

# Medway NHS Foundation Trust

## Inspection report

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

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

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

## Ratings

### Overall rating for this trust

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Requires improvement 

Are resources used productively?

Inadequate 

Combined quality and resource rating

Requires improvement 

# Summary of findings

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

## Background to the trust

Medway NHS Foundation Trust is a single site hospital based in Gillingham, Kent. The trust is a provider of acute and specialist services that service a population of 405,000 across Medway and Swale.

The trust's main clinical commissioning groups (CCG) are NHS Swale clinical commissioning group and NHS Medway clinical commissioning group.

The health of people in Medway is varied compared to the national average with six of the national indicators for health scoring better and 11 worse than the national average. About 21% (11,600) of children live in low-income families. Life expectancy for both men and women is lower than the England average.

Medway NHS foundation trust was one of 14 trusts included in the Keogh Mortality Review. Consequently, a rapid responsive review was carried out of the trust in May 2013, and the findings resulted in the trust being placed into special measures in July 2013. The Care Quality Commission (CQC) undertook two comprehensive inspections of Medway Maritime Hospital in April 2014 and August 2015. The trust was rated 'inadequate' overall at both these inspections.

The trust was last inspected in November and December 2016, the trust was found to have improved with an overall rating of 'requires improvement', and as a result was taken out of special measures.

At the last inspection in 2016 the trust was found to be in breach of the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were: Regulation 10 – dignity and respect; Regulation 12 – safe care and treatment and Regulation 18 – staffing.

In the financial year 2017 to 2018, the trust had an income of £265,000,000. The trust predicts it will have a deficit £46,800,000 in 2018 to 2019. Whilst the financial situation impacts on how the trust provides services, CQC does not report on this aspect of the trust's work. Our remit is to focus on the quality and safety of the services that are being provided.

## Overall summary

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



## What this trust does

The trust has 655 beds spread across various core services including 25 critical care beds, 158 inpatient surgical beds, 19-day surgery beds, 318 medical beds, 66 children's beds, 20 neonatal cots and 69 maternity beds. The trust has 17 main operating theatres. Four of the 17 operating theatres are for day surgery.

The trust provides the following services at this location:

- Urgent and emergency services
- Medical care (including older persons care)
- Surgery

# Summary of findings

- Critical care
- Maternity
- Gynaecology
- Services for children and young people
- End of life care
- Diagnostics
- Outpatients

In addition to standard specialties at the trust, the trust provides the following specialist services: Macmillan cancer care unit, West Kent centre for urology, West Kent vascular centre, regional neonatal intensive care unit, foetal medicine unit and stroke services for the local population.

In the year to December 2017 there were:

121,856 emergency department attendances. Of these 27,254 (22.37%) were aged under 16, 2,714 (2.23%) were aged 16 or 17 and the remainder were 18 years and older.

438,098 first and follow up outpatient appointments.

258,740 diagnostic tests

22,919 surgical admissions. Of these, emergency admissions accounted for 41.5% of all admissions (9,515) and 58.5% (13,359) were elective admissions, of which 9,321 were day case and 4,083 were inpatient stays

The trust has 4,400 staff supported by 430 volunteers, making the trust the largest employer in Medway. This includes 1,240 registered nurses and 543 medical staff. A council of 25 governors represent 11,000 public members of the trust. The board of directors comprises of five executive directors, seven non-executive directors (including the chair) and five non-voting directors.

The trust had two clinical directorates, unplanned and integrated care and planned care. Each directorate leadership team consists of an executive director of clinical operations, deputy director of nursing and a deputy medical director.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

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

## What we inspected and why

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

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

# Summary of findings

Our comprehensive inspection of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at trust level. Our findings are in the section headed 'Is this organisation well-led?' We inspected the well-led key question on 2 and 3 May 2018.

Prior to this, we gathered information and data from the trust, NHS improvement, and stakeholders (community organisations with an interest in healthcare provided by the trust). We held focus groups for different staff in February 2018.

At the last inspection in November and December 2016, we rated the trust as 'Requires improvement'. We considered all the information we held about the trust when deciding which core services to inspect and based out inspection plan on the areas considered to be the highest risk.

We conducted an announced inspection of six core services on 10 and 11 April 2018, which were Emergency and urgent care, Medicine (including older persons care), surgery, critical care, outpatients and diagnostics.

At the last inspection in 2016, three of the core services was rated as good, with the remaining five rated as requires improvement. We inspected outpatients and diagnostics separately for the first time on this inspection.

When aggregating the overall rating, the ratings from the previous inspection in November and December 2016 were used for core services that were rated following that inspection, but were not re-inspected. We can only re-rate following inspection and the improvements that have taken place in the core services we inspected are reported.

We are aware of improvements in other core services through engagement visits and data supplied by the trust. For example, there have been improvements made in the provision of play therapist provision, but this is not reflected in the ratings, as we did not inspect services for children and young people during this inspection and our methodology only allows ratings to be changed following inspection.

## What we found

### Overall trust

The trust has implemented a number of changes since our last inspection to improve safety and it was noted, this had been sustained. However, there were still improvements to made in key areas such as retention of staff, mandatory training and ensuring safety checks were completed. There was recognition from the executive and senior management team that there was still work to be done to make sure a culture of safety existed across the whole of the organisation.

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

- The trust was rated good for effective and caring. We rated safe, responsive and well-led as requires improvement.
- We did not inspect maternity, gynaecology, end of life care or services for children and young people.

We are monitoring the progress of improvements to these services and will re-inspect them as required.

### Are services safe?

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

- We found that overall, the mandatory target of 85% compliance was being met by the trust; however, some teams were below the target. We did recognise the rates of compliance had improved and were continuing to improve. We found some safety checks, such as fridge temperatures, emergency equipment and fire safety checks were not undertaken consistently.

# Summary of findings

- Nursing staff levels were not meet national recommendations in the critical care services to keep people safe from avoidable harm and to provide the right care and treatment.
- The frequency of cleaning audits in high risk areas wasn't consistently carried out in line with the national specifications for cleanliness.

However,

- Improvements to the management of the deteriorating patient and the management of sepsis noted at the last inspection had been maintained. All staff we spoke with understood their responsibilities to raise concerns and report incidents and near misses. The acute response team successfully supported staff to keep more unwell patients cared for onwards.
- All staff understood their responsibilities with reporting incidents. The incident reporting culture was good and learning from incidents was shared. The management of serious incidents demonstrated a clear process and staff learned from them through a variety of tools such as 'lessons of the week', SWARM events and simulation training.
- Although we found some patients were not always cared for in areas of their speciality, regular checks were undertaken to ensure they remained safe.
- We found there were systems and processes in place to safeguard adults and children from abuse or harm. Incidents were investigated quickly, lessons learned and changes in practice were shared with staff.

## Are services effective?

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

- Care and treatment was based on national guidelines and evidence based best practise. Each programme monitored the quality and effectiveness of treatment through continuous local and national audits.
- We saw members of multidisciplinary teams worked well together throughout the hospital and supported each other to provide care. Multidisciplinary teams within the hospital and with external health care partners worked to deliver care in line with best practice.
- Patients had comprehensive assessments of their needs and staff worked collaboratively to understand and meet the range and complexity of patients' needs.
- The hospital was a 'smoke free' zone and the trust supported other national public health initiatives. Staff gave patients dietary advice and signposted them to other support networks to assist with lifestyle changes.
- The trust provided opportunities for learning and continuous development. Staff could access a variety of training internally and externally. They were supported to develop into link roles, speciality roles and leadership roles.
- Staff had a good understanding of the Mental Capacity Act, 2005 and best interest decisions. However, training for mental capacity act and deprivation of liberties, were below the trust target.

## Are services caring?

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

- Feedback from patients we spoke with during the inspection was positive, they told us staff were kind and understanding. Staff maintained patient privacy, dignity at all times and this was embedded within the culture of the services we visited. Chaperones were available in all outpatient and diagnostic imaging areas.
- Staff involved patients and those close to them in decisions about their care and treatment. We saw staff took time to understand the specific needs of patients and took time to explain their care and treatment.

# Summary of findings

- We saw staff introduce themselves and treat patients with kindness and compassion. Staff took time to interact with people in a respectful and caring way. We saw staff involve patients in their discussions during ward rounds.
- Staff and volunteers supported patients with kindness and respect. They responded with kindness and understanding to patients who became distressed. Staff provided emotional support to patients to minimise their distress and could signpost them to services outside of the hospital when required.

## Are services responsive?

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

- There were still issues with flow throughout the hospital. The implementation of the clinical control centre gave better oversight of where the issues in flow were within the hospital. However, we saw patients being cared for in areas outside of their speciality and receiving treatment in some areas for longer than was ideal, whilst waiting for beds in the right places. There were delays in some areas whilst waiting for consultant review. However, whilst patients were waiting for transfer, patients were cared for and kept safe.
- National standards were not being met in the emergency department, for the time it took for patients to be admitted, transferred and discharged. Waiting times in surgery, medical care, outpatients and diagnostic imaging were worse than the national averages
- We saw patients moved to different wards and we saw patients were often placed in wards which were not the specialist area for their condition. There were a large number of patients moved during the night, which was not in line with best practice.
- The hospital had a high number of mixed sex accommodation breaches. They had acknowledged non-compliance with mixed sex accommodation, which was due to several factors. Prior to April 2018 the trust reported mixed sex accommodation figures for assessment areas only, excluding wards and other inpatient departments. This had resulted in the higher number. A programme of work was to be implemented which included improved signage, embedding of the policy with staff, investigating missed sex breaches as they occurred. From April 2018, the trust forecast a downward trajectory of mixed sex breaches as the programme of work moved on. The most recent data available indicated the trust was in line with its trajectory.

However,

- The trust planned and provided services in a way that met the needs of local people. They worked with commissioners, external providers and local authorities. This had resulted in the trust having one of the lowest delayed transfer of care rates in the country.
- The adult emergency department had recently introduced a new process to improve flow by ensuring patients were treated in the most appropriate setting.
- There were systems in place to aid the delivery of services to patients living with dementia, volunteers were trained to be dementia buddies and carers were given 'passports' so they could visit their friends and relatives out of normal visiting hours.
- We saw the process for the management was clear and the relevant teams investigated and dealt with complaints. We saw there was openness and honesty in complaint responses and evidence of learning from complaints. However, responses were not always in line with the times set out in line with the trust's policy.

## Are services well-led?

Our rating of well-led changed from good. We rated it as requires improvement because:

# Summary of findings

- A recent change in organisational structure resulted in staff telling us they were unclear as to what directorate they were in. They felt the change in structure had not been communicated well in why the change was made or what the changes were. We found local leaders were visible, approachable and supportive. Some staff told us they did not think the senior leadership team was visible.
- The culture throughout the organisation was a mixed picture. Some staff worked in silos. It was clear they felt patients within their department who should have been in another area were not a priority for them and held the other team in the patient's care at fault. Other teams worked well with staff in and out of the hospital, with the patient at the centre of heart of what they did.
- Some staff reported bullying and harassment remained a problem and felt this was not dealt with well and they had difficulties escalating issues or getting resolution if they had raised issues. Other staff described a healthy culture of openness and honesty where they felt they could challenge or be challenged. We found managers promoted a positive culture that supported and valued staff.
- It was not always clear in every service where staff had identified and escalated risk, although there was a clear process in place. There was a clear governance structure and the leadership teams had an oversight of the risks in the department and had processes in place to reduce these risks, and reviewed this regularly.

However,

- The trust's vision and values were clearly displayed throughout hospital; staff understood them and demonstrated them. The appraisal system had recently been adapted to ensure staff member's development was in line with the values.
- A number of innovations and improvements had an impact on the delivery of care throughout the hospital. They had resulted in reduction in numbers of falls in the community, reduction in hospital acquired pressure ulcers and improvement in the delayed transfer of care rates.

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## Ratings tables

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

## Outstanding practice

We found examples of outstanding practice in emergency and urgent care, medical care, critical care, and surgery.

## Areas for improvement

We found areas for improvement including 12 breaches of legal requirements that the trust must put right.

We found 28 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

## Action we have taken

We have issued requirement notices to the trust. Our action related to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10 Dignity and Respect; Regulation 12 Safe Care and Treatment; Regulation 15 Premises and Equipment; Regulation 17 Governance; Regulation 18 Staffing.



# Summary of findings

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

## What happens next

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

## Outstanding practice

Staff in the children's emergency department had worked with other health agencies to improve asthma care in children in the local community. This included inhaler check clinics and information for parents and carers looking after children with asthma.

