Maidstone and Tunbridge Wells NHS Trust

Inspection report

Maidstone District General Hospital
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Ratings

Are services well-led? Good

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

Maidstone and Tunbridge Wells NHS Trust provides a full range of general hospital services and some aspects of specialist complex care to around 590,000 people living in the south of West Kent and the north of East Sussex. The trust has a team of over 5000 full and part-time staff. The trust provides specialist cancer services to around 1.8 million people across Kent and East Sussex via the Kent Oncology Centre, which is sited at Maidstone Hospital, and at Kent and Canterbury Hospital in Canterbury. They also provide outpatient clinics across a wide range of locations in Kent and East Sussex.

Maidstone and Tunbridge Wells NHS Trust is part of the Kent and Medway wide Integrated Care System. This partnership has been formulated to bring health and social care together across Kent with the aim of providing the best possible care for their population in the most appropriate place.

We carried out an unannounced inspection of the end of life services provided by this trust

as part of our continual checks on the safety and quality of healthcare services. This service is provided by one team across both acute sites.

We also inspected the well-led key question for the trust overall.

We did not inspect any other core services, we are continuing to monitor the progress of improvements to all services.

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

- We rated end of life care services as requires improvement.
- We rated the trust well-led as good.
- In rating the trust, we took into account the current ratings of the services not inspected this time.

Our findings

- The trust overall rating for caring and well-led was good, and safe, effective, responsive was requires improvement.
- Not all staff had completed their safeguarding training. Patients' personalised needs and preferences were not always recorded in a timely way, particularly when there was a delay in recognising a patient was approaching the end of their life. Some services were not available seven days a week.
- There was a reliance on limited information in some areas to measure the responsiveness, effectiveness and quality of a service. Risks were not always identified and recorded for all services.
- The impact of the delivery of the equality and diversity and inclusion strategy was reported to be variable with middle managers reported to not be fully engaged.

However:

- There was enough staff to care for patients and keep them safe. Staff had training in most key skills, understood how to protect patients from abuse, and managed safety well. Infection risks were well controlled. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. Safety incidents were well managed and lessons learned from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Services were planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran the trust well using reliable information systems and supported leaders to develop their skills. The trust's vision and values were well understood, and people were clear their role in making the trust strategy work. Staff felt respected, supported and valued. The trust engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

How we carried out the inspection

During the inspection we visited wards and departments across both Tunbridge Wells Hospital and Maidstone Hospital where end of life care was provided. This included wards, mortuary, bereavement office and the chaplaincy to assess how EOLC was delivered. We spoke with staff including palliative care leads, medical and nursing staff, patient liaison officers, porters, mortuary staff, and hospital chaplains. We reviewed the medical records of 11 patients who were receiving EOLC and observed care provided by medical and nursing staff on the wards. We spoke with family members whose relative was receiving EOLC and we also spoke with 4 patients.

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

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

Our findings

Outstanding practice

We found the following outstanding practice:

- Three hundred and eighty senior leaders had completed the Exceptional Leaders Programme (ELP), introduced as part of their culture and leadership programme. The programme was being further developed to become exceptional leadership for all, tailored to support leadership development as staff progress through their career. The trust also offered a ward manager programme aligned with the ELP programme.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with one legal requirement. This action related to one service.

Core service- End of Life Care

- The trust must ensure there is a robust process to monitor risk associated with the service. (Regulation 17)

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure there is clear and effective oversight of the equality, diversity and inclusion strategy and ensure the impact of actions and initiatives are evaluated in a timely way. (Regulation 17).

Core service – End of Life Care

- The trust should ensure plans are developed to ensure compliance with trust mandatory training requirements. (Regulation 18)
- The trust should ensure that clinicians receive training to enable the early recognition of the dying patient. (Regulation 18)
- The trust should ensure that patients who are identified as dying have an individualised care plan started as soon as possible to ensure their needs are understood. (Regulation 9)
- The service should ensure that there is sufficient staffing cover within the team to train and develop ward based staff. (Regulation 12)
- The service should ensure they develop systems to monitor their performance and achieve good outcomes for patients. (Regulation 17)
- The trust should ensure that staff report incidents in line with trust policy. (Regulation 17)

Our findings

- The service should ensure there is a robust process to monitor risk associated with the service. (Regulation 17)
- The service should ensure that actions or escalations from meetings are documented, monitored and shared with relevant staff. (Regulation 17)
- The trust should consider additional training for ward based staff regarding relevant care for the dying patient to minimise specific risk issues such as pressure sores, nutrition and hydration.
- The trust should consider reviewing the level of chaplaincy cover across the trust.
- The service should consider developing an audit schedule outside of the annual NACEL return.

Is this organisation well-led?

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

Leadership

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

Leaders had the experience, capacity, capability, and integrity to ensure the strategy was delivered and risks to performance addressed. Leaders were visible and approachable.

Compassionate, inclusive, and effective leadership was sustained through a leadership strategy and development programme and effective selection, deployment and support processes and succession planning. Talent management was used to identify and develop staff and the chief executive officer (CEO) described a healthy pipeline of future leaders.

The people strategy included a talent management approach and leaders talked about a shift from bringing people into the organisation, to developing from within. The trust had a multi-cultural workforce, although the trust board and senior leadership team were not fully reflective of the population, they provided a service to. There had been an increase in the number of women in the team creating what was referred to by the trust as a more 'reasonable balance'. The most recent non-executive director (NED) was from the local community bringing with them knowledge and an understanding of the local area. The trust had recently appointed an associate non-executive director as part of the trust board intentions to become more representative of the population served by the trust. The Chair and CEO understood the importance of diversity and were taking actions to improve this at executive and leadership levels in the trust.

