls team, and specialist nurses.

Are outpatients services caring?

Good

Compassionate care
- We observed staff interactions with patients as being friendly and welcoming. We saw staff stopping in corridors to greet patients that they knew and ask after their well-being.
- With permission we were able to observe a patients clinic appointment. We saw that the doctor was polite to the patient and took time with them discussing the patients care needs, and answering their questions. We observed that the patient's examination was performed with dignity, and that they were informed about what was happening throughout.

Patient understanding and involvement
- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand. Patients told us that they felt included in decisions that were made about their care and that their preferences were taken into account.
- One patient said, "The consultant is always very good about talking me through my care plan". Another patient said, "They explained everything".
- There were patient leaflets in each waiting area which provided patients with information about the department, how they could complain, and information on diseases and medical conditions. We saw patients reading this information.
- The department ran a Patient User Partnership Group meeting every two months. We were shown the minutes from the last two meetings. During the meetings staff and patient representatives discussed improvements that could be made to the service. The matron told us that they had invited patients that had previously complained about aspects of the service to join this group.

Emotional support
- All of the patients we spoke with were complimentary about the way the staff had treated them. One patient said, "I have always been treated well, the staff are always very polite". Another patient said, "Staff couldn't be more pleasant".
- Patients also told us that they had been treated with dignity in the department. One patient said, "They always put the curtains around when I need to undress, and they always warn you when they are coming in".
- Another patient when asked about whether they were treated with dignity said, "I would give this hospital 20 out of 20".
- The layout of the department meant that in one area patients received treatment in cubicles with a curtain between them and the corridor. The manager told us that they considered this a dignity issue as patient conversations could be overheard. The manager also showed us treatment rooms in Walmer A which were very tight for space. This meant that it was difficult for patients to dress and undress behind the privacy curtain as it was such a confined space.
- We observed in one clinic a patient becoming distressed by a long delay waiting for their appointment. We saw that staff supported the patient immediately and that the interaction with the patient was sympathetic and supportive.

Outpatients

Are outpatients services responsive?

Requires improvement

Key responsiveness facts and figures

- Some of the patients that we spoke with complained about the waiting times in clinics. This was an ongoing problem with some clinics waiting times being worse than others.
- We were told by both staff and doctors that the main reason for long waiting times was the overbooking of clinics.
- Clinic templates were agreed by the division leads and medical teams. The department had no input on the templates that had been agreed. We saw examples of over booked clinics.
- On the day of our visit the gynaecology clinic had two doctors so there were two clinic spaces at each appointment. However at 10am four patients were booked to attend and at 10.15am five patients were booked to attend. This meant that the clinic was unable to see all of these patients at their allotted time and the clinic would therefore run late. We were told by staff that this was a regular occurrence. Data that we examined confirmed this.
- We spoke with a junior doctor and trainee surgeon who were running clinics, they were happy with the way that the department was run and felt that clinics ran smoothly. Both told us that clinics were routinely overbooked as the templates did not match the number of patients requiring appointments.
- Staff completed a '30 minute wait audit'. This audit examined how long patients were kept waiting for their appointments. This data was logged monthly.
- We saw that most clinics had some delays. In February 2014, urology clinic saw 12 patients in total, four patients were seen within 30 minutes, three within 31-40 minutes, two within 41-50 minutes, and three within 51-60 minutes.
- Some clinics ran late because the doctors arrived late for their clinic. We looked at the data for January and February and saw that in both months the respiratory clinic had started late. According to data the doctor who ran this clinic had started the January clinic one hour late meaning all of the 18 patients attending the clinic had waited between 51-60 minutes for their appointment, the same doctor had started the February clinic at least 31 minutes late meaning of the 21 patients attending the clinic two were seen between 31-40 minutes after their appointment time, three between 41-50 minutes, three between 51-60 minutes, and eight patients had to wait more than 60 minutes for their appointment.
- Patients told us that staff always told them how late clinics were running and why. They also said that staff offered those beverages and use of the telephone. The matron told us that staff had been given training to help them to cope when clinics were running late and offer the right support.
- The manager told us that when doctors turned up late for clinics staff this reported as an incident.
- The trust had mostly met national targets for the two week wait target for patients with a suspected cancer. The trust's 2013 data shows that over 94% compliance (national average 93%) for ten months of the year. However in both July and August 2013 the trust fell below the national average with 92% of patients being seen within the two week target.
- The 18 week targets had also mostly been met. For example in the latest data for January 2014 the trust saw 3231 patients for their first appointments in less than 18 weeks from referral to appointment. However, 359 patients were not seen within 18 weeks. This meant that 90% of patients were seen within the 18 week target. A breakdown of these figures showed that some specialties were consistently not meeting the target and national average. For example, Orthopaedics which had from April 2013 to date had fallen below target every month.
- In order to manage the appointment waiting times the central booking team updated each division of the trust daily and passed on the relevant information for patients that had not been seen within the 18 week target.
- We were told by the central booking team that they only dealt with 60% of new referrals and that the remaining 40% of appointments were handled directly by the divisions themselves. The figures quoted in this report relate to the appointments booked by the central booking system.
- The trust was unable to supply data to establish compliance with the 18 week targets for first appointments booked directly through divisions.