The trust had developed a 'Green book', which consisted of emergencies, and management protocols for clinical emergencies. This allowed staff to have easy access to protocols for treatment during an emergency, and was in line with best practice.

A minimally invasive surgery tool "Da Vinci Robot" had been implemented to care for patients undergoing prostate surgery. This allows surgeons to perform complex and precise procedures in a way not possible with the human hand.

The trust is a hub of the West Kent Urology Cancer Centre. This meant prostate cancer patients across the whole region could benefit from this service. The service also had future plans to expand the range of procedures carried out by the tool.

Surgery implemented a bereavement service led by a consultant. This enabled families of patients who had died to obtain any unanswered questions and to raise any concerns they may still have.

The emergency and urgent care department had developed a specific pathway for patients who had broken their hip. This meant a multi-disciplinary team worked together and ensured patients were assessed and treated as quickly as possible. An associate practitioner facilitated the pathway.

The emergency and urgent care department was part of an education collaborative. Emergency departments within the South-East region had joined to provide education, each department offered a different educational course and staff from all hospitals attended.

Implementation of the frailty model in medical services had reduced the number of falls in the community and the number of admissions to the service, and directorate involved patients and the public in developing services.

The trust had one of the lowest delayed transfers of care rates in the country. It had worked hard with external partners improve the discharge processes for patients. This demonstrated there was better patient flow through the hospital and better discharge planning.

The trust had worked to reduce the numbers of patient falls in hospital. The appointment of a falls prevention clinical specialist nurse, falls awareness campaign and the implementation of a falls investigation toolkit had resulted in an 11 per cent reduction in falls in from April to March 2017.

Medical care departments had several volunteers recruited in the role of 'Dementia Buddies'. A volunteer told us they undertook specialist dementia training to carry out the role.



# Summary of findings

The trust provided monthly “carers’ coffee breaks” in the hospital canteen. The purpose of the carers’ coffee breaks was to provide emotional support to the relatives and carers of patients living with dementia. We saw details of the coffee breaks advertised to carers of patients on Will Adams Ward.

## Areas for improvement

Action the trust **MUST** take to improve:

- The trust must increase consultant cover to provide 16 hours per day consultant cover and meet the Royal College of Emergency Medicine recommendations.
- The trust must ensure emergency equipment within the emergency and urgent care department is checked consistently.
- The trust must ensure fire safety checks are undertaken in the emergency and urgent care service.
- The trust must ensure the flooring and walls in theatres meet the Department of Health’s Health Building Note 00-09.
- The trust must ensure they meet with the national specifications for cleanliness on the frequency of cleaning audits carried out in all high-risk areas.
- The trust must ensure nursing staff are appropriately skilled and competent to carry out their roles, to provide safe care, in the surgery department.
- The trust must ensure they meet the Department of Health’s standard on eliminating mixed sex accommodation, except where it is in the overall best interests of the patient or reflects the patient’s choice.
- The trust must ensure there are no patients staying overnight in the recovery area.
- The trust must embed an effective system to ensure the service meets the trust targets for mandatory training, including safeguarding training to protect vulnerable adults and children and young people from harm and abuse.
- The trust must have an effective system to ensure only clinically suitable patients were cared for in the surgical areas.
- The trust must take action to improve referral to treatment time performance, in the outpatient department.
- The trust must plan for an automated system for the cleaning of ultrasound equipment in line with Health and Safety Executive guidance.

Action the trust **SHOULD** take to improve:

- The trust should ensure fridge temperature checks are completed daily, in emergency and urgent care service.
- The trust should ensure the door in the emergency and urgent care major’s escalation area is secure.
- The trust should ensure there is restricted access to the adult emergency and urgent care service department.
- The trust should consider how to reduce the length of time patients wait in the majors waiting area awaiting specialist review or admission.
- The service should ensure all staff are competent to use medical equipment.
- The trust should implement an effective system to ensure patients were not fasted for longer periods than clinically necessary.
- The trust should address the referral to treatment time for admitted pathways for surgery.

# Summary of findings

- The trust should embed effective systems and ensure staff use them to record data in a timely manner and to protect personal and confidential data from the risks of loss.
- The trust should work to retain nursing staff to address the gaps in rota coverage and high reliance on bank and agency staff, and the high turnover rate.
- The trust should ensure effective communication from the senior management team.
- The trust should implement an effective system to respond to patient complaints in compliance with timelines set in the trust's complaint policy
- The trust should ensure that all staff comply with mandatory training requirements set by the trust and by professional body guidelines.
- Nursing and medical staffing levels on the critical care units should comply with the Guidelines for the Provision of Intensive Care Services, 2015.
- Pharmacist cover on the critical care unit should ensure seven-day cover. The current five-day cover met the minimum requirement and impacted the efficiency of the units.
- Critical care patients should not be routinely nursed in recovery beds as stated in the Guidelines for the Provision of Intensive Care Services, 2015.
- Critical care patients discharge should not be delayed once they are deemed wardable.
- Out of hour discharges should be avoided as per Guidelines for the Provision of Intensive Care Services, 2015.
- The outpatient department should formalise a strategy.
- The trust should ensure that they meet their own target for outpatient prescriptions, monitor, and audit this process.
- The trust should ensure that complaints are responded to within the target response times.
- The trust should ensure that monitoring of the medicines fridge in the magnet resonance imaging department.
- The trust should the administration of injectable contrast dye are undertaken in line with trust policy.
- The trust should ensure that resuscitation equipment is available and appropriately checked in line with trust policy.
- The trust should develop a strategy for diagnostic imaging that includes plans for addressing staffing shortages, equipment upgrades and the use of electronic systems.
- The trust should introduce systems that ensure managers can monitor capacity and demand within the department and that current manual alerts are digitalised.
- The trust should continue to improve waiting times for diagnostic imaging.
- The trust should take steps to ensure management responsibilities in diagnostic imaging are adequately covered.
- The trust should ensure that directorate and trust leaders are visible within the diagnostic imaging department and that changes are implemented with consultation and involvement of relevant staff.

# Summary of findings

## Is this organisation well-led?

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

We rated well led as requires improvement.

We found the senior leadership team had the stability, capability, capacity and integrity to ensure strategy could be delivered and address risks to performance. However, the systems and processes to support this were not sufficiently embedded to be able to drive improvement. Having driven many improvements across the trust, leaders had taken time to identify next steps to continue that improvement journey. The implementation of the new structures should release the executive team to focus on the strategic direction, rather than acting down to enable operational improvements as had been necessary. This should enable the trust to increase the pace at which improvements are made

The trust had demonstrated improvements in quality and safety of care had got better. However, the governance structure, systems and process were not fully embedded. It was not easy to see how the board was getting assurance. There had been a recent review of governance arrangements, which was still in transition at the time of inspection. The trust acknowledged there was still work to do.

The organisation had processes to manage current and future performance. We saw there were systems and processes in place to assess, prevent, deter, manage and mitigate risk throughout the organisation. However, we found risk management was reactive, there was no forward look or awareness/acknowledgement of anticipated risks. In addition, it was not always clear to see where risk had been escalated from ward to board.

We found staff satisfaction throughout the trust was mixed. They did not always feel empowered to raise concerns and teams were often working in silos. There were processes for staff to raise concerns, they did not always know what they were and felt no change would happen as a result of concerns being raised. Other staff described a healthy culture of openness and honesty where they felt they could challenge or be challenged. We found managers promoted a positive culture that supported and valued staff. The senior leadership team recognised work need to be done to improve the culture of the organisation and was developing processes to support staff and promote their positive well-being.

There were improvements required in the financial position of the trust. They had not met their control total for 2017/18 and they were negotiating their control total for 2018/19 at the time of inspection. There were plans in place for a cost improvement programme. However, this needed strengthening in order to realise the savings proposed.

The trust engaged with people who used services, the public, external partners and staff to develop and deliver high quality service. However, not all staff felt the trust engaged when there was a change in the organisation of services. The trust was in the process of establishing which communications methods were most effective with staff. Following this piece of work, the internal communications plan would be reviewed and adjusted.

Work looking at data quality had been undertaken and was on-going. Prior to this, the trust had to pause reporting 18 weeks referral to treatment time, because of poor data quality. The trust had returned to reporting as they had made improvements in recording the 18 weeks referral to treatment time pathways with a reduction of more than 16,000 open pathways mainly through validation.

The trust had a clear vision and values which had been shaped by feedback following engagement with members of staff, through surveys, workshops and focus groups. Staff had a clear understanding of the vision and values.

## Summary of findings

There were systems in place to share learning from incidents and complaints. The trust had developed a learning strategy and were keen to develop further. However, the pace at which this had occurred meant not as much improvement was demonstrated compared with the potential.

The management of complaints had improved in terms of the process and quality. The right individuals and teams investigated complaints, however the response time to complaints was still not in line with the trust's complaint policy.

## Ratings tables

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

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

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

### Ratings for the whole trust

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

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

## Ratings for Medway Maritime Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018
Medical care (including older people's care)	Good ↔ Jul 2018	Good ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Good ↔ Jul 2018
Surgery	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Good ↑ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018
Critical care	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018
Maternity	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Services for children and young people	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
End of life care	Good Mar 2017	Good Mar 2017	Good Mar 2017	Requires improvement Mar 2017	Requires improvement Mar 2017	Requires improvement Mar 2017
Outpatients	Good Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Diagnostic imaging	Requires improvement Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
<b>Overall*</b>	Requires improvement ↔ Jul 2018	Good ↔ Jul 2018	Good ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018	Requires improvement ↔ Jul 2018

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

# Medway Maritime Hospital

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## Key facts and figures

Medway Maritime Hospital is a single site hospital based in Gillingham. Medway Maritime Hospital, serves a population of more than 405,000 across Medway and Swale districts.

Medway Maritime Hospital was originally a Royal Naval hospital; opened in 1905. The NHS acquired the hospital from the Navy in 1961. Buildings were modernised as part of the modernisation scheme and the hospital reopened in 1965 as Medway Hospital. In 1999, the hospital changed its name to “Medway Maritime Hospital”, following a development programme, which saw the hospital increase in size and services transferred from St Bartholomew’s in Rochester and All Saints in Chatham.

The trust became a foundation trust in 2008 and there have been significant changes to the senior management team and board during this time. However, in the last 12 months, the senior management team and boards have remained stable.

The trust has 4,400 staff supported by 430 volunteers, making the trust the largest employer in Medway. This includes 1,240 registered nurses and 543 medical staff. A council of 25 governors represent 11,000 public members of the trust. The board of directors comprises nine executive directors and seven non-executive directors, including the chair.

In December 2017, the trust reduced their directorates from three to two. Planned care directorate, which includes perioperative and critical care programme, children’s and women’s health programme and surgical services. Unplanned and integrated care directorate, which includes acute specialist medicine, acute medicine and cancer and clinical support services. A leadership team that consists of a director of clinical services, deputy director of nursing, and a deputy medical director leads each directorate. This leadership style is referred to a triumvirate.

Specialities included, day-surgery, general surgery, trauma, orthopaedics, maternity, services for children and young people, critical care, neonatal intensive care, emergency medicine, general medicine and specialist medicine. In addition, specialist services: Macmillan cancer care unit, West Kent centre for urology, West Kent vascular centre, regional neonatal intensive care unit, foetal medicine unit and stroke services for the local population.

The hospital has 655 beds, across the various core services. Medway Maritime hospital operates 24 hours per day and has an accident and emergency department. The hospital has approximately 121,856 emergency department attendances, and 438,098 first and follow up outpatient appointment

During the inspection, we spoke with 69 patients, 13 carers/relatives and over 149 members of staff from various disciplines. We checked over 78 patient records, and 29 drug charts. We observed care being delivered and attended meetings, safety briefings and handovers.