The trust introduced the Exceptional Leaders Programme (ELP) as part of their culture and leadership programme. It was informed by staff feedback and learning from other excelling trusts. Three hundred and eighty senior staff from across all directorates and across all staff groups had completed the programme. The trust's people and organisational development strategy, developed through consultation, integrated leadership development. This was a strategic priority for the trust and a key enabler for other objectives. The programme was being developed to become exceptional leadership for all, tailored to support leadership development as staff progress through their career. The trust also offered a ward manager programme aligned with the ELP programme. Participants also received on the ward support from nurse-coaches to help them consolidate their learning and skills development through reflective practice.

Our findings

The trust operated a clinical led model with a chiefs of service structure. The chiefs of service were part of the executive team. The effect of moving to this model was described as positive, with the trust coming out of financial special measures soon after the change. Historically, consultants were reported to have been disengaged, which had now changed, and the trust had realised and unlocked money to invest. Additional positive impacts following the change in leadership model had included new pathways impacting positively on the performance against the cancer 62 week waits.

Senior nurses were very positive about the clinical leadership model, linked with what was delivered by executive leaders. All leaders were reported to be supportive and visible on frontline wards. NEDs also talked about visiting wards and engaging with key personnel to corroborate what they were being told or had heard. Staff networks spoke positively about the relationship they had with the chief executive.

The trust's executive team also played key roles in the local healthcare system. For example, the CEO was the Senior Information Risk Owner for West Kent Health and Care Partnership, and Chair for the Kent and Medway Cancer Alliance. The trust also provided mutual aid to other neighbouring organisations when required.

The trust had been placed in Level 1 of the NHS System Oversight Framework (SOF). This was reported to have been awarded to the trust for consistently high performance and their active leadership role in supporting local and integrated care board priorities.

Vision and Strategy

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

There was a clear statement of vision and values, driven by quality and sustainability. The trust's organisational vision was Exceptional People, Outstanding Care (EPOC). All improvement activity, regardless of size and impact were expected to have links to the organisation's vision. This ensured all projects, activities and goals were aligned to the strategy, and provided a clear line of sight, so individuals could see what they did contributed to the trust's goals. The trust used their exceptional people outstanding care improvement programme to provide a structured approach to support delivery of their vision. The vision had six themes with clear goals.

The trust's EPOC improvement programme was intended to create an improvement culture where problems were analysed and unpacked, data was used to drive decisions, a small number of things were done well before moving to the next and an approach which connected improvement throughout the organisation.

The trust's mission, vision and values had been translated into a robust and realistic strategy and well defined achievable and relevant objectives. The strategy was aligned to local plans in the wider health and social care economy and services were planned to meet the needs of the relevant population. The trust had 2 acute hospitals, with each maintaining emergency departments and critical care units. Leaders believed this is why they had been able to continue to develop services and meet increasing demand.

Our findings

The trust's overarching strategy included 6 strategic themes patient experience, patient safety and clinical effectiveness, patient access, systems and partnerships, sustainability, and people. Supported by 6 strategic initiatives: clinical, digital transformation, EPOC improvement programme, people and culture, West Kent integrated care partnership and patient and carer. Each strategic theme was reviewed by the board twice a year.

Culture

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

There were 6 staff networks covering most of the protected equality characteristics as defined by the Equality Act 2010. Although some were new and still developing, with the newest being in place for 5 months, the most mature had been in place for 7 years. They all had access to the senior leadership team and the board and the networks had supported with deep dive reviews into employee relations cases. Networks members spoke about feeling valued. While the networks were invited to support the trust's work from action plans such as the workforce race equality standard (WRES) action plan, they were not always involved in the development of these plans.

The trust was committed to equality, diversity and inclusion (EDI) and had an EDI strategy developed through consultation. However, from discussions it was unclear how the strategy was being driven or effectively managed through the trust. There seemed to be a disconnect between strategy implementation and what happened in practice. For example, there was no committee which kept oversight of EDI, although the intention to develop a committee, formed part of the strategy. Following the inspection the trust informed us the delivery of the EDI strategy was overseen via the People and Organisational Development Committee (PODCO), who reported to the trust board. In addition for 2023/24 the trust had made EDI one of its priority breakthrough objectives with progress tracked via the embedded Strategy Deployment Review process.

Information from the staff survey showed staff from ethnic minority groups were less likely to experience harassment, bullying or abuse from patients, relatives or the public but were more likely to experience this from colleagues. Disabled staff were more likely to experience harassment, bulling and abuse from patients, relatives and the public as well as from colleagues (although this had fallen slightly from the previous year). The CEO was aware of this outcome in the staff survey although approaches to improve this were not provided. Staff networks indicated that while there was a strong message of inclusion and intolerance of discrimination, this was not always reaching the middle layers of line management. Examples of overt homophobic, misogyny and racist behaviour (both personally experienced and witnessed) were provided, with action taken when it was escalated to the executive team. The trust was taking action to reach middle managers through the exceptional leaders course.

The trust had representation of both disabled staff and staff from ethnic minority groups at band 5 in clinical roles, with an improving representation of ethnic minority staff at band 6. At band 6 and 7 there had been a consistent increase in the number of disabled staff compared with other bandings. Little progress had been made in increasing the representation of disabled staff in bands 8a and above. There was one board member with a declared disability. While there was an improvement in the number of staff from ethnic minority groups at bands 8a and above in clinical roles, this was not reflected in non-clinical roles, and White staff were more likely to be appointed from short listing. There had been recent appointments of people from ethnic minority groups to the NED team, but people from ethnic minority groups remained underrepresented at board level.

Our findings

The trust executive team accepted that they were not as racially diverse as the communities they served. Actions they were taking to improve this included reverse mentoring and having diversity and inclusion representatives on executive recruitment panels. There had been recent appointments to the NED team from ethnic minorities.