Outpatients

- Most of the patients that we spoke with told us that they were satisfied that their first appointment had been booked within a reasonable timescale. Data provided indicated that patients were seen on average 5-8 weeks following initial referral.

Ensuring attendance

- We received multiple complaints about the number of cancellations that patients had experienced for their follow up appointments. The trust operates under guidance that except in exceptional circumstances, clinics could not be cancelled without eight weeks' notice.
- Data showed that 20% of cancellations did not comply with this guidance. We were told that follow up appointments were booked by the divisions. Data showed that 12% of booked outpatient's appointments in the past three months had been cancelled however data did not indicate whether these cancellations were first or follow up appointments.
- Trust-wide data showed that in January 2014 85013 patients visited the department; the trust in the same month cancelled 10984 patients appointments.
- Staff told us that where appointments needed to be cancelled it was generally the follow up appointments that were moved as these did not affect the 2 week and 18 week target.
- Data provided by the trust showed that patients waited and average of 9 weeks for their follow up appointment.
- However, patients that we spoke with reported waiting much longer for their appointments. For example we spoke with one patient who had had their follow up appointment cancelled twice and had waited eight months for their appointment. They said that the rebooking of these appointments was not an issue, but said that it had caused them inconvenience. They said, "It's frustrating, you get the time off work and sort yourself out, and then they change it again. This appointment is important to me, and it makes me feel like it isn't important to them". Medical secretaries that we spoke with confirmed that this was an ongoing issue.

Access for all patients

- Translations services were available by telephone.
- The manager told us that where patients needed a more complex consultation and where it had been identified that telephone translation was not appropriate face to face translators were booked, although this service needed to be organised in advance.
- Where patients had requirements due to religion or culture the department would accommodate their needs. For example where a female patient's culture or religion required that they only be examined by a female doctor the department would ensure that this requirement was respected.

Communication with patients and GPs

- Following appointments at the clinics GP letters were sent by the divisions' medical secretaries to inform them of what had taken place and any further action that may be needed.
- Medical secretaries told us that the trust expected GP letters to be processed and sent within 72 hours. Trust-wide we found that there were inconsistencies in meeting these targets.
- One medical secretary told us that they had 83 outstanding tapes of GP letters waiting to type and that each of these tapes represented more than 20 letters. The medical secretary had covered three clinics and 27 consultants or staff grades.
- Their workload had increased following a recent administration review. They said, "Nobody came to us and asked us what was workable, the trust does not fully understand what a medical secretary does". They went on to say, "A lot of areas are run on goodwill, we come in early and stay late. We are loyal to our doctors. This loyalty has now gone since the review".

Seven day services

- The department was open Monday to Friday. We were told that occasionally a clinic would run on a Saturday but that this was arranged on an ad hoc basis.

Complaints handling (for this service)

- Patients who attended the department where asked to fill out a questionnaire and post it into the comments box in each area.
- Comments were reviewed and discussed daily and more formally at team meetings.
- The results from the satisfaction survey were displayed on a notice board in a patient area.
- The manager collected information on patients experience during a weekly walk the floor audit. This audit looked at ten patients from each clinic and staff interviewed them to obtain their views on the

department and their experience of care. The manager told us that they would analyse the results of this audit and where any patterns or trends were seen they would look to make service improvements.

- We were shown how the department had reviewed the way in which it manages patients coming into the department. The matron told us that as a result of feedback from surveys which showed that patients did not feel informed by staff about waiting times for clinics the department had reviewed procedures and staff training in this area. As a result the department had produced guidelines for staff on meeting and greeting patients into the department along with a competency assessment which all staff had completed.
- The sister in the department demonstrated how the service had been further improved following a patient's complaint about feeling rushed by staff during the 'meet and greet' process. She explained that she had discussed the incident with the staff concerned and that they had reflected on the incident and discussed as a team how they could have improved the patient's experience of the service. She said, "We don't apportion blame, but we support staff through the complaints process".

Are outpatients services well-led?

Requires improvement

Vision and strategy for this service

- The manager was able to describe to us the trust's vision.
- We were told that the executive team had never visited the department; all of the nursing staff we spoke with told us that they had never met the Chief Executive of the trust. One member of staff said, "To be honest if he was sat out there in the waiting area I would not know who he was".
- Staff we spoke with felt loyalty to their department and their department manager. They told us that their manager and matron were both good leaders. For example one staff member said, "The manager here is fantastic, I can't praise her enough".
- Staff were aware that the department was going through a consultation process and could be redesigned. There was a sense from staff that these decisions were made at a higher level and that the changes would happen to them rather than them feeling a part of the process. For example, one staff member said, "What will be will be, we will do what we always do – Get on with it and keep smiling!"
- The department relied on the goodwill of its staff in being flexible with their shifts, and taking on extra hours. This meant that although the departments staffing met with the needs of the service that may not be sustainable in the long term.