# Summary of findings

## Summary of services at Medway Maritime Hospital

**Requires improvement**   

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

- Overall, the mandatory target of 85% compliance was being met by the trust; however, some teams were below the target. We did recognize the rates of compliance had improved and were continuing to improve. This included safeguarding vulnerable adults and children, and mental capacity. Patient were not always in the area of their speciality, patients staying overnight in the recovery areas in main theatres and there were mixed-sex accommodation breaches.
- Frequency of cleanliness audits were not always undertaken in line with the national specification for cleanliness.
- Safety checks such as safety checks, such as fridge temperatures, emergency equipment and fire safety checks were not undertaken consistently within the emergency department.
- There was poor flow and capacity through the emergency department. This meant patients waited many hours in the majors waiting area. Patients experienced significant delays whilst awaiting specialist review or to be placed in a bed on a ward.
- In the surgery department, we found the environment was not intact, in line with Department of Health's Health Building Note 00-09. Additionally, there was a lack of a system to ensure actions and learning from patients' deaths.
- Outpatient and surgery services were not meeting national standards for referral to treatment times.
- Although staffing levels in the hospital had improved there were still areas operating below guidelines, notably in surgery and critical care.
- Consultant staffing levels in the emergency department remained below the Royal College of Emergency Medicine recommendations. However, since our inspection amendments had been made to the consultant's rota which increased consultant cover to 14.5 hours on weekdays and eight hours at weekends. Additional cover at weekends was provided by long term locums.
- The trust had undertaken a number of initiatives to try and recruit consultants

However:

- Staff responded appropriately to the deteriorating patient and treated in line with national guidance. There was effective sepsis management, and understood and their responsibilities to raise concerns and report incidents and near misses.
- Clinical staff ensured that patient treatment and care was delivered with kindness and compassion. Staff provided emotional support to patients to minimise their distress. We saw examples where staff included patients in decisions about their care and treatment, and treated them with dignity and respect.
- Staff used professional guidance and best practices, including risk assessment tools and safety checklists correctly to support safe care.
- We saw good examples of multidisciplinary team working, across the hospital and with external agencies. We observed collaborative working and communication from all members of the team.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005
- Staff knew the trusts vision and values and they positively demonstrated these in their practice during the inspection.

## Summary of findings

- Implementation of the frailty model had reduced the number of falls in the community and the number of admissions to the service, and directorate involved patients and the public in developing services.

# Urgent and emergency services

Requires improvement   

## Key facts and figures

The urgent and emergency care department at the Medway Maritime hospital is located in Gillingham, Kent. It is run by Medway NHS Foundation trust. In early 2016, work began to modernise the urgent and emergency care department with the intention of improving capacity and streamlining the service to reduce the time it takes for patients to be seen. The new building was due to open in May 2018. The urgent and emergency care department at Medway Maritime hospital provides a 24-hour, seven day a week service to the local area.

There were 121,856 emergency department attendances. Of these 27,254 (22.37%) were aged under 16, 2714 (2.23%) were aged 16 or 17 and the remainder were 18 years and older.

The urgent and emergency care department has co-located primary care facility (operated by a separate provider) and a separate children's emergency department. The children's emergency department is accessible from the main urgent and emergency care department and is secured with swipe card access. Patients are directed on arrival to the most appropriate health care provider.

The department is a trauma unit but more severely injured patients go to the nearest major trauma centre if their condition allows them to travel there. Otherwise, they would be treated at Medway Maritime hospital, where staff follow a protocol to decide which injuries they could treat or would have to be treated at another hospital.

There was a specialist stroke service, with front door frailty input and is supported by a seven-day consultant led ambulatory care unit. Frailty is a needs related service which uses a nationally recognized assessment tool to identify patients. Identifying and managing frailty was undertaken when patients attended the department.

The urgent and emergency care department at Medway Maritime hospital has a five-bedded resuscitation area, 11 cubicles for major emergencies (majors), 12 majors escalation trolleys, four cubicles for minor injuries (minors), a mental health assessment room and two triage/rapid assessment rooms. There is a majors and a minors waiting area. There is a designated paediatric resuscitation bay within the resuscitation area. Total capacity is for 40 patients when the new building opens this will increase to 58. There are two triage rooms and five assessment rooms in the children's emergency department. There is an ambulatory care ward near to the urgent and emergency care department, where staff direct patients from the emergency care department if appropriate following a clinical assessment. The ambulatory care ward undertakes day case assessments, rapid access clinics; inpatient stays and facilitated early discharge.

Urgent and emergency services were last inspected in 2017 when overall, we rated it as requires improvement. We rated caring, effective and well-led as good, responsive, and safe as requires improvement.

This inspection was announced and we inspected all five key questions. We spoke to 16 patients and carers and over 20 staff from different disciplines, including support and administration staff, nurses, doctors, managers and ambulance staff. We observed daily practice and viewed 23 sets of records. Before and after our inspection, we reviewed performance information about the department and reviewed information provided to us by the trust.

## Summary of this service

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

# Urgent and emergency services

- The emergency department did not meet the requirements of the Royal College of Emergency Medicine guidelines of consultant cover. The requirements state that consultant cover must be provided a minimum of 16 hours a day. This remained unchanged since our previous inspection when we found consultant cover within the department still did not meet these requirements.
- Some issues that we identified during the previous inspection had not been effectively addressed. These included, daily safety checks of emergency equipment, daily monitoring of fridge temperatures, an open door in the majors escalation area and a lack of fire safety monitoring. This meant the systems put in place after our last inspection to address these issues were ineffective.
- Compliance in mandatory training for medical staff was 79%% which did not meet the trust target of 85%. However, compliance in mandatory training had improved since our last inspection and was an improving picture and as at June 2018 was 83.8%.
- Compliance in Mental Capacity Act training amongst medical staff was 68%, which did not meet the trust target of 85%. However, staff demonstrated a good understanding of the Mental Capacity Act and safeguarding of vulnerable people. Patient consent to treatment was undertaken in line with trust policy and national guidelines.
- Over the 12 months from February 2017 and January 2018, 22 patients waited more than 12 hours from the decision to admit until being admitted. The highest number of patients waiting over 12 hours was in January 2018 with 15 patients.
- Patients and visitors were able to access all areas of the adult department, as access was not restricted to staff only.
- There was poor flow and capacity through the department. This meant patients waited many hours in the majors waiting area. Patients experienced significant delays whilst awaiting specialist review or to be placed in a bed on a ward.
- The department consistently failed to meet the four hour NHS constitution 4hour standard. The standard stipulates that 95% of patients be admitted, transferred or discharged within four hours. The trust did not meet the standard in any of the 12 months from February 2017 to January 2018. Performance varied between 76% in February 2017 and 89% in November 2017.
- The trust's urgent and emergency care Friends and Family Test performance (% recommended) was consistently worse than the England average from January 2017 to December 2017.
- Although medical staff now completed the correct level of safeguarding both medical and nursing staff failed to meet the trust target of 85% in compliance with safeguarding training.

However:

- Staff were professional and cared for patients in a kind and compassionate manner. Feedback from patients and relatives was positive.
- The department worked closely with the local Healthwatch group, they attended the monthly 'meet the matron events' which were attended by patients and relatives.
- The leadership team supported staff and provided new staff with an individual induction plan and educational plans to ensure the skills they brought to the team were recognised along with identifying training needs.
- There was consistent recording of information within the patient records reviewed. This included good completion of risk assessments and pain scores.

# Urgent and emergency services

- Care provided to patients suffering with sepsis (infection) was in accordance with National Institute for Health and Care Excellence guidelines. This was an improvement since our last inspection. Local audits showed good compliance with adherence to national guidelines in the management of sepsis.
- Staff were aware of the escalation processes used in times of increased demand on the service. This was an improvement since our last inspection.
- Streaming of patients had been introduced since our last inspection, this ensured patients were directed to the service best able to meet their needs. The streaming of patients aims to make care more efficient and take pressure away from emergency departments by having a primary healthcare professional “stream” patients coming through hospital doors, who can then refer them to primary healthcare or an emergency department.
- Staff monitored patients who were at risk of deteriorating appropriately. Early warning scores were in use in both adult and paediatric areas.
- The completion of the first phase of the new emergency department building was due for completion in quarter 2 of 2018/19.
- which would mean patients were assessed and treated in a more appropriate environment, which met their needs.
- There was adequate provision for the assessment and treatment of patients attending with a mental health illness, which ensured they were kept safe. Risk assessments of patients attending with a mental health illness were consistently completed.

## Is the service safe?

### Requires improvement → ←

- Our rating of safe stayed the same. We rated it as requires improvement because:
- The service was still not staffed to meet the 16 hours per day consultant presence target despite permanent locum consultants supporting the service. Advertisements for recruiting consultants had been unsuccessful.
- Compliance in mandatory training for medical staff was 79%% which did not meet the trust target of 85%. However, compliance in mandatory training had improved since our last inspection and was an improving picture and as at June 2018 was 83.8%.
- Compliance with safeguarding training amongst nursing staff and medical staff was below the trust target of 85%.
- During our last inspection, we saw there was a fire door propped open in the majors escalation area. The fire door was external and led to a raised concrete area with steps. This meant there was a potential risk that patients who may not be able to assess danger could injure themselves if they went through the open door. We saw this door was open during this inspection despite notices on the door advising that they should not be opened. This indicated the process implemented after the last inspection to ensure the doors were kept shut was not effective.
- Weekly fire safety checks were not undertaken, this was consistent with our findings at our previous inspection, which meant the department had failed to address the issue and take action. The management team had identified that there was a lack of fire safety checks undertaken and had introduced a weekly checking regime to address this.
- Daily checks of emergency equipment were not undertaken consistently, this was identified at our previous inspection.
- Daily medicine fridge temperature monitoring was not undertaken consistently, this was also found at our previous inspection.

# Urgent and emergency services

- We reviewed six sets of paediatric records all had not been fully completed. Common themes of missing information included; child's weight, pain score, no signature or name of staff member writing in notes, no date or time of entry in notes and no evidence of discharge.

However:

- The department had systems and processes in place to safeguard adults and children from abuse or harm. Staff demonstrated a good understanding of the trusts safeguarding policies, procedures and what to do should a safeguarding concern arise.
- A comprehensive investigation had been undertaken following a never event. There was an action plan to implement the recommendations, with staff allocated to them. We saw evidence, which confirmed actions had been completed, and there was a plan and timeframe for them all to be completed. The mental health room used for conducting mental health assessments was compliant with the Quality Standards for Liaison Psychiatry Services.
- Streaming of patients had been introduced since our last inspection, this ensured patients were directed to the service best able to meet their needs. The streaming of patients aims to make care more efficient and take pressure away from emergency departments by having a primary healthcare professional "stream" patients coming through hospital doors, who can then refer them to primary healthcare or an emergency department.
- Medicines were stored securely and staff followed appropriate procedures for controlled drugs.
- Infection control and prevention practices were undertaken consistently to reduce the risk of infection. Hand hygiene practices had improved since our last inspection when we observed they were not consistently undertaken during busy times.
- When things went wrong patients received an apology and were given information about changes the service made to prevent the same thing happening. We saw the trust had applied the duty of candour regulation.
- We found staff recognised incidents and knew how to report them. Incidents were investigated quickly, and shared lessons learned and changes in practice with staff.
- The service used adult and paediatric national early warning scores. This ensured staff were effectively able to check patients for risk of deterioration. We saw that patients at risk were identified and clinically managed.
- Patients presenting with suspected sepsis were treated in line with national guidelines, this was an improvement since our last inspection. Local audit data confirmed sepsis management was in line with national guidelines.
- The six paediatric patient records we reviewed showed that they were all seen within 15 minutes for initial assessment. This meant children were assessed quickly to ensure care and treatment was given quickly.

## Is the service effective?

Good   

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

- Ninety-eight percent of nursing staff and 100% of reception staff had a completed appraisal. This exceeded the trust target of 85%. This showed an improvement since our last inspection.
- Staff provided care and treatment based on national guidance and evidence based practice and used this to develop new policies and procedures.

# Urgent and emergency services

- One of the consultants had developed a paediatric patient safety leaflet for viral wheeze. The leaflet was based on national and best practice guidance. The leaflet was provided to parents and carers and contained relevant information about managing a viral induced wheeze in children. We saw there were a variety of paediatric guidelines and policies in use within the paediatric department, which reflected evidence based, practice.
- The department had a specific fractured neck of femur (broken hip) pathway, which enabled this group of patients to be treated efficiently, which was based of best practice. The pathway was audited for compliance and patient outcomes. Data from this audit demonstrated a significant improvement in mortality rates since the implementation of the pathway.
- The leadership team monitored the effectiveness of care and treatment through continuous local, national audits and investigation. For example, every patient who attended with sepsis who did not receive treatment in line with national guidelines, an investigation was undertaken to ensure lessons were learnt.
- Since our last inspection, a specific resuscitation team working in the resuscitation department had been implemented. Staff had received training and undertaken competency assessments in two new roles, a trauma practitioner and a resuscitation practitioner.
- Staff regularly reviewed patients pain levels and recorded pain scores.
- New staff received a package of support including a mentor, week induction, competencies, and educational courses. Staff had defined educational development pathways.
- We saw examples of good multidisciplinary working. Doctors, nurses, associate practitioners, clinical support workers and other healthcare professionals supported each other to provide care.