Recruitment processes had been reviewed, with work continuing to reduce bias in the process following identification of some barriers to inclusive recruitment. The trust was supporting partners across the integrated care system in the development of reduced bias recruitment training. The trust had also introduced EDI representatives into the interview process. Following our inspection, the trust informed us they were developing a values-based recruitment training package to be delivered to all recruiting managers by April 2024. The trust was also embarking on a campaign to promote the importance of staff declaring their protected characteristics.

Trust leaders had participated in reverse mentoring, when a more junior employee mentors someone more senior than them. This was described as inspirational and grounding and had created a greater understanding and appreciation of others lived experiences. The trust was exploring the possibility of offering this to other groups of staff.

Following concerns being raised, the trust had reflected on the support offered to internationally educated nurses, indicating the initial offer had not fully met the needs of staff. A group was formed, including representatives of the staff concerned, to build a support package more suited to meet their needs.

Staff from ethnic minority groups and White staff were equally as likely to enter the disciplinary process and access non mandatory professional development.

In all metrics of the national staff survey, disabled staff had worse experiences than non-disabled staff across the board. Whilst some metrics had improved from the previous year, such as the number of disabled staff believing the trust provided equal opportunities for career progression or promotion, other metrics had deteriorated, such as disabled staff feeling valued for their work. The percentage of disabled staff saying that their employer had made reasonable adjustments to enable them to carry out their work had also fallen (although this remained above the national average). The trust level of disability declaration was broadly in line with the national average from NHS staff survey data. The Workforce Disability Equality Standard (WDES) action plan, intended to improve these metrics, was brief and did not identify specific and measurable actions with action owners to drive improvements for disabled staff experience at the trust.

Staff survey results were reviewed at clinical divisional level and areas that had greater than 5% change from previous surveys were explored in depth. Candour, openness, honesty, transparency and challenges to poor practice were encouraged. The trust leadership actively promoted staff empowerment to drive improvement, and raising concerns was encouraged and valued. Staff actively raised concerns and those who did were supported.

Concerns were investigated sensitively and confidentially, and lessons were shared and acted on. When something went wrong, people received a sincere and timely apology and were told about any actions being taken to prevent the same thing happening again.

The trust had the equivalent of a full-time freedom to speak up guardian (FtSUG) supported by approximately 30 safe space champions. The champions role had been developed in collaboration with the equality, diversity and inclusion team, with the aim of creating a safe space for all staff to feel comfortable to speak up. Recruitment to this role

continued to ensure all sites where the trust provided a service were covered. The trust had recognised the number of staff speaking up from satellite sites reduced if the FtSUG did not spend time on site. We heard an example of when there had been a cluster of concerns from one area, the guardian worked with the clinical leaders and the organisation's development team to improve the staff experience.

Governance

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

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, were clearly set out, understood and effective. Staff were clear about their roles and accountabilities.

The trust board's mechanism for assuring itself about the operation of its governance arrangements was through the Strategy Deployment Review (SDR) designed to identify areas of concern and to encourage data-led board focus through key lines of enquiry in the monthly Integrated Performance Report (IPR) supported by a risk register.

The board and other levels of governance in the organisation interacted well with each other. There was a clear committee structure with all forums accountable to the trust board for assurance or to the executive team. The five divisions had a performance divisional board and a quality or governance board alternate months. This was mirrored by directorate monthly governance and monthly finance and performance boards. While there was good engagement with divisions, there were 11 committees directly reporting into the quality committee. This volume had the potential to impact the effectiveness of the committee. Through conversation it was clear this had been acknowledged as a challenge and a review had begun. A Complaints, Legal, Incidents, Patient Advice & Liaison Service (PALS), Audit and Mortality group was being planned to reduce the burden to the committee. In order to test the effectiveness of their quality governance the trust had plans in place to commission an external governance review.

At the time of the inspection, the trust was preparing for the financial year end 2022 to 2023 and was preparing its financial plans for 2023 to 2024. The external auditor had given a clean audit opinion on the trust's accounts in 2021 to 2022, including the value for money opinion. The trust told us it was expecting to receive formal assurance from its internal auditors the operation of its internal controls, was satisfactory for the financial year 2022 to 2023.

Financial governance of the SDR was channelled formally through the transactions of the finance and performance committee (IPR and finance report) and the audit and governance committee (Risk Register review.)

The finance report, including metrics under the strategic theme of sustainability, was appended to the IPR. The trust told us that, in common with other trust, it had found it difficult to make the recurrent improvements underpinning its financial plans; however, it had sufficient financial strength to meet the financial plans that it had agreed for 2022 to 2023.

Investment cases were scrutinised by the finance and performance committee and the programme management office reported quarterly to the committee as to whether promised benefits had been achieved.

Management of risk, issues and performance

Our findings

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

There was an effective and comprehensive process to identify, understand, monitor and address current and future risks. Performance issues were escalated to the appropriate committees and the board through clear structures and processes. The trust was performing well compared to other NHS trusts in emergency and urgent care access and in meeting targets related to cancer treatment time (62 day).

The risk management process in the trust was well established at divisional and directorate level with identification of risk and risk assessment leading to inclusion on the relevant risk registers. The trust wide risk register was a compilation of these registers. Risks of 15+ (red) were escalated to board committees for review and reviewed by the chief of service and the chief executive officer quarterly. The executive team also reviewed these risks. Deep dives were also used to greater integrate risks, particularly long-standing ones. Following the inspection, the trust informed us the trust board received a biannual report of all high scoring risks. To ensure the board and subcommittees recognised emerging to the trust strategy, the board also undertook biannual horizon scanning risk workshops.

The breakthrough objectives for each strategic theme and the risks to delivery of these were set out in the Integrated Performance Report (IPR). Information included in the IPR were the objective, risks to the objectives, the controls in place to manage such risks, sources of assurance, any gaps in assurance and the details of performance against the objective. Any risk associated with the delivery of strategic risks were highlighted to the executive team through the SDR process.