Governance, risk management and quality measurement

- Outpatients held a monthly clinical governance meeting and produced a monthly governance report which was used to inform the trust's Board and other stakeholders. During the meeting all areas of governance were discussed and reported on along with any learning or changes to the service.
- The department used a number of tools to gather the data required to meet with the trust's governance arrangements and were responsive in reporting incidents.
- The governance report also outlined staff attendance at mandatory training, staff sickness levels, and compliance with the departments audits such as the hand hygiene audit.
- Health and Safety was monitored using risk assessments and with staff raising risks to the trust's risk register where appropriate. We found that the department manager and deputy had a good understanding of risk assessment and were able to describe items on the risk register to us.
- Complaints and compliments were investigated and staff were involved in any service improvements that had been identified.
- The number of complaints along with a breakdown and analysis of the complaints were included in the governance report and fed up to the board.

Leadership of service

- The manager described the way in which they investigated any complaints or concerns about staff. They said that this was investigated in a way that didn't proportion blame. The manager said that they felt confident that staff would report any incidents or near misses and would not be afraid to come forward if they had made a mistake.
- Staff that we spoke with told us that the manager was approachable and that they would felt they could go to

them with any concerns. One member of staff said, "I know if I was concerned about anything at all I could talk to the sister or her deputy and they would listen and help me with it".

Culture within the service

- All of the staff that we spoke with were able to describe their individual roles. This was backed up by competency assessments of staff that ensured that they both understood and were able to perform their roles to a required standard.
- The manager of the department and the matron were able to outline the departments governance procedures, they were also able to tell us how their department was performing in all areas.
- Throughout our visit we saw that the department was calm and ordered.
- Patients told us that they were well informed and that staff were both friendly and supportive of them.

Innovation, improvement and sustainability

- We asked staff about the trust's 'Dragon Den' initiative which had been devised to encourage staff to bring forward any ideas or initiatives that they had which they felt would improve the service. We were told that no one from the department had attended 'dragons den'. Staff told us that this was because they didn't have the time to look at the intranet to read about initiatives. The manager told us that they printed off the trust's weekly newsletter and made it accessible to staff to try to engage staff in trust-wide developments.
- Staff were aware of the issues around overbooked clinics and waiting times for patients. Staff told us that they were often dealing with the stress that managing sometimes angry patients due to waiting times created. However, staff told us that these were decisions that were made and influenced outside of their department and did not therefore feel empowered to make changes.
- Although there was awareness amongst all staff groups about overbooked templates, and patient waiting times no improvements had been made around issue.
- Staff had completed incident reporting forms but were unable to demonstrate that the department had improved on these issues.
- Templates set for some clinics did not meet with patient requirements. Data which evidenced this was being collected daily by the department, the central booking department, and medical secretaries. We were not informed of any work being done by the trust to alleviate this problem despite a number of staff including managers and doctors raising this with us as a persistent issue.
- GP letters were not being sent consistently within the 72 hour target. Although staff were aware of the issue which they said was caused by a staff restructure within the department, there was no apparent strategy to improve the situation.
- The central booking service was not always able to give patients appointments within the NHS England and Clinical Commissioning Groups regulations 2012 two and 18 week targets. They had however developed systems to ensure that divisions were kept regularly informed where they had fallen short of these targets to ensure that patients were offered the best possible alternative.

Outstanding practice and areas for improvement

Outstanding practice

- Staff were caring
- There were good clinical outcomes for patients who had a stroke. The length of stay for stroke patients was 13.2 days with an expected rate of 17.5 days compared to similar trust's (January to December 2013 data).
- The critical care unit monitored its performance and data from Intensive Care National Audit and Research Centre (ICNARC) and showed that patient outcomes were good.
- Staff had learnt and changed practices as the result of 'Never Events' in the maternity services.
- Incident reporting was leading to learning and changes in the outpatients' service.

Areas for improvement

Action the hospital MUST take to improve

- Ensure there are appropriate levels and skills mix of staffing to meet the needs of all patients.
- Ensure safety is a priority in A&E.
- Ensure patients leave hospital when they are well enough with their medications.
- Ensure that maintaining flow through the hospital and discharge planning is effective and responsive. Patients must not be moved numerous times, and not during the night. When patients are well enough they must leave hospital.
- Ensure that staff are aware that at a board level there is an identified lead with the responsibility for services for children and young people.
- Ensure staff are fulfilling their roles in accordance with current clinical guidance.
- Ensure medications are stored safely.
- Ensure the administration of all controlled drugs is recorded.
- Ensure that procedures for documenting the involvement of patients, relatives and the multi-disciplinary team 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times. All forms must be signed by a senior health professional.
- Ensure patients are not experiencing unnecessary waits for follow up appointments at outpatients and when waiting in outpatients for appointments.
- Ensure there is adequate administrative support for outpatients. On the day of our inspection one medical secretary was responsible for sending out 1,660 GP appointment letters and had not met the within 72 hour target.

Action the hospital SHOULD take to improve

- Ensure quicker response time to prevent escalation of Grade 2 pressure ulcers to Grade 3.