However:

- The hospitals performance in the Royal College of Emergency Medicine (RCEM) 2016/17 consultant sign-off audit was in the lower quartile for three standards.
- From January 2017 to December 2017, the trust's unplanned re-attendance rate to the department within seven days was consistently worse than the national standard of 5% and worse than the England average in all twelve months.
- The trust reported that from April 2017 to December 2017 Mental Capacity Act training had been completed by 73% of staff in within urgent and emergency care, which did not meet the trust target of 85%.

## Is the service caring?

Good   

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

- Staff provided care that promoted people's dignity. Observations of care showed staff maintained patient privacy, dignity at all times, and this was embedded within the culture of the service.
- We observed the mental health liaison team showing compassion whilst undertaking their assessment of patients.
- We observed staff took time to understand patient's specific needs through talking to them and gentle encouragement.
- Patients, families and carers were generally positive about the care received and we observed compassionate and courteous interactions between staff and patients.



# Urgent and emergency services

- We observed nurses, doctors and other professionals introducing themselves to patients at all times and explaining to patients and their relatives about their care and treatment options.

However:

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

## Is the service responsive?

**Requires improvement** ● ➡ ➡

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

- During the last inspection, we observed the flow of adult patients through the department required improvement. Adult patients experienced significant delays whilst awaiting specialist review or to be placed on a ward. We observed the same during this inspection. We found adult patients experienced significant delays whilst awaiting review by the specialist medical team.
- Data supplied to us by the trust showed the time from referral to a specialist team and the decision to admit (adult patients only) varied between 93 minutes and 239 minutes. This meant patients were spending extended periods of time within the department awaiting a review from a specialist.
- During our inspection, we observed multiple patients receiving treatment, trying to sleep or waiting within the majors waiting area.
- During our last inspection, the trust had just launched a new medical model, which facilitated prompt referral reallocation to a specialist assessment areas and medical triage. Staff told us how the model was no longer working, as senior triage of patients did not occur. However, since of last inspection the medical model has been reviewed and redesigned with input from the clinical leadership team, this model will be reviewed in July 2018.
- The model was designed to give specialty input into the patient's treatment plan and aimed to ensure clinical teams are responsible for patients care despite their location within the hospital. It was hoped that the model would enable shorter length of stays for patients.
- From February 2017 to January 2018 Medway NHS Foundation Trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted, was worse than the England average. Performance against this metric showed a general trend of improvement over the period (with poorer performance recorded in September and December 2017) but the percentage of patients waiting more than four hours from the decision to admit until being admitted continued to be much higher than the England average.
- Over the 12 months from February 2017 and January 2018, 22 patients waited more than 12 hours from the decision to admit until being admitted. The highest number of patients waiting over 12 hours was in January 2018 with 15 patients.
- Staff explained how they had 'boarded' and 'lodged' patients within the department. Lodged patients were to be admitted to the hospital under a specialist team but they were waiting for a bed to become available. Boarded patients were awaiting specialist review and there was insufficient room in the department for them so they waited in the majors waiting room. were excess to the capacity of the department.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard in three out of the 12 months from January 2017 to December 2017.

# Urgent and emergency services

- The trust accepted the NHS constitutional standard of 95% of patients to be admitted transferred or discharged within four hours remained a challenge. However, the trust had a agreed trajectory for improvement and an action plan. In addition, the Trust did meet the constitutional standard in June 2017 (95%).
- The trust has a target to close complaints within 30 days and complex complaints within 60 days. Only 28% of complaints were closed within 30 days and 67% of all complaints were closed within 60 days. This was an improvement since our previous inspection when the average time taken for the service to respond to a complaint was 62 days.

However:

- The service recognised that demand and flow throughout the department was a key issue. The adult emergency department had recently introduced a new streaming process to improve flow by ensuring patients were treated in the most appropriate setting. Streaming is the initial rapid assessment undertaken by a nurse when patients arrive in the department which determines which is the most appropriate department for the patient to be treated. Patients are then directed to the most appropriate department.
- The service took account of individual needs such as learning disabilities and dementia during triage and we saw they were noted in assessments. Carers, families and escorting mental health professionals were involved in information gathering to ensure patient needs were documented.
- There was a frailty pathway to help provide appropriate care for the significant number of patients with related needs. The frailty is a patient centred pathway which involves multidisciplinary teams and other agencies and is designed to support older people to stay within the own home.
- The department had worked with the mental health provider to improve services for people with mental health needs who presented to the emergency department.
- The paediatric emergency department had access to play specialists, located in the children and young people's department at the hospital.
- From January 2017 to December 2017, the monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was generally similar to the England average.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The trust planned and provided services in a way that met the needs of local people. They worked with commissioners, external providers and local authorities.
- There was a box within the department, which contained resources to help provide emotional support to parents who had lost a child.

## Is the service well-led?

Good   

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

- The service had a clear vision and strategy that all staff understood and put into practice.
- Staff and managers were clear about the challenges the department faced. They explain the risks to the department and the plans to deal with them.

# Urgent and emergency services

- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.
- All senior staff were passionate about delivering high quality care to patients, whilst supporting and leading staff other operational staff to achieve this.
- The department's clinical lead regularly liaised with mental health services to ensure support to vulnerable patients groups. The department understood the need to ensure equality in the care for mental health patients and patients with physical health needs.
- Consultant leadership in the department was committed and consultants demonstrated an understanding of the patients within the department and their needs.
- Staff said that there had been some improvements and some areas of deterioration since our last inspection. Areas of improvement included better triage processes, streaming of patients better staffing including middle grade doctors, nurses and associate practitioners.
- The department had governance, risk management and quality measures to improve patient care, safety and outcomes. However, the trust risk register was not the same as the risks on a poster displayed within the department.
- The department worked closely with the local Healthwatch group, they attended the monthly 'meet the matron events' which were attended by patients and relatives.

However:

- Leaders raised concerns regarding the use of the majors waiting area to 'board' patients whilst awaiting a speciality review or admission. Leaders felt patients received sub optimal care and a poor patient experience if cared for in this area for a prolonged period of time. The management team had raised concerns to the trust leadership team and felt their concerns had not been recognised. We observed that it had become acceptable to 'lodge' or 'board' patients within the department but this was not permitted elsewhere in the hospital. The trust internal professional standards state that patients should have a specialist review within 30 minutes of the time of referral however this did not happen with patients in the emergency department.
- During this inspection, we identified some issues that were also identified at the last inspection. These included; inconsistent daily checks of emergency equipment, daily monitoring of fridge temperatures, weekly fire safety checks, open door in the escalation area and not meeting the trust target for compliance with mandatory training. This meant the processes and systems put in place by the leadership team following the last inspection had not been effective.
- Staff told us that flow and capacity through the department was worse than during our last inspection. Staff told us that using the majors waiting area for patients awaiting specialist review or admission had become normalised practice. We observed that this was normalised practice as additional staff were rostered on each shift to care for patients within this area.

## Outstanding practice

Staff were able to report clinical incidents anonymously, this meant if a staff member wanted to raise a sensitive concern, they could do so in a way that ensured their identity remained confidential.

The department was nominated for three national awards. The pathway for patients with broken hips had been nominated of a Health Journal Society award and a Parliamentary award. The staff recruitment strategy had been nominated for a Health Journal award.

# Urgent and emergency services

Staff in the paediatric department had worked with other health agencies to improve asthma care in children in the local community. This included inhaler check clinics and information for parents and carers looking after children with asthma.

The service had developed a specific pathway for patients who had broken their hip. This meant a multi-disciplinary team worked together and ensured patients were assessed and treated as quickly as possible. An associate practitioner facilitated the pathway.

The department was part of an education collaborative. Emergency departments within the South East region had joined to provide education, each department offered a different educational course and staff from all hospitals attended.

## Areas for improvement

Action the trust **MUST** take to improve:

The service must ensure emergency equipment is checked consistently.

The service must ensure fire safety checks are undertaken.

The service must increase consultant cover to provide 16 hours per day consultant cover and meet the Royal College of Emergency Medicine recommendations.

Action the trust **SHOULD** take to improve:

The service should ensure fridge temperature checks are completed daily.

The service should ensure the door in the majors escalation area is secure.

The service should ensure there is restricted access to the adult department.

The service should consider how to reduce the length of time patients wait in the majors waiting area awaiting specialist review or admission.

The service should ensure medical staff are compliant with mandatory training and improve compliance in safeguarding and Mental Capacity Act training.

# Medical care (including older people's care)

Good   

## Key facts and figures

The medical care service at Medway NHS Foundation Trust provides acute specialist medicine services: gastroenterology; respiratory; cardiology; endocrinology; diabetes; dermatology; neurology and rheumatology. In addition, they offer haematology and acute oncological services. They also offer domiciliary non-invasive ventilation and sleep services. There are 318 medical inpatient beds located across 14 wards.

The trust had 31,661 medical admissions from November 2016 to October 2017. Emergency admissions accounted for 62% of all admissions (19,626), 1.2% were elective (384) and 36.8% were day case (11,651).

Admissions for the top three medical specialties were:

- General medicine (17,913)
- Gastroenterology (4,447)
- Clinical haematology (1,835)

At the last inspection, we rated three or more key questions for the service either inadequate or requires improvement so we re-inspected all five key questions.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection, the inspection team visited 10 areas:

- Cardiac care unit
- Medical assessment unit
- Medical infusions suite
- Endoscopy (Joint Advisory Group on Gastrointestinal Endoscopy Accreditation)
- Lawrence ward- oncology
- Milton ward, Harvey ward and Tennyson ward - care of the elderly
- Keats ward and Will Adams ward - gastroenterology

We looked at 29 patient records including 24 drug charts. We spoke with 12 patients and three visitors and a number of staff who worked in medical care. Staff interviews included volunteers, housekeeping staff, clinical engineers, technicians, consultants, doctors, physician associates, nurses, student nurses and care support workers.

## Summary of this service

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

Staff responded well to the deteriorating patient and there was effective sepsis management. They understood their responsibilities to raise concerns and report incidents and near misses.

# Medical care (including older people's care)

Compliance to mandatory training met the trust target of 85% and continued to improve, reaching a rate of 87% in June 2018.

The service had sufficient medical and nursing staff to provide safe care and treatment. Staffing levels were reviewed regularly to respond to changes in demand.

Although compliance to mandatory training rates was below the trust target, the rates were continuing to improve.

The service provided care and treatment based on national guidance and evidence of its effectiveness. Patients had comprehensive assessments of their needs, and staff worked collaboratively to understand and meet the range and complexity of patients' needs.

Staff were competent to do their roles and had opportunities to attend external training course. However, consent was not always obtained or recorded in line with relevant guidance and legislation.

Patients were frequently admitted to areas outside of the speciality they required, and discharges delayed. The service's referral to treatment times was worse than the England average. However, there were systems in place to aid the delivery of services to patients living with dementia, a system to be able to flag patients with additional or individual needs.

Implementation of the frailty model had reduced the number of falls in the community and the number of admissions to the service, and directorate involved patients and the public in developing services.

We found managers promoted a positive culture that supported and valued staff. However, the vacancy rate for the directorate was worse than the trust target and staff did not have a clear understanding of the new management structure.

## Is the service safe?

**Good** ● → ←

- Our rating of safe stayed the same. We rated it as good because:
- We found staff responded well to the deteriorating patient and there was effective sepsis management. We saw clear processes of on-going assessment and escalation were clearly documented in patient records. Patients received timely consultant review on admission and staff completed comprehensive risk assessments for the prevention for falls and pressure ulcers.
- All staff had access to the electronic incident reporting system and understood their responsibility to report concerns. The service investigated incidents effectively and we saw evidence of shared learning from incidents.
- The trust used a systematic approach to nurse staffing levels to ensure that patients received the nursing care they needed. Departments used an electronic rostering system, which used default staffing levels to allocate nursing staff for each shift. Senior sisters discussed and reviewed planned staffing levels at their weekly meetings.
- Overall, we judged there was sufficient medical staffing with the correct skill mix to meet the needs of the patients on a day-to-day basis. There were suitable arrangements in place for medical support out of hours.
- All records we viewed were comprehensive, contemporaneous and reflected the care and treatment patients received.
- Overall, the management of medicines was safe. Nursing staff administered medicine in line with best practice and there were effective monitoring systems in place. However, there were some omissions in fridge temperature monitoring.