Each strategic project had a project governance group and project risk register, and when there were emerging risks to delivery, a special meeting was held with NEDs to brief them about these risks. A quarterly strategic projects report was provided to the board and included the risks to delivery of the projects.

The Head of Internal Audit's opinion on the trust's risk management, control and governance processes was that there was reasonable assurance there was a generally sound system of internal control, designed to meet the organisation's objectives, and that controls were generally being applied consistently.

The clinical audit programme was a mix of local and national audits involving all clinical services provided by the trust. Annually over 300 clinical audits were carried out.

The Tunbridge Wells Hospital was built under the Private Finance Initiative (PFI). The Trust had engaged a senior professional with PFI provider experience who supported the active management of the contract. The trust acknowledged that the PFI provider had not yet provided £1m lifecycle investment due contractually, although no asset risks had been identified so far; and evidenced as part of partnership working that the PFI provider was making good the design flaws to reduce the risks of Legionella identified on the risk register.

Information Management

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

Our findings

Integrated reporting supported effective decision making. There was a holistic understanding of performance, which sufficiently covered and integrated the views of people with quality, operational and financial information. Quality and sustainability both received sufficient coverage in relevant meetings at all levels.

Data or notifications were consistently submitted to external organisations as required. There were robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Information technology systems were used effectively to monitor and improve the quality of care.

Staff received helpful data, which supported them to adjust and improve performance as necessary. Performance information was used to hold management and staff to account. The information used in reporting, performance management and delivering quality care was usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.

The trust's care coordination centre was a place where decisions were made in real time, which were reliant on current data. Multiple aspects of daily decision making were managed by staff based in this centre. Information was pulled from various sources and displayed in the centre and used in managing patient flow. Use of accurate data had also been used effectively in the management of referral to treatment time.

The trust had taken a phased approach to the introduction of new systems, building on the ethos of do a few things well before moving on to the next. This approach had been taken with the electronic patent record which was said to be working well.

Information had also been used in the evaluation of the reliability and effectiveness of systems, for example the introduction of a new e-rostering system for medical staff, this had failed and had impacted negatively on junior doctors' lives. Time and effort were invested into trying to make the system work, but it had been acknowledged by the trust it was time to change the system.

The trust had reviewed and evaluated the system used to capture a wealth of information including incidents and complaints and was in the process of introducing a new system identified as better able to meet their needs. The system would enable the trust to monitor incidents and performance. The plan was to link safety issues with audits and risk.

Engagement

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

A full and diverse range of people's views and concerns was encouraged, heard and acted on to shape services and culture. The trust was working hard to proactively engage and involve all staff (including those with protected equality characteristics). The trust was transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them. The CEO stated ensuring connection from staff to the board, ongoing communication and engagement at all levels, was a core part of their role.

Our findings

Doctors in training were provided with a voice through both the director of medical education who ran the local medical educational board and the guardian of safe working hours. There had been some distress caused by the trialling of a new rostering system and there had been a period of time when the junior doctors had felt they were not being listened to; although the matter was being addressed. In general staff spoke positively about their relationship with the executive team and the board.

The patient safety team shared learning across the trust through a learning report. Team members visited wards and shared the report, which was also displayed in ward areas. Feedback from staff had led to the development of the learning hub.

Psychological first aiders and the trust wellbeing team were available to provide support to staff. Staff could self-refer, and information indicated staff were encouraged to engage with the support available following traumatic events.

After action reviews were being used for staff following a serious incident. Feedback was positive from staff, who liked the more immediate learning and felt this provided a safe space for open discussion and learning without the need for appointing blame.

It was clear from discussions the trust took patient feedback and engagement seriously. Information from a variety of sources was used by the trust to evaluate the patient experience. This included inpatient surveys and local Healthwatch surveys, PALS and complaints. Data showed communication and information access was a theme and this was one of the trust's breakthrough objectives. Information from the friends and family test had influenced an increase in carparking on both main hospital sites. All feedback was treated equally with, for example comments about the thickness of bread also leading to a change.

A team that did not have positive results for engagement in the most recent staff survey were facilities and estates. This was well understood by the CEO and there had been a restructure of the division into 2 separate groups, with new leadership for estates; and facilities now sitting within the COO portfolio. It was felt that these actions would improve the situation for the teams by providing certainty and stability.

The trust's people strategy was developed with external support. A range of activities took place to ensure the views of the trust's diverse workforce was captured. This had included engagement with medical staff, administration teams, estates workers, staff networks, and staff side representatives.

Wide reaching engagement with staff, the public and partners had formed part the process for the design of the planned new orthopaedic centre. Volunteers actively collected feedback from patients and their families in several areas of the hospital.

Learning, continuous improvement and innovation

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

Our findings

There was a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research. There was knowledge of improvement methods and the skills to use them. There were organisational systems to support improvement and innovation work, including staff objectives, data systems, and ways of sharing improvement work. The trust made effective use of internal and external reviews, and learning was shared and used to make improvements.

Following a never event, involving the misplacement of a naso-gastric tube, the trust had looked at national recommendations, and the issue was added to risk register until robust measures to reduce the risk of reoccurrence were in place. A working group was formed to take forward actions from the investigation where risks were highlighted. The resulting action plan was monitored through this group which reported to the quality committee.

Following a trust wide survey of the safety culture and incident reporting within the trust, a safety syllabus level one training to promote incident reporting was launched. Level 2 training was also now part of required training for all medical and band 7 staff.

The trust's care coordination centre was a hub where activity was monitored, and steps taken in a coordinated way to aid patient flow. There was a positive impact on the number of patients discharged before midday and the length of time patients waited in the emergency department for a bed to become available. This included liaising with the cleaners to ensure a bed space was cleaned and made available, communication with porters, careful monitoring of waiting times in the emergency departments, patient length of stay and discharge arrangements including patient transport.