# Medical care (including older people's care)

However,

- Information provided to us prior to inspection indicated mandatory training was way below the trust target. However, an update from the trust at March 2018, showed compliance to mandatory training was 83.6% for the unplanned and integrated care directorate. Although this remained below the trust target of 85%, it was an improving picture.
- Staff understood how to protect patients from abuse and knew the process to report abuse. However, staff were not trained to the recommended safeguarding training levels. There were 52 children aged 17 or under treated on medical wards between January and December 2017. Seven percent of staff on medical wards were trained to safeguarding children level three.
- Internal infection control audits showed varying levels of compliance. In March 2018 six out of nine areas we visited had met the National Standards of Cleanliness target of 95% in the housekeeping audits. In the same period, six out of ten areas met the trust target of 100%, two areas scored less than the trust target and two areas did not complete the audit for hand washing audits.

## Is the service effective?

Good   

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

- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- The service received and reviewed all guidelines from the National Institute for Health and Care Excellence (NICE). Nominated clinical leads reviewed the guidelines and assessed the compliance level within their areas. Each directorate developed and monitored action plans to meet the guidance and scheduled audits to assess the level of compliance.
- Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- Staff were competent to perform their roles, received comprehensive inductions, completed competency documents and had regular appraisals. Nurses we spoke with reported they had good training opportunities to develop their skills and felt well supported by their line managers. However, some competency documents were incomplete.
- All relevant staff, teams and services were involved in assessing, planning and delivering patient care and treatment. Staff worked collaboratively to understand and meet the range and complexity of patients' needs.
- We observed examples of good multidisciplinary working. This included effective working relations with speciality doctors, nurses, therapists, specialist nurses and general practitioners. Medical and nursing staff and care support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care
- Staff demonstrated a good understanding of the mental capacity act. Staff we spoke with were clear about how to assess a patient who lacked capacity. We observed a doctor complete a capacity assessment for a patient during the ward round and saw completed capacity assessments in patient records. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.
- The Deprivation of Liberty Safeguards, and orders by the Court of Protection authorising deprivation of a person's liberty, were used appropriately.



# Medical care (including older people's care)

- Nursing staff completed nutritional risk assessments when patients were admitted to hospital, Staff identified and monitored the nutritional and hydration needs of patients; however, we saw some examples where staff failed to meet these needs.

However;

- Although staff were clear on consent processes and procedures, we saw some staff interact with patients and saw consent was not always obtained or recorded in line with relevant guidance and legislation.
- Medway NHS Foundation Trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade D in latest audit, April to June 2017. For the same time period 12 months previously (April to June 2016) the trust also achieved grade D.

## Is the service caring?

**Good** ● → ←

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

- Staff took the time to interact with patients and their relatives in a respectful and considerate way. We observed all members of the multi-disciplinary team had a good bedside manner, introduce themselves and explain their role.
- Staff involved patients and those close to them in decisions about their care and treatment welcomed patients and their relatives to ask questions.
- Staff provided emotional support to patients to minimise their distress. The hospital had arrangements in place to provide support when needed, which included help from specialists such as end of life care, diabetes and dementia nurses.
- We spoke with patients who told us they felt safe in hospital, staff were gentle, caring and compassionate. We saw examples of thank you notes and cards written to staff from patients expressing their gratitude and some wards displayed these.

## Is the service responsive?

**Requires improvement** ● → ←

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

- There were a large number of mixed sex accommodation breaches. The commentary around this appears in the overall assessment of trust above.
- Staff told us that patients were frequently admitted to other parts of the hospital because of pressure on bed capacity. Outliers are patients admitted to wards outside of their speciality. This was a risk as the general environment was not always appropriate and staff did not always have the experience and expertise to manage the 'outlying' patients' conditions. Ward managers and matrons told us they spent a large proportion of their time trying to move patients to wards, which met their needs.
- The medical services discharged 38,418 patients in 2017 and of 21% were delayed. Staff told us delays occurred due to waits for medication and obtaining the appropriate equipment in the patient's home prior to discharge. There were high levels of patient moves out of hours.

# Medical care (including older people's care)

- From February 2017 to January 2018 the trust's referral to treatment time (RTT) for admitted pathways for medical care was worse than the England average. Performance ranged from 65% to 80% compared to an England average of 88% to 90%. Performance generally improved from February to October 2017 but this was followed by a deterioration from November 2017 to January 2018 with 66% of admitted patients treated within 18 week in the latest month.

However;

- From November 2016 to October 2017 the average length of stay for medical elective patients at the trust was 4.2 days, which was better than the England average of 5.8 days. For medical non-elective patients, the average length of stay was 6.3 days, which was similar to the England average of 6.5 days.
- The trust had improved its discharge processes with external partners and had one of the lowest delayed transfer of care rates in the country.
- There were systems in place to aid the delivery of care to patients living with dementia. The trust had a dementia and delirium specialist nursing team which staff could refer to either by phone, bleep or in person. The team assessed patients and liaised with local community services and the patient's relatives. On discharge, staff referred these patients to community memory services if required.
- The trust had a system for flagging patients with additional or individual needs on the electronic patient administration system. This meant specialist staff to contact patients and their families prior to admission, do make sure additional requirements were in place at the time of admission.

## Is the service well-led?

Good   

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

- There had a been a change in organisational structure. Staff told us the new structure meant there was clearer oversight of each programme and better governance.
- The trust's vision was to aspire to be the best by using the trust's values in everything they did. We saw values statements based on the word "BEST", which meant "Bold, Every person counts, Sharing and open and Together". All staff were able to tell us the trust's vision, 'BEST' but not all staff members were familiar with the trust's values.
- Managers across the trust promoted a positive culture that supported and valued staff. Staff we spoke to reported they were encouraged to raise concerns and received feedback on their performance. Staff spoke in positive terms about the team working with medical and specialist support to provide care.
- There were clear lines of accountability for through the medical specialities, through the directorate governance structure. Governance meetings were well attended and risk, key issues and learning shared.
- The implementation of the frailty model had reduced the number of falls in the community and the number of admissions to the service.
- The service had improved its delayed transfer of care rates, such that they had one of the lowest rates in the country.
- The directorate involved patients and the public in developing services

However;

# Medical care (including older people's care)

- However, some staff told us the management structure was top heavy and there was a lack of understanding of the new structure. They told us there was poor visibility of the board and felt there was a disconnect between them and senior leaders.
- The vacancy and turnover rates for the directorate were worse than the trust target.

## Outstanding practice

- Implementation of the frailty model had reduced the number of falls in the community and the number of admissions to the service, and directorate involved patients and the public in developing services.
- The trust had one of the lowest delayed transfers of care rates in the country. It had worked hard with external partners improve the discharge processes for patients. This demonstrated there was better patient flow through the hospital and better discharge planning.
- The trust had worked to reduce the numbers of patient falls in hospital. The appointment of a falls prevention clinical specialist nurse, falls awareness campaign and the implementation of a falls investigation toolkit had resulted in an 11 per cent reduction in falls in from April to March 2017.
- Medical care departments had several volunteers recruited in the role of 'Dementia Buddies'. A volunteer told us they undertook specialist dementia training to carry out the role.
- The trust provided monthly "carers' coffee breaks" in the hospital canteen. The purpose of the carers' coffee breaks was to provide emotional support to the relatives and carers of patients living with dementia. We saw details of the coffee breaks advertised to carers of patients on Will Adams Ward.

## Areas for improvement

Actions the trust **MUST** take to improve:

- The trust must ensure they meet the Department of Health's standard on eliminating mixed sex accommodation, except where it is in the overall best interests of the patient or reflects the patient's choice.
- The trust must embed an effective system to ensure the service meets the trust targets for safeguarding training to protect vulnerable adults and children and young people from harm and abuse.

Actions the trust **SHOULD** take to improve:

- The trust should ensure consent is obtained or recorded in line with relevant guidance and legislation.
- The trust should ensure staff compliance with infection prevention and control compliance is within the trust target.
- The service should ensure all staff have been trained and are competent to use medical equipment.

# Surgery

Requires improvement   

## Key facts and figures

Medway Maritime Hospital delivers a range of general and specialised surgical services including planned and emergency procedures. These included inpatient and day care services covering a range of specialties including colorectal, breast, vascular, orthopaedics, urology, maxillofacial, ear nose and throat, chronic pain management and laparoscopic keyhole surgery.

The trust has 14-day case and 158 inpatient surgical beds. The service has 17 main operating theatres. Four of the 17 operating theatres are for day surgery. These form part of the Sunderland Day Care Unit. The trust has seven surgical wards: Arethusa, Kingfisher, McCulloch, Pembroke, Phoenix, Sunderland and Victory.

The service has a pre-operative care unit (POCU), where patients change, prepare and have admission checks before going to theatre for elective surgery. POCU has 12 small cubicles, with seating for patients and their relatives and four consultation rooms. For emergency admissions, the hospital has an eight-bedded surgical assessment unit (SAU), with a four-bay assessment area, adjacent to Kingfisher Ward. The hospital's emergency department can refer patients to the SAU for assessment pending emergency surgery. The SAU also has a triage room, a seated waiting area and a clinic room.

The trust had 22,919 surgical admissions from November 2016 to October 2017. Emergency admissions accounted for 41.5% of all admissions (9,515) and 58.5% (13,359) were elective admissions, of which 9,321 were day case and 4,083 were inpatient stays.

During the inspection, we visited theatres, Sunderland Day Care Unit, Arethusa, Kingfisher, McCulloch, Pembroke, Phoenix, Sunderland and Victory Wards. We spoke with 59 staff members, including all grades of medical and nursing staff, clinical support workers, physiotherapists, occupational therapists and housekeeping staff. These were a mixture of permanent, bank and agency staff. We spoke with eight patients and four relatives.

We observed nursing, doctor and multi-disciplinary team handovers, nursing safety huddles and drug rounds. We also reviewed patient records, medicine prescription charts, and performance data before, during and after the inspection.

We also took into account views and feedback provided at staff focus groups and drop-in sessions, which we facilitated before the inspection.

## Summary of this service

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

- While the service improved in some areas, it stayed the same or became worse in others since the last inspection.
- The service could not be assured if nursing staff were appropriately skilled or competent to carry out their roles, to provide safe care.
- Ineffective paper systems in theatres and shifts for medical staffing created risks to data quality, timeliness of the data collected and the loss of personal and confidential information.

# Surgery

- The service did not meet Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment HBN 00-09. The service had not addressed the worn floors in the corridor to the theatre since the last inspection. We also saw a damaged wall in an anaesthetic room. This created the risks of spreading infection as damaged areas can make cleaning difficult.
- While the service had improved staff recruitment, there remained significant challenges to retain staff. This caused gaps in rota coverage and high reliance on bank and agency staff. This issue was identified at the last inspection and continued to require improvement.
- Actions and learning from patient deaths had not improved since the last inspection. Information about actions and learning was not always complete and there was not a system to ensure learning was discussed and shared with staff.
- The trust did not meet the Department of Health's standard on eliminating mixed sex accommodation.
- Capacity to manage the number of patients being admitted led to significant shortfalls in the responsiveness of the service. This issue was identified at the previous inspection and continued to require improvement.
- Staff morale was low and felt the return of a bullying culture after a short-lived positive experience since the trust came out of special measures. Communication from the senior management team was poor.

However:

- Following this inspection, trust information provided to us showed an overall 85.5% of staff had completed mandatory training as at June 2018 achieving the trust's training completion target of 85%. This meant staff had the correct level of training in line with trust policy. Having a sufficient level of mandatory training meant staff were supported in fully and correctly applying the appropriate skills for their roles.
- There were correct processes around the safe management of medicines, including controlled drugs. This had improved since the last inspection.
- Patients were provided privacy and dignity during intimate examinations and personal care. This was identified as an issue in the last inspection.

## Is the service safe?

**Requires improvement**   

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

- The service remained not meeting the Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment HBN 00-09. The worn floors in the corridor to the theatres had not been addressed since this concern was identified in the last inspection. We also saw several holes on a wall in an anaesthetic room which can harbour dirt and dust, making cleaning difficult.
- Whilst staff understood how to protect patients from abuse, the service had not improved on safeguarding training completion since the last inspection. We saw overall poor completion rates for safeguarding vulnerable adults training at level two; and children and young people at level three.
- Although the service had improved in the recruitment of nursing staff, challenges to retaining them remained. Therefore, there were gaps in rota coverage and continued high reliance on bank and agency staff. This issue was identified at the last inspection and continued to require improvement.

# Surgery

- Actual staffing levels were lower than planned for prolonged periods within the surgical service, despite staff raising this as incidents. However, the trust told us staffing was reviewed every morning and staff may be reallocated according to ward needs to ensure safe staffing across the directorate.