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 Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good ➔➔ Aug 2023	Requires improvement Mar 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.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maidstone Hospital	Requires improvement Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018
The Tunbridge Wells Hospital at Pembury	Requires improvement Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018
Overall trust	Requires improvement Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good → ← Aug 2023	Requires improvement Mar 2018

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

Rating for Maidstone Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Services for children & young people	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Critical care	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018
End of life care	Good → ← Aug 2023	Requires Improvement → ← Aug 2023	Good → ← Aug 2023	Good ↑ Aug 2023	Requires Improvement ↓ Aug 2023	Requires Improvement → ← Aug 2023
Maternity and gynaecology	Good Feb 2015	Good Feb 2015	Good Feb 2015	Good Feb 2015	Good Feb 2015	Good Feb 2015
Outpatients and diagnostic imaging	Good Feb 2015	Not rated	Good Feb 2015	Requires improvement Feb 2015	Requires improvement Feb 2015	Requires improvement Feb 2015
Surgery	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018
Urgent and emergency services	Requires improvement Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018
Overall	Requires improvement Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018

Rating for The Tunbridge Wells Hospital at Pembury

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Services for children & young people	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Critical care	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018
End of life care	Good ↑ Aug 2023	Requires Improvement →← Aug 2023	Good →← Aug 2023	Good ↑ Aug 2023	Requires Improvement ↓ Aug 2023	Requires Improvement →← Aug 2023
Maternity and gynaecology	Requires improvement Feb 2015	Requires improvement Feb 2015	Good Feb 2015	Good Feb 2015	Requires improvement Feb 2015	Requires improvement Feb 2015
Outpatients and diagnostic imaging	Good Feb 2015	Not rated	Good Feb 2015	Requires improvement Feb 2015	Requires improvement Feb 2015	Requires improvement Feb 2015
Surgery	Requires improvement Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018
Urgent and emergency services	Requires improvement Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018
Overall	Requires improvement Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018

Maidstone Hospital

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Description of this hospital

The Maidstone and Tunbridge Wells Specialist Palliative Care Team (SPCT) is a trust-wide service encompassing both hospital sites. The service provides care for patients with non-curative illnesses and also supports those closest to them. End of life care (EOLC) was not seen as the sole responsibility of the SPCT.

Although there is one team, this report relates to Maidstone Hospital. Please refer to a separate report for Tunbridge Wells Hospital.

The SPCT consist of 1.0 Whole Time Equivalent (WTE) palliative care consultant and 9.8 WTE clinical nurse specialists (CNS) and an EOLC facilitator (15 hours per week). The team works in association with their respective community palliative care teams and in partnership with local voluntary sector hospice providers. In addition, a trust chaplaincy team provided multi-faith support.

The SPCT were available six days per week, Monday to Saturday 9am to 5 pm. Outside these hours the SPCT service was covered by telephone support from the local hospice linked to the hospital.

During the inspection we visited wards and departments across both Maidstone Hospital and Tunbridge Wells Hospital where end of life care was provided and carried out.

This included wards, mortuary, bereavement office and the chaplaincy to assess how EOLC was delivered.

We spoke with staff including palliative care leads, medical and nursing staff, patient liaison officers, porters, mortuary staff, and hospital chaplains.

We reviewed the medical records of 11 patients who were receiving EOLC at either this hospital or Tunbridge Wells hospital and observed care provided by medical and nursing staff on the wards. We spoke with family members of patients receiving EOLC and we also spoke with 4 patients.

We reviewed performance information held about the trust.

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

- EOL patients personalised needs and preferences were not always recorded. There was sometimes a delay with the recording of patient's needs and preferences. The EOL team was not available seven days a week.

Our findings

- There was no available data to measure the responsiveness or availability of the EOL. The service did not always use effective systems to improve the awareness of risks and issues and manage performance.
- Not all staff involved in the delivery of EOL care were clear about their responsibilities and accountabilities. EOL staff did not always collect reliable data to understand performance and make decisions and improvements.

However:

- The service generally had enough staff to care for patients and keep them safe. Staff had training in key skills and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
- Leaders were experienced and ran services well and supported staff to develop their skills.

End of life care

Requires Improvement 

Is the service safe?

Good 

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

Mandatory training

The service provided mandatory training in key skills to all staff working in the Specialist Palliative Care Team and monitored compliance.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us they had been given protected time to complete this training. All staff had completed equality and diversity, information governance and data security and moving and handling training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Nursing staff received and kept up-to-date with their mandatory training. We reviewed the mandatory training compliance rates for staff working within the Specialist Palliative Care Team (SPCT). This showed an overall compliance rate of 100% for mandatory training and exceeded the trust target which was set at 85%.

The SPCT had specific role End of Life (EOL) mandatory training to complete. However, there was a shortfall with this compliance as two modules had recently been added to the mandatory training schedule. After the inspection the trust outlined plans to ensure staff became compliant, however this did not pose a patient safety concern.

Safeguarding

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

SPCT staff received training specific for their role on how to recognise and report abuse. We reviewed the safeguarding mandatory training compliance rates for the SPCT staff. This showed 100% of staff had completed training at level 3 for adults and children safeguarding level 2.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They knew how to identify adults and children at risk of, or suffering, significant harm, how to make a safeguarding referral and who to inform if they had concerns.

We heard of one example when a patient had disclosed information that raised concerns, and this was appropriately raised as a safeguarding concern.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

End of life care

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff using PPE such as gloves and aprons. We saw staff adhered to the 'bare below the elbow' infection prevention and control guidance.

We visited several areas in which EOL care was provided. This included hospital wards, the mortuary, multi-faith rooms and bereavement offices. All these areas appeared clean, tidy and well maintained. We saw personal protective equipment including gloves and aprons were readily available. There were appropriate handwashing and hand decontamination facilities in all areas.

Effective measures were in place to ensure the health and safety of everyone who came into contact with a deceased person's body. Staff we spoke with were knowledgeable about these infection, prevention and control (IPC) measures and could describe how they washed and prepared the body after death.