However:

- Following this inspection, trust information provided to us showed an overall 85.5% of staff had completed mandatory training as at June 2018 achieving the trust's training completion target of 85%. This meant staff had the correct level of training in line with trust policy. Having a sufficient level of mandatory training meant staff were supported in fully and correctly applying the appropriate skills for their roles.
- Staff continued to complete risk assessments including escalation of deteriorating patients for timely medical review in line with trust policies.
- There were correct processes around management of medicines, in line with trust policy. Medicines including controlled drugs were stored securely, had correct stock balances and were within expiry dates.
- We saw a positive and embedded incident reporting culture since the last inspection. Staff had the knowledge to exercise the Duty of Candour when mistakes in their care had led to significant harm. We saw evidence from root cause analysis investigations that the service applied the Duty of Candour following serious incidents.

## Is the service effective?

**Good**   

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

- Patients were treated with evidence based care and treatment. Staff followed national guidance such as NICE and the Royal College of Surgeons. The service had a comprehensive local audit programme to measure performance.
- The service used routinely monitored and collected information to improve care. Benchmarking data showed most of the patient outcomes were similar to national averages. The trust's performance demonstrated continuous improvement in some areas since the previous year.
- The trust held staff appraisals and reported annually from April to March, with a trust completion target of 85%. Trust data from April to December 2017 showed 79.5% of surgical staff had an annual appraisal. The trust assured us the remaining 20.9% surgical staff were due to complete their appraisals by March 2018. Appraisal data from April to December 2017 showed 100% of qualified allied health professionals and 88.4% of medical staffing had annual appraisal.
- Staff provided food and drink to meet patient needs and improve their health. They used special feeding and hydration techniques as necessary and made adjustments for patients with religious, cultural and other preferences.
- This service managed patients' pain relief effectively. We saw an example when a patient was responded to quickly when showing non-verbal signs of being in pain. All seven pain assessment tools we reviewed were fully and correctly completed.
- We saw good examples of multidisciplinary team working, across the hospital and with external agencies.
- Although not all relevant staff had Mental Capacity Act level two and deprivation of liberty safeguards training, staff we spoke with understood how to assess mental capacity and work within the legal requirements of the Mental Capacity Act (2005) when required. Trust data provided to us after the inspection showed 76% training completion rate as at June 2018 which was worse than the 2016 figures

# Surgery

However:

- The service had no assurances if nursing staff were appropriately skilled and competent to perform their roles, to provide safe care. Other than safe medicines management, there were no competency checks for Phoenix and McCulloch Wards for nursing staff. At the time of inspection, the competency templates to support the checks were still awaiting approval six months since its proposal.
- While the service had introduced audits on pre-operative fasting times, trust data showed patients often fasted for longer periods than clinically necessary. Following this inspection, the trust informed us this service had implemented the audit recommendations. For example, patients that can be identified during the WHO checklist that are going to wait for longer than two hours for surgery were now given water up to two hour before surgery.
- Trust data from April to December 2017 showed 73.1% of surgical staff completed Mental Capacity Act level two and deprivation of liberty safeguards training. This was worse than the trust target of 85% and had deteriorated since the last inspection.

## Is the service caring?

**Good**  

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

- Staff cared for patients with compassion. Feedback from patients confirmed staff treated them with respect and kindness, even during staff shortage and busy periods. Patients noted staff were caring, genuine and friendly.
- Patients overall stated they received good communication about their care and staff involved them in decision-making. We saw staff involved patients and their relatives for discharge arrangements.
- Staff treated patients with privacy and dignity during intimate examinations and personal care. This had improved since this was an issue found in the last inspection.
- We saw good examples of staff providing emotional support to patients. The trust also provided a chaplaincy service available to provide emotional and spiritual support for patients and their loved ones in different denominations of faith.
- Patients could access patient information leaflets about their surgery, before and after the procedure.

However:

- The NHS Family and Friends Test response rate of 25% was worse than the national average of 29%, from December 2016 to November 2017. This had not changed since the last inspection. The recommendation rates were also worse than the national average.

## Is the service responsive?

**Requires improvement**   

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



# Surgery

- There had been no improvements with access and flow within the service and across the hospital since the last inspection. Patients were constantly moved to different wards and we saw placements of medical patients in surgical beds, and patients with intensive care needs in recovery. Staff and patients told us the service also carried out bed moves and discharges late in the evening.
- The trust's referral to treatment time for admitted pathways for surgery was worse than the England average. This had not changed since the last inspection and continued to require improvement. Only urology performed better than the England average.
- The trust had not met the Department of Health's standard on eliminating mixed sex accommodation.
- Over the last two years, the percentage of cancelled operations as a percentage of elective admissions at the trust showed an overall decline.
- The service could not provide theatre utilisation rates during inspection. Trust information provided to us following this inspection showed 79.8% theatre utilisation for all theatres for April 2018. Of these, utilisation for main theatres was 87% and day case was 71.1%. This provided the service information to monitor the efficiency on theatre utilisation.
- While the average number of days the service took to investigate and close complaints since the last inspection had improved significantly, 42.4% of all complaints remained open after 30 days. This remained not in line with trust policy and continued to require improvement.

However:

- The service made reasonable adjustments and took action to remove barriers for patients who found it hard to use or access services. This included interpreting services, services for patients living with dementia and facilities for bariatric patients.
- Staff arranged appropriate equipment to meet patient needs before surgery to enable timely availability of equipment after discharge.
- We saw openness and honesty in complaint responses and evidence of learning from complaints.

## Is the service well-led?

**Requires improvement**   

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

- While the trust had a governance structure to manage the service's risks, issues and performance, they did not indicate all risks were considered. We reviewed the trust and service risk registers. We saw that items on the register matched the things senior staff told us were on their "worry list". This included patient flow and the nursing staff shortage, which also fitted with areas we identified for improvement during our inspection. We saw evidence of mitigation of identified risks, for example, appropriate induction topics for junior doctors covering night shifts. However, we did not see the worn floors in the corridor of the main theatres and holes in a wall in the anaesthetic room on the trust-wide or service risk registers.
- Staff satisfaction continued to be mixed in some areas. A few staff felt there was an improved culture when the trust came out of special measures but that this was short lived. They felt that staff morale had deteriorated and there was a return of the bullying culture since changes to the senior management team structure in autumn 2017. A few staff reported they did not know who their line manager was and a few were told off for raising a concern about a senior manager's behaviour.



# Surgery

- While staff felt they worked well with their managers, they continued to experience pressure to take additional patients and medical patients on the surgical wards and in recovery.
- The trust had introduced training to support and develop leaders, such as matron development days. However, staff felt they did not have time to attend training due to staff shortage on the wards.
- We saw poor communication about the change of visiting hours for visitors. Staff we spoke with told us they had not been informed of the change until they found out when patients and their visitors challenged them.
- Information management was ineffective. We saw paper records to record all surgical cases in theatres, despite the service introducing an electronic system. The trust was also unable to provide the number of medical staffing shifts available per month due to the data being collected manually. However, following this inspection, the trust assured us they were on plan to implement electronic rostering for medical staff by September 2018.

However:

- Staff in all areas knew and understood the vision and values, and how they played a part in their roles.
- The service held regular monthly mortality and morbidity meetings. The purpose of the meetings was to allow clinicians to discuss patient deaths and other adverse events in an open manner, review care standards and make changes if needed.
- The trust had improved its engagement with staff, the public and their stakeholders. We saw they had introduced various initiatives and use feedback from their engagement to make improvements for this service.

## Outstanding practice

- The service implemented a minimally invasive surgery tool “Da Vinci Robot” to provide care to patients undergoing prostate surgery. Under the control of a highly-trained surgeon, the tool performed complex and precise procedures in a way not possible with human hands. The trust is a hub of the West Kent Urology Cancer Centre. This meant prostate cancer patients across the whole region could benefit from this service. The service also had future plans to expand the range of procedures carried out by the tool.
- The service implemented a bereavement service led by a consultant. This enabled families of patients who had died to obtain any unanswered questions and to raise any concerns they may still have.

## Areas for improvement

Actions the trust MUST take to improve:

- The trust must ensure the flooring and walls meet the Department of Health’s Health Building Note 00-09.
- The service must ensure they meet with the national specifications for cleanliness on the frequency of cleaning audits carried out in high-risk areas.
- The service must ensure nursing staff are appropriately skilled and competent to carry out their roles, to provide safe care.
- The trust must ensure they meet the Department of Health’s standard on eliminating mixed sex accommodation, except where it is in the overall best interests of the patient or reflects the patient’s choice.
- The trust must ensure there are no patients staying overnight in the recovery area.
- The trust must embed an effective system to ensure the service meets the trust targets for mandatory training, including safeguarding training to protect vulnerable adults and children and young people from harm and abuse.

# Surgery

- The hospital must have an effective system to ensure only clinically suitable patients were cared for in the surgical areas.

Actions the trust SHOULD take to improve:

- The service should implement an effective system to ensure patients were not fasted for longer periods than clinically necessary.
- The trust should address the referral to treatment time for admitted pathways for surgery.
- The trust should embed effective systems and ensure staff use them to record data in a timely manner and to protect personal and confidential data from the risks of loss.
- The trust should address the issues of low staff morale and bullying culture to support staff health and well-being.
- The trust should ensure effective communication from the senior management team.
- The trust should implement an effective system to respond to patient complaints in compliance with timelines set in the trust's complaint policy.

# Critical care

Requires improvement   

## Key facts and figures

The trust identified Critical care as: “the treatment and monitoring of people who are in a critically ill or unstable condition”. The critical care team supported the care of inpatients across all of the hospitals specialities.

We inspected the following services:

- Nine bed level 3 Intensive Care Unit (ICU)
- Six bed level 2 Medical High Dependency Unit (MHDU)
- Ten bed level 2 Surgical High Dependency Unit (SHDU) 'Trafalgar'

An acute response team, acting as an outreach critical care team, provided a supportive role to the wards, medical, surgical and nursing staff when caring for deteriorating patients and supporting patients discharged from critical care. This team was available 24 hours a day, seven days a week.

The trust was part of the South East Critical Care Network.

During our inspection we visited all three adult critical care units and the acute response team. We spoke with 32 staff members who included all grades of medical and nursing staff, senior managers, clinical support workers, physiotherapists, occupational therapist and pharmacists. We spoke with three relatives and six patients. We observed the care and treatment patients were receiving, attended multi-disciplinary unit rounds and reviewed 12 patient records including medicine prescription charts.

Before our inspection we reviewed performance information from and about the Trust and data from the Intensive Care National Audit and Research Centre (ICNARC).

## Summary of this service

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

- Patient flow throughout the hospital resulted in delayed discharges and very high occupancy rates. This was having a significant impact on discharges from the medical and surgical high dependency units.
- Patients were being cared for in recovery beds when no intensive care bed was available. This impacted on nurse staffing and posed an increased risk and unsuitable environment of care for critically ill patients.
- Out of hours discharges (between 10:00pm and 7:00am) were above national average.
- Nursing cover did not always meet the minimum requirement in line with the Guidelines for the Provision of Intensive Care services 2015. This included ratio of nurses to patients and the availability of a supernumerary nurse in charge.
- There was a shortage of medical cover for critical care units. This was identified in the service's risk register. There were however remedial actions being taken in recruitment and training initiatives.
- Staff did not feel they understood the senior leadership structure since this had been reorganised in the last two months and staff commented the senior management team was not always accessible or visible.

# Critical care

- There was a lack of middle management stability and staff had concerns over key people leaving the service. During inspection the matron was present and was leaving after the week of inspection. The internal secondment advert was in place, but when speaking to staff and to the matron during inspection no one had been appointed yet and there was a plan to escalate a member of staff to the role but had not been put into place.
- Staff feedback was that they related to the vision and values identified but did not feel they had a voice in the decision-making processes. For example, there had been a change of visiting times for patients and unit staff were not consulted on the impact of this.

However

- Care was evidence based and staff used national guidance and the service was looking at ways to improve patient care and treatment. The critical care service was actively engaged in research to improve patient care and treatment.
- The needs and preferences of different people were taken into account when delivering and coordinating services. These included coordinating care with other services as well as families and carers. Patient feedback was consistently positive.
- Medical staff compliance to mandatory training had improved and was better than the trust target.
- There was a governance structure to manage the service and the leadership team implemented measure to address risks and performance effectively and regularly reviewed these.
- There was a strong focus on continuous learning including the use of external accreditation and participation in research.

## Is the service safe?

**Requires improvement** ● ➡ ➡

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

- The service had not improved its mandatory training compliance since the last inspection and compliance in seven out of ten modules for medical staff and four out of nine modules for nursing staff did not meet the trust target.
- Staffing levels did not always ensure guidelines of the minimum ratio of one nurse to one level three patient, one nurse to two level two patients and a supernumerary nurse in charge of the unit was always met.
- There was a lack of medical cover for critical units. This was identified in the service's risk register, there were remedial actions being taken in recruitment and training initiatives to try to address this.
- The trust had 1 whole time equivalent critical care pharmacist who provided a clinical pharmacy service Monday to Friday. Out of hours clinical pharmacy advice was available by telephone through the on-call pharmacist. Staff told us that a lack of cover during weekends affected the service.
- There was a heightened reliance on recovery beds to nurse critically ill patients and this was seen to impact on nurse staffing.
- The ICU stationary store had a lot of paper stored on the floor and the floor appeared dusty.

However:

- Staff were clear about what was seen as a safeguarding issue and how to escalate safeguarding concerns.

# Critical care

- We observed good practice in relation to infection prevention and control. All clinical practice areas were visibly clean and tidy and staff adhered to good hygiene practices. Infection prevention and control prompts, information and leaflets were readily available for staff and everyone entering the units.
- There was a safe environment on the critical care units. Equipment was well stocked and readily available for the service and staff received training.
- We found evidence of assessment of patient risk with associated documents fully completed. There was a coordinated approach to assessing and managing patient risk with the use of the acute response team and the clinical co-ordination centre.
- There was a consultant rota that ensured critical care services had a consultant available 24/7.
- There were good systems and processes in place with regards to the management of medicines. The medicine charts we reviewed had been completed in line with trust and national guidelines.
- The service showed good incident management and used these as an opportunity to develop the service and provide teaching to staff.

## Is the service effective?

Good   

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

- Care was evidence based and staff used national guidance and had good access current local safety standards for invasive procedures (LocSSIPs).
- The service was looking at ways to improve patient care and treatment. The critical care service was actively engaged in research to improve patient care and treatment.
- There was good monitoring of pain and nutritional status of the patients, and a care plan to support this.
- Staff were competent and the service provided good opportunities for learning and professional development. For example, the advanced critical care practitioner course.
- There was good teamwork and communication within the multidisciplinary team.
- Staff supported patients in actively achieving healthier lifestyles, the most current initiative being a medical led smoking cessation programme.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

However:

- At the time of inspection pharmacy support did not meet Guidelines for the Provision of Intensive Care Services (GPICS) standards; this was listed on the risk register and there were plans to address this.

## Is the service caring?

Good   

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

# Critical care

- Feedback from patients and relatives we spoke with was consistently positive and praised staff's care and availability.
- Staff took time to interact with people who use the service and those close to them in a respectful and considerate way. There was a culture of empathy in the service.
- Staff had a good understanding of the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially.
- There was a holistic approach to care with patient and family involvement. Patients told us they felt part of the team.

## Is the service responsive?

**Requires improvement** ● ➡ ➡

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

- Critical care patient flow was highly impacted by the lack of available beds on the wards. This was having a significant impact on discharges from the medical and surgical high dependency units.
- Patients were being cared for in recovery beds when no intensive care unit bed was available. This appeared to have become routine practice.
- Out of hours discharges (between 10:00pm and 7:00am) were above national average.

However:

- Access to care was based on people's needs. Facilities and premises were appropriate for the services being delivered.
- The needs and preferences of different people were taken into account when delivering and coordinating services. These included coordinating care with other services as well as families and carers.
- The trust had recently established a clinical co-ordination centre to monitor and direct patient flow within the hospital.

## Is the service well-led?

**Requires improvement** ● ➡ ➡

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

- Staff did not feel they understood the senior leadership structure since this had been reorganised in the last two months and staff commented the senior management team was not always accessible or visible.
- There was a lack of middle management stability and staff had concerns over key people leaving the service. No viable alternatives had been found in a suitable timeframe creating a hierarchical gap and uncertainty for the staff. This raised concerns about succession planning and the risk of staff without the necessary experience having to fill roles they were not ready for
- Staff feedback was that they related to the vision and values identified but did not feel they had a voice in the decision-making processes. For example there had been a change of visiting times for patients and unit staff were not consulted on the impact of this.
- Not all staff were aware of the freedom to speak up guardian role.

# Critical care

However:

- Leadership was knowledgeable about issues and priorities for the quality of services
- There was a clear statement of vision and values and defined objectives that were achievable and relevant. In addition, the medical high dependency unit had developed a supporting vision and values relevant to the department.
- Within the critical care units there was a culture of safety and staff felt able to raise concerns with their own management teams.
- There was a governance structure to manage the service and the leadership team implemented measure to address risks and performance effectively and regularly reviewed these.
- There was a strong focus on continuous learning including the use of external accreditation and participation in research.

## Outstanding practice

- The Green book. This book consisted of 36 emergency situations and their respective algorithms for the management of acute clinical emergencies. It enabled staff to have easy access to emergency algorithms for treatment and was consistently reviewed in line with best practice and guidelines.

## Areas for improvement

Action the trust SHOULD take to improve:

- Nursing and medical staffing levels on the critical care units should comply with the Guidelines for the Provision of Intensive Care Services, 2015.
- Pharmacist cover should ensure seven-day cover. The current five-day cover met the minimum requirement and impacted the efficiency of the units.
- Critical care patients should not be routinely nursed in recovery beds as stated in the Guidelines for the Provision of Intensive Care Services, 2015.
- Patients discharge should not be delayed once they are deemed medically ready to transfer to a ward.
- Out of hour discharges should be avoided as per Guidelines for the Provision of Intensive Care Services, 2015.

# Outpatients

Good 

## Key facts and figures

Medway Maritime Hospital provides outpatient appointments for a variety of specialties where assessment, treatment, monitoring and follow up are required. The hospital has medical and surgical speciality clinics, as well as paediatric and obstetric clinics.

The outpatient clinics are located in different areas. Outpatient areas one to eight and the pharmacy are located in the main building. The phlebotomy department is in an adjacent building. The trust runs a small number of clinics at other local hospitals.

Outpatient services are provided at a number of locations throughout the site. The main outpatient department is located just off the main entrance to the Medway Maritime Hospital and there are also individual outpatient areas located in specialty areas. The outpatient department is responsible for the facilitation of the clinics, although they are clinically managed by the specialties.

During the inspection, we visited outpatient areas one to eight, phlebotomy, the pharmacy. We spoke with 20 members of staff including managers, consultants, nursing staff and administrative staff. We spoke with 21 patients and their relatives. We reviewed eight sets of patient records.

The outpatient department is part of the women's and children division, which is part of the planned care directorate.

## Summary of this service

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

- There was no way of monitoring how many medical staff in outpatients were compliant with mandatory training.
- Referral to treatment targets remained consistently worse than the national average on most pathways.
- The response time for outpatient complaints was worse than the hospital's target.
- The outpatient pharmacy department could not provide assurance that turnaround times were being accurately monitored following issues with the electronic system used to track outpatient prescriptions.
- Signage for the outpatient pharmacy was non-existent.
- The outpatient department did not have oversight of how many medical staff had completed their mandatory training as these staff were managed by their individual speciality.

However:

- The service managed patient safety incidents well.
- The trust monitored patients who could be at risk of harm from a long wait to see a clinician.
- Staff were competent to perform their roles and received regular appraisals.
- Staff cared for patients with compassion and feedback from patients regarding their care was continually positive.
- Risks for the service had been identified at a service level, but wider risks such as the referral to treatment targets were not identified.



# Outpatients

- Staff knew and understood the hospital vision and values and told us the culture of the department was positive.
- Staff told us their line managers and senior managers were visible and supportive.

## Is the service safe?

**Good** 

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

- The service controlled infection risks well. The areas we visited appeared visibly clean, tidy and free from clutter. Audits generally demonstrated required standards of cleanliness were met.
- Assessment of patient risk was well managed. Clinical oversight of patients waiting over 52 weeks for an appointment was embedded in practice. There was a gradual reduction in the number of patients waiting over this time.
- The service provided mandatory training in key skills to nursing staff and made sure everyone completed it.
- Staff kept appropriate records of patients care and treatment. Records we reviewed were tidy and in good order with the correct documentation present.

However:

- Two serious incidents were reported by the department. However, we reviewed the RCAs for these and found that dates for action plan implementation was not included on one, and documents had not been ratified and disseminated as part of the action plan in the other.
- We observed that one child had been seen in an adults' outpatient clinic in the dermatology department. Whilst we were told this was unusual, children and young people should always be seen in a dedicated clinic, not part of an adults' clinic. Following the inspection the trust advised that outpatient staff had appropriate levels of safeguarding training which indicated that there were mitigations in place regarding this issue.
- As the medical staff that worked in outpatients were managed by their individual specialities, it was not possible to ascertain how many medical staff that worked in outpatients had received an appropriate level of training, including safeguarding training.

## Is the service effective?

We do not rate effective in outpatient services as there is not sufficient evidence to rate them.

We found:

- The service made sure staff were competent for their roles and new or temporary staff were given an induction and orientation to the department.
- The appraisal rate for nursing staff was better than the trust target. This had improved since our last inspection.
- The service monitored the effectiveness of care and treatment. The service took part in national audits, such as the UK Parkinson's audit.
- Different staff groups worked together as a team to benefit patients. The fracture clinic encompassed staff from outpatients, as well as diagnostic imaging to provide a "one stop" clinic.

# Outpatients

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005. We saw that training compliance on these topics for nursing staff was better than the trust target.

## Is the service caring?

**Good** 

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

- Staff cared for patients with compassion. Feedback from patients we spoke with on inspection reflected staff were kind and understanding.
- Patients privacy and dignity was upheld, and we observed staff knocking and waiting before entering consultation rooms.
- We saw examples of staff providing emotional support to patients. Clinics had access to specialist nurses who had additional training in emotional and psychological support. The trust also provided a chaplaincy service to provide emotional and spiritual support for patients and their loved ones in different denominations of faith.
- Staff involved patients in decisions about their care and treatment. We observed consultations where patients were given options and time to consider these.

However:

- The NHS Friends and Family Test (FFT) results for outpatients were slightly worse than the England average between August 2017 and February 2018.

## Is the service responsive?

**Requires improvement** 

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

- Waiting times and arrangements to admit, treat and discharge patients were generally worse than national standards set:
- The trust's referral to treatment time for non-admitted pathways were consistently worse than the national average. Only thoracic and neurology performed better than the England average during 2017.
- From February 2017 to January 2018, the trust's referral to treatment time for incomplete pathways was consistently worse than the England average. The latest figures for November 2017 showed 82% of patients on an incomplete pathway were treated within 18 weeks compared to the England average of 89%.
- In the last four quarters, the trust performed worse than the 93% standard for people being seen within two weeks of an urgent GP referral, with the exception of just one quarter (Q3 2017/18).
- The trust performed worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral in all of the last four quarters. There has been no improvement in performance over time.
- Signage to the outpatient pharmacy was confusing and we observed patients and visitors not able to locate it easily during our inspection.

# Outpatients

- The outpatient pharmacy department was not monitoring their prescription turnaround times and we observed patients waiting up to three hours for their prescription during our inspection.
- Complaints were not responded to in line with the timescale set by the hospital.

However:

- The trust's "did not attend" rate was better than the England average, indicating that work completed by the trust regarding text message reminders and information had a positive effect.
- The trust performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) in three out of the last four quarters, with an improvement in performance over time.
- The service made reasonable adjustments for patients who found it hard to use or access services. This included interpreting services, and services for patients living with dementia and learning difficulties.

## Is the service well-led?

**Requires improvement**



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

- Whilst there were dedicated matrons, directorate service managers and a head of operational performance, there was no one staff member dedicated to driving the outpatients service forwards. Following the inspection, the trust advised that the programme management team were responsible for this.
- There was no formal department strategy although senior staff could articulate the direction and aim of the outpatient department. This had not been addressed since our last inspection.
- There was no vision or values documented for the outpatient department, however the trust's vision and values were well understood by the staff and reflected in their work. They were publicised on posters and documentation throughout the hospital.

However:

- While there were two senior vacancies in the overarching management structure of the surgical services programme, staff told us they felt well supported and able to raise issues and concerns with their own line managers and senior managers.
- The culture throughout the department was positive and staff felt valued and supported in their roles.
- Since our previous inspection, we saw that the outpatient department had identified risks on the risk register and senior staff were aware of these risks.

## Areas for improvement

Action the trust MUST take to improve

- The service must ensure there is a process in place for dealing with children that need to be seen in the adults outpatients department.
- The service must take action to improve RTT performance.