Portering staff were aware of the IPC measures to take when transporting patients and could describe training they had received. This included transporting patients with cultural or religious differences or who had an infectious disease.

We reviewed the mortuary area and saw it was visibly clean and followed IPC guidance. We reviewed cleaning records which were up to date and demonstrated areas had been cleaned regularly. Staff identified what had been cleaned and signed their name once it was completed.

Environment and equipment

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

We visited the mortuary, chapel, multifaith room, and bereavement room which were all suitable facilities to meet the needs of patients and their relatives. The mortuary had a viewing room that was appropriate for relatives visiting the deceased patient. All were appropriately signposted.

Access to the mortuary for authorised staff was via a secure key-card system. All other staff used an intercom system to request entry.

All access to the mortuary, including by authorised staff, was recorded in a visitor log which prompted visitors to sign in and out. All relevant areas within the mortuary were monitored by CCTV. During out of hours only trained portering staff had access to the mortuary. All access requirements were monitored and reviewed on a yearly basis.

The mortuary was clean and odour free. It had storage capacity for 68 deceased patients, including capacity for children and bariatric patients. There were also 5 deep freezers suitable for longer term storage of deceased persons, these were also suitable for bariatric patients.

We reviewed a Human Tissue Authority (HTA) audit which had been completed in February 2023 for the mortuary environment. The results showed some minor 'non-conformities' against HTA standards. The trust had developed an action plan to resolve or reduce the impact the issues raised. While it is the responsibility of the HTA to regulate the mortuary, we reviewed the action plan and saw some actions had been completed and others were in progress, with names of those responsible added to each action.

End of life care

Staff across the trust who delivered end of life (EOL) care said they had enough suitable equipment to help them to safely care for patients. For example, the service used specialist syringe drivers for patients who required a continuous infusion of medicine to control their symptoms. EOL patients were often nursed on an air mattress to limit pressure damage. Nursing teams did not report any issues and confirmed these items were readily available and were obtained from a trust wide central equipment library.

In the mortuary we saw there were a suitable numbers of trolleys, including specialist trolleys, used to transport a deceased person from the wards to the mortuary. We saw all trolleys had suitable coverings to maintain dignity and privacy of the deceased person. New hoists had recently been delivered that would allow easier access to high and low fridge spaces.

Assessing and responding to patient risk

Ward staff provided care to patients requiring palliative and end of life (EOL) care. They completed risk assessments for patients who were deteriorating and in the last days or hours of their life. However, these were not always started in a timely manner.

Ward based staff used a nationally recognised tool to identify deteriorating patients. Staff described how they would escalate to medical staff if they had a concern or the tool indicated escalation was required.

Ward based staff were required to start an Individualised Care Plan for the Dying Patient when a patient was identified as EOL and placed on the EOL pathway. However, the SPCT team told us this document was not always started in a timely manner as patients were not always identified as being end of life. The SPCT team had identified there was a potential risk that patients approaching end of life might not be reviewed appropriately, or staff looking after them might not be given adequate support and guidance. The SCPT team had commenced a programme of education with medical staff to consider if a patient may be end of life when undertaking ward rounds.

Staff both on the wards and in the SPCT shared key information to keep patients safe when handing over their care to others. Staff across the trust could access pathways and escalation processes for the identification of patients approaching EOL. However, as staff did not always identify EOL patients early, the use of these pathways was not always effective.

Ward based staff knew about and dealt with any specific risk issues. However, when we looked at a sample of patient records, they indicated the SPCT had to sometimes intervene with ward based nursing teams to ensure appropriate care for patients with specific risk issues like pressure ulcers. Staff told us they completed pain assessments and ensured patients basic health care needs were met such as mouth care and washing.

Handovers included all necessary key information to keep patients safe. We attended one of the daily handover meetings and observed it followed a standard format and included information about safeguarding issues, incidents, and patients with urgent needs.

The mortuary staff showed us warning notices that alerted staff if patients had a pacemaker or implantable defibrillator. These were also used to highlight if there were patients with similar names to avoid identification errors.

Staffing

The service had generally enough specialist nursing and other support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

End of life care

Staff throughout the hospital delivered end of life and palliative care and were supported by the dedicated Specialist Palliative Care Team (SPCT). The SPCT were responsible for providing support and guidance to all staff who delivered care and treatment to patients who had been identified as EOL.

The SPCT was fully staffed, however they reported an increasing workload was putting increased strain and demand on its ability to fulfil their role. In addition, sickness levels within the team had impacted its ability to provide EOL training to ward based staff.

The mortuary team covered the mortuaries on both hospital sites on a rota basis. The managers and mortuary staff were experienced in their roles.

Chaplaincy and bereavement staff provided care and support to EOL patients and their relatives. The chaplaincy team were responsible for offering spiritual and religious support to patients, relatives and staff. They were able to offer Christian and Anglican support within the team and had access to other faith leaders in the community. The service had EOL volunteers supported by the chaplaincy team, and they were in the process of actively recruiting additional volunteers.

There were challenges within the chaplaincy team to provide sufficient cover. The two chaplains also supplied out of hours support on a rotational basis.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The EOL team had one consultant employed by the trust. They provided consultant cover across both hospital sites and were responsible for reviewing all patients who had been identified as EOL and had started on the EOL pathway. They were available for clinical advice, support and training and they provided support to patients, relatives and staff. All staff we spoke with gave positives examples of the level of support provided by this consultant.

However, with only one consultant employed by the service, this meant there was limited consultant cover across both trust sites during the day.

The service could access the trust haematology and oncology consultant teams, who had received palliative care training, Monday to Friday.

Additionally, on call consultant provision for evenings and weekends was provided through a service level agreement with the local hospice. The local hospice would also provide consultant cover on an informal basis for unplanned sickness or annual leave. The service did not routinely employ locums or trainee doctors to cover absences such as sickness or annual leave.

After the inspection we were advised a second palliative care consultant had been interviewed and appointed, with a start date to be agreed.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care. EOL care plans were not always started in a timely way, and there was limited audit of record keeping to promote learning or improvement.

End of life care

Patient notes were comprehensive, and all staff could access them easily. Staff used a combination of an electronic and paper records, which all staff had access to. In November 2021 the trust had transferred from paper records to an Electronic Patient Record system (EPR). Patient information was therefore recorded electronically. At the time of inspection, the specialised paperwork relating to EOL care was still paper-based. However, the trust were in the process of incorporating this paperwork into their EPR.

Care records were completed by ward based staff and information was uploaded onto the EPR. SPCT had access to laptop computers for this purpose and could view patient records remotely.

The EPR was shared by other trust teams which meant no delays in staff accessing patient records. Staff, including consultants who were part of the Kent and Medway system, could also access this system.

Records, both paper based and electronic, were stored securely. Paper records were stored securely on wards and departments we visited. Each member of the team had a personal log-on to the EPR which was secure. Staff had to complete information governance training before they could use it.

We reviewed the results of the National Audit of Care at End of Life (NACEL) from 2021/2022 which found the Individualised Care Plan for the Dying Patient was always not started early enough, and patient's personalised wishes and discussions were not recorded. The service acknowledged this document was not always started, or completed fully, when the patient was started on the EOL pathway.

We reviewed the Individualised Care Plan for the Dying Patient which staff were required to commence when a patient was identified as EOL. This was a two part document consisting of a clinical review, and care plan, we saw this recorded the personalised needs and preferences of the patient.

We reviewed 11 of these documents within patient records and found the majority had been completed appropriately. However, there were incomplete sections within the care plan to detail the patient's preference for spiritual and/ or religious care, and any psychological and emotional needs. We spoke with ward staff who said it was not always clear who should complete each part of the document.

The SPCT did not complete any routine audit of EOL patient records outside of the annual NACEL return. This meant the service did not know how accurate their record keeping was and if any learning or improvement could be identified.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The specialist palliative care team worked with specialty and ward based staff to provide the management and administration of medication for palliative care patients with complex needs. The SPCT reported good links with the hospital pharmacy team. Medicines, including anticipatory medicines given at the end of life, were prescribed using an electronic prescribing system. This system mitigated against potential prescribing errors.

The SPCT had specially trained nurse prescribers and medicines management standard operating procedures to follow. The SPCT nurse prescribers were able to review patient medications and change prescriptions, as appropriate, to meet the specific needs of EOL patients.

End of life care

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw in care records that medicine was available for patients and regularly reviewed. We observed a daily handover meeting where staff met to discuss all the patients that were due to be seen that day, and this included a review of any medicines they were prescribed if needed. The patients and carers we spoke with told us staff provided them with appropriate medicines information and advice.

Staff completed medicines records accurately and kept them up to date. Staff completed records at the same time they saw patients on wards. Staff in the SPCT had laptops that enabled them to access records remotely.

Incidents

Staff recognised and reported incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. There were missed opportunities to report delays in identifying EOL patients.

The trust had an incident reporting policy. The SPCT and staff delivering care to EOL patients, told us they understood their responsibilities regarding the reporting of incidents and gave us examples when they had raised an incident. For example, they were encouraged to incident report when patient discharges were not activated.

The SPCT could easily identify incidents related to EOL from the addition of a tick box added onto the electronic database. They regularly reviewed and investigated all incidents that were graded as moderate or above harm.

Although both ward staff and SPCT staff knew how to report incidents, we heard examples when incidents were not always reported. For example, when there were delays in identifying patients or delays to starting the pathway.

The results of the most recent National Audit of Care at End of Life (NACEL) 2021/2022 confirmed that 33% of trust staff strongly agreed, and 50% of trust staff agreed, they felt able to raise a concern about EOL care.

Is the service effective?

Requires Improvement

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. However, audits showed some personalised preferences were not recorded in a timely way.

Staff followed up-to-date policies to plan and support the delivery of high quality care according to best practice and national guidance. We looked at a range of policies and procedures, which were based on recognised End of Life (EOL) guidelines and quality standards, such as the National Institute for Health and Care Excellence (NICE).

The service participated in the annual National Audit of Care at End of Life (NACEL). We reviewed results of the latest NACEL from 2021 to 2022. One of the metrics from the audit identified the Individualised Care Plan for the Dying Patient

was always not started early enough, and patient's personalised wishes and discussions were not recorded. Results showed that 77% of the time, the time from admission to recognition of dying was 48 hours or longer. This meant that staff were not always able to deliver care based on patient's individual needs or preferences because they had not been documented.

Patients had an individualised plan of care which reflected their personal needs. If the patient was at EOL this was supported by the individualised care and communication record for a person in the last days or hours of life. This was in line with national standards and guidelines. However, delays in filling out the Individualised Care Plan for the Dying Patient meant patient's personalised wishes and discussions were not always recorded in a timely way.

Ward staff delivering end of life care told us they were able to access policies on the trust intranet.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We shadowed staff and attended meetings with them and looked at care records, we saw staff placed great emphasis on supporting patients and their families with their emotions and feelings.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. However, once a patient was identified as EOL assessment was not always effective.

Staff on the wards used a nationally recognised screening tool to monitor patients at risk of malnutrition.

We reviewed 11 records for EOL patients. We found the malnutrition universal screening tool (MUST) had not always been used appropriately to identify and score nutritional and hydration requirements once a patient had moved onto the EOL pathway.

We saw evidence on the electronic patient record of mouth care for those patients unable to tolerate fluids and care plans for patient mouth care for patients who were unable to tolerate food or fluids.

We reviewed the 2021/22 results of the most recent National Audit of Care at End of Life (NACEL). This showed that 71% of staff strongly agreed or agreed they were confident in their ability to discuss hydration options with patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Both ward staff and staff in the SPCT prescribed, administered and recorded pain relief accurately. Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Ward staff used the pain assessment charts on the electronic patient record.

We reviewed the 2021/22 results of the National Audit of Care at End of Life (NACEL). This confirmed that 74% of staff said they were confident in their ability to assess and manage pain and physical symptoms.

Patient outcomes

The service monitored the effectiveness of care and treatment. However, there was limited evidence to determine if findings were used effectively to make improvements and achieve good outcomes.

End of life care

The service had an annual programme of end of life audits which was predominately based on the NACEL programme. However, we did not see audits to measure referral times and the responsiveness of the SPCT.

The trust provided data that showed from April 2022 to September 2022, 78% of patients achieved their preferred place of death. However, although the data was recorded there was no narrative to say whether this had improved or declined over the years, or whether this met relevant standards. This meant there was only a moderate level of assurance that service standards, such as care after death, and information provided for bereaved people, were consistently being achieved.

Managers did not always share and make sure staff understood information from the audits. Many of the staff we spoke with in teams told us they did not know what audits had been carried out. However, they were aware of routine audits carried out within the service, such as infection control audits.

The SPCT monitored patient outcomes and safety performance data using the EOL specific dashboard. The reported compliance levels were 74% for the completion of the Individualised Care Plan for the Dying Patient, prescribing anticipatory medications and recording of preferred place of death. This was compared to 73% reported nationally. These issues were noted within the EOL improvement plan and action plans had been implemented to improve compliance rates.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

SPCT staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Most staff we spoke with had many years of experience working in EOL, and most of them were senior nurses. The SPCT had six nurses who had completed nurse prescriber training. We looked at data which confirmed nurse prescribers had completed an annual declaration to show they kept up to date with their competence and skills in this area.

Managers supported SPCT staff to develop through yearly constructive appraisals of their work, and data provided by the trust showed 100% of staff had had an appraisal. This was against a trust target of 85%.

Managers made sure SPCT staff attended team meetings or had access to full notes when they could not attend. We looked at a sample of team meeting minutes to see that they were held regularly and documented adequately. However, both staff and managers confirmed workload pressures had meant team meetings had not always taken place as planned. The team had discussed this and had committed to hold meetings and had diarised future meetings.

SPCT staff had the opportunity through the appraisal process and supervision to discuss training needs and were supported to develop their skills and knowledge. Staff confirmed these conversations had taken place and described how they were supportive.

All ward staff received an introduction to EOL care as part of their induction and completed online courses which were related to EOL and palliative care.

The SPCT team delivered EOL specific training courses face to face in the form of workshops or ward visits to eligible staff. However, increasing workloads and staffing issues within the SPCT had affected the ability of the team to deliver this training effectively.

End of life care

Porters received training to enable them to transport patients to the mortuary. There was specific training for portering staff to ensure they could access the mortuary out of hours in the event a patient had died. Access to the mortuary out of hours was reliant on this training being up to date. Training was provided and reviewed annually by the mortuary manager and access to the mortuary removed if the training had lapsed.

Volunteers had received recognised EOL training from a charity to enable them to support patients and their relatives.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss EOL patients and improve their care.

Ward staff told us the SPCT were visible on wards especially when delivering training such as the new SWAN (Signs, Words, Actions, Needs) initiative. The SWAN initiative was a mechanism for promoting person / family centred care and emphasising personhood after death. The service used a swan symbol to identify a patient as EOL, this ensured staff provided a sensitive and emotional approach to care for patients and their relatives.

We heard many positive examples when the SPCT worked collaboratively with other hospital staff including palliative and oncology nursing and medical staff. We observed good working relationships between staff who worked at different hospital sites such as the bereavement staff.

We saw excellent MDT working relationships between bereavement, chaplaincy and mortuary staff. In addition, we observed a patient discharge to the local hospice and saw coordinated and timely interactions between ward staff, patient discharge team members and portering staff.

There was a good uptake of EOL volunteers. These volunteers were drawn from the existing cohort of trust volunteers. They received additional training from a charity and provided emotional support to EOL patients and relatives if they wanted it.

There was a bi-monthly MDT EOL steering group meeting with an executive chair. This was regularly attended by staff, including the bereavement, mortuary and chaplaincy staff.

There were regular Kent and Medway EOL steering group meetings. These were regularly attended by the SPCT and other partner organisations across Kent.

The bereavement team described how they worked with medical staff, who completed death certificates, and with the registry office where deaths were reported.

Seven-day services

The SPCT team was not available seven days a week. However key services were available through established procedures to support timely patient care.

The EOL team provided an inpatient advisory service, Monday to Saturday (including Bank Holidays) between 9.00am and 5.00pm.

End of life care

An out of hours palliative support telephone line was available and managed by palliative care nurse specialists. This was provided via a service level agreement with a local hospice. Out of hours consultant cover was also provided by the local hospice under the same agreement.

The mortuary team did not routinely work at evenings or weekends. However, they would attend if assistance was needed for a transfer in or out of the mortuary.

Portering staff were available to transport patients when needed at all times. They were always available to support the transition of deceased patients from the wards to the mortuary. A limited number of porters received specific training and had access to the mortuary out of hours and weekends. Their access was monitored and reviewed annually. If their training went out of date their access to the mortuary was removed.

The bereavement team officers worked 30 hours during the day Monday to Friday and these hours were aligned to the local registrar's opening hours. There was no provision for out of hours or on call work.

The chaplaincy team were available during the day Monday to Friday. Out of hours cover was provided by the chaplaincy team on a rotational basis.

Health promotion

Staff gave patients practical support to help them live well until they died.

We saw relevant information promoting support on every ward. There were Macmillan support centres within the trust which were staffed by volunteers