# Outpatients

- The service must ensure that they meet their own target for outpatient prescriptions and monitor and audit this process.
- The service must ensure that complaints are responded to within the target response times.
- The outpatient department should formalise a strategy.
- The outpatient pharmacy signage should be made clearer.

# Diagnostic imaging

Requires improvement



## Key facts and figures

The trust provides a diagnostic, interventional and therapeutic service for the local population, seeing patients from GP surgeries, hospital clinics, inpatient wards and the Emergency Department. The diagnostic and imaging department carries out routine x-rays, as well as more complex tests such as Magnetic-Resonance Imaging (MRI) and Computerised Tomography (CT) scans. The department also provides nuclear medicine, osteoporosis and the management of bone and thyroid clinics aligned to these services. Most imaging services are provided at Medway Maritime Hospital. A range of services are also provided at a local community hospital in Swale and a plain film x-ray service at two local prisons.

The department was re-accredited with the Imaging Service Accreditation Scheme (ISAS) in November 2017.

The trust undertook 258,740 diagnostic tests from January 2017 to December 2017.

### Activity by modality

A breakdown of diagnostic test activity by modality at Medway NHS Foundation Trust from January 2017 to December 2017 is shown below:

Test	Total activity	% of all activity
Computerized Axial Tomography	31,280	12.1%
Diagnostic Ultrasonography	39,035	15.1%
Plain Radiography	150,865	58.3%
Single Photon Emission Computerized Tomography	170	0.1%
Magnetic Resonance Imaging	21,735	8.4%
Fluoroscopy	7,550	2.9%
Nuclear	8,105	3.1%

(Source: NHS England)

# Diagnostic imaging

The department was situated within the main outpatient area of the hospital, with an additional x-ray facility situated in area five of the outpatient clinic area. During our inspection we visited x-ray, MRI, CT, osteoporosis dxa scanning, interventional radiology and ultrasound departments. We spoke with 18 staff including managers, consultant radiologists, sonographers, radiographers, nursing staff and administrative staff. We also spoke with seven patients and three relatives.

As part of our inspection, we looked at hospital policies and procedures, staff training records and competency assessments, audits, performance dashboards, meeting minutes and governance records.

## Summary of this service

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- Systems, processes and practices did not always keep people safe and safeguarded from abuse because;

Cleaning of ultrasound probes did not meet guidance presenting an infection risk.

Resuscitation equipment was not adequately monitored.

Turnover, vacancy and sickness rates were higher than the trust target.

Safety huddles were not sufficiently recorded.

- The provider had not ensured the proper and safe use of medicines because;

Fridge temperatures were not monitored in line with trust policy.

Contrast injections used within CT were not checked by a second registered person as required by local policy and national guidance.

However,

Following inspection, the trust provided us with assurance these issues had been dealt with and would continue to be monitored.

- Waiting times for scans were worse than the national averages in some areas including MRI, CT, ultrasound and dxa scanning.
- Report turnaround times for general imaging was longer than the trust target of five days. The average time from imaging to report taking seven days.
- Changes to the process for obtaining porters to transport inpatients had resulted in delays and waits for patients.
- There was limited space in some areas of the department for patients in wheelchairs.
- There was no formal strategy for diagnostic imaging at the time of inspection. Although the management team had developed a draft strategy it had not been agreed or implemented.
- There were four vacant leadership posts within diagnostic imaging. There good local leadership within the imaging department with staff consistently telling us that imaging department managers were approachable. However, staff said senior trust and directorate leaders were not visible in the department. They felt that changes were implemented without their involvement, consultation or their concerns being listened to.
- IT systems did not support the monitoring of demand, activity and capacity across the modalities within the department.

# Diagnostic imaging

However;

- The completion of mandatory training was better than the trust target overall.
- There were quality assurance systems to monitor the safety of equipment within the department.
- There was appropriate safety signage within the department.
- Environmental cleaning audit results were consistently good.
- Patient safety incidents were investigated and action was taken to monitor and improve safety. Radiation incidents were reported and monitored in line with legislation.
- A radiation protection advisor, radiation protection supervisors and local rules were present in each modality in diagnostic imaging.
- Chaperones were available patients were receiving care and support from a member of the opposite sex.
- Staff demonstrated understanding of the needs of patients who were vulnerable and those who might be frightened, confused or phobic. Where patients were anxious about the process of the scan, staff made arrangements for them to visit the department prior to their appointment so they were familiar with the process and the equipment in use.
- Staff provided patients with information leaflets and allowed time for discussion prior to procedures.
- Volunteers were available to support patients and we observed them doing so with kindness and respect.
- The diagnostic imaging department conducted their own patient satisfaction survey every six months. Results from the most recent survey showed that 99% of patients felt that their privacy and dignity was respected.
- There were governance procedures in place with sufficient contact and advice for the provision of radiation protection supervisor services. There were regular radiation protection committee meetings and governance meetings and in place.

## Is the service safe?

### Requires improvement



We previously inspected jointly diagnostic imaging with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- The temperature of a medicines fridge within the MRI department was not monitored daily in line with trust policy. There were out of date paper copies of patient group direction for a contrast agent no longer used in the MRI department.
- The trust policy stated that intravenous medicines must always be checked by a second registered person. However, staff in CT told us this was not always possible as there was only one registered staff member on shift at night. The trust told us they took action to address this issue immediately by developing a flow chart of action to be taken and ensuring that all staff were aware that intravenous medicines should be checked by a second general radiographer working on site overnight.
- A resuscitation trolley in the interventional radiology department, shared with other modalities, was not checked daily at weekends. There was no paediatric equipment available in CT and there were boxes stored in front of the CT resuscitation trolley. This meant that staff may not be able to access the necessary equipment quickly in an emergency.

# Diagnostic imaging

- We were told that safety huddles were held on a weekly or daily basis in each modality, but there were no records of these.
- Ongoing monitoring and audit of patients from the emergency department in the CT waiting area was not being carried out in line with action the trust told us they had taken following a previous inspection.
- Turnover, vacancy and sickness rates were worse than the trust target. This showed that there were recruitment difficulties and additional pressure on staff to cover shifts.
- The process for cleaning ultrasound probes was not in line with Health and Safety Executive guidance where there was a wipe clean system with no long term automated system planned. A risk assessment we were told had been carried out could not be produced by the trust.
- Patient and radiology information systems did not interface sufficiently to enable staff to monitor capacity and demand and reporting processes were reliant on manual alert systems.

However;

- The completion of mandatory training was above the trust target of 85% overall.
- There were quality assurance systems to monitor the safety of equipment within the department. These included risk assessments and radiation safety processes.
- Environmental cleaning audit results were consistently good.
- Reported patient safety incidents were investigated and action taken to monitor and improve safety. For example, radiation incidents were reported to the radiation protection advisor who monitored control measures and provided advice.
- A radiation protection advisor, radiation protection supervisors and local rules were in place in each modality in diagnostic imaging. There was appropriate signage within the department informing people of rooms where radiation exposure was taking place.

## Is the service effective?

We do not rate effective in diagnostic imaging services as there is not sufficient evidence to rate them.

We found:

- The diagnostic imaging service identified and implemented relevant best practice and guidance and they audited their practice locally against the guidance.
- The trust participated in national benchmarking of the diagnostic imaging service. This showed they performed well in comparison to other trusts in areas such as waiting times for inpatients to receive x-rays and CT scans.
- The trust participated in the Imaging Services Accreditation Scheme (ISAS) and they were duly accredited.
- The service regularly reviewed the effectiveness of care and treatment through local and national audits and regular audit meetings.
- The diagnostic imaging service undertook regular discrepancy meetings where errors and differences in reporting were reviewed as per Royal College of Radiology guidance.
- There were clear induction processes for new staff and bank/agency staff. All staff were subject to annual competency assessments on induction and .



# Diagnostic imaging

- Radiologists attended relevant multidisciplinary meetings, for example in relation to cancer pathways and oncology meetings.
- Staff understood the relevant consent and decision making requirements of consent. There were appropriate processes in place for obtaining consent.

## Is the service caring?

**Good** 

We previously inspected jointly diagnostic imaging with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- Chaperones were available in the department when patients were receiving care and support from a member of the opposite sex.
- Staff demonstrated understanding of the needs of patients who were vulnerable and those who might be frightened, confused or phobic. They were patient and calm and treated patients with dignity and respect.
- Where patients were anxious about the process of the scan staff made arrangements for them to visit the department prior to their appointment so they were familiar with the process and the equipment in use.
- Staff provided patients with information leaflets and allowed time for discussion prior to their scan.
- Volunteers were available to support patients and we observed them doing so with kindness and respect.
- The diagnostic imaging department conducted their own patient satisfaction survey every six months. Results from the most recent survey showed that 99% of patients felt that their privacy and dignity was respected.

However;

- There were no chaperone signs within the department alerting patients to the fact that they could have a chaperone if they were being supported by a member of staff of the opposite sex.

## Is the service responsive?

**Requires improvement** 

We previously inspected jointly diagnostic imaging with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- Waiting times for scans were worse than the national average in some areas including MRI, CT, ultrasound and dexta scanning. There had been improvement over time but these areas consistently remained worse than above the national average.
- Report turnaround times for general imaging was longer than the trust target of five days. The average time from imaging to report took seven days. This meant that delays in reporting had the potential to lead to delays in treatment.
- We were told that changes to the process for obtaining porters to transport patients to and from the wards for scans had resulted in delays. This resulted in imaging staff transporting patients themselves or patients waiting for long periods of time to be collected.

# Diagnostic imaging

- There was limited space in some areas of the department for patients in wheelchairs. This included some changing areas and some clinical areas. The automatic doors in CT were not working at the time of our inspection which had the potential to affect people's ability to move into the department independently.

However;

- There was a system in place which enabled staff to identify patients living with dementia through the use of a discrete sticker placed on their records. Patients who were vulnerable, including those living with dementia, could bypass queues which reduced the potential risk of distress.
- There was evidence of learning from complaints and changes to practice as a result. For example, staff had received training in relation to customer care and conflict resolution.

## Is the service well-led?

### Requires improvement



We previously inspected jointly diagnostic imaging with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- There was no formal strategy for achieving priorities and delivering good quality, sustainable care. However, managers had a good understanding of what the priorities were and had developed business cases to upgrade equipment and to convert processes into digital form within the department.
- Staffing shortages were identified as a key risk within the department and some action had been taken to improve this with the development of a job evaluation scheme so that staff could develop their skills and careers. However, staff we spoke with told us that the ageing equipment within the department made it difficult to attract staff.
- Staff reported that senior trust and directorate leaders were not visible within the department and that they felt that changes were implemented without their involvement, consultation or their concerns being listened to.
- There were four vacant leadership posts within the department and this had affected staff. For example, in some modalities they did not have regular staff meetings and staff did not always receive clear feedback when reporting incidents and concerns.
- IT systems did not support the monitoring of demand, activity and capacity across the modalities within the department. This meant that it was difficult for managers to manage the access and flow within the department sufficiently.

However;

- There was good local leadership within the imaging department with staff consistently telling us that imaging department managers were approachable.
- There were governance processes apparent, including the provision of external radiation protection advice. There were regular radiation protection committee meetings.

There were clear governance arrangements in place with structured meetings and information cascaded to relevant staff.

## Areas for improvement

Action the trust MUST take to improve:

# Diagnostic imaging

- The trust must plan for an automated system for the cleaning of ultrasound equipment in line with Health and Safety Executive guidance.

Action the trust SHOULD take to improve:

- The trust should ensure that monitoring of the medicines fridge in MRI and the administration of injectable contrast dye are undertaken in line with trust policy.
- The trust should ensure that resuscitation equipment is available and appropriately checked in line with trust policy.
- The trust should ensure the service meets the trust targets for mandatory training.
- The trust should develop a strategy for diagnostic imaging that includes plans for addressing staffing shortages, equipment upgrades and the use of electronic systems.
- The trust should introduce systems that ensure managers can monitor capacity and demand within the department and that current manual alerts are digitalised.
- The trust should continue to improve waiting times for diagnostic imaging.
- The trust should take steps to ensure management responsibilities in diagnostic imaging are adequately covered.
- The trust should ensure that directorate and trust leaders are visible within the department and that changes are implemented with consultation and involvement of relevant staff.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

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

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

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

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

# Our inspection team

Louise Thatcher, Inspection manager led this inspection. Catherine Campbell, Head of Hospital Inspection oversaw our inspection of the trust overall.

The team included nine inspectors, one executive reviewer, 12 specialist advisers, and one expert by experience.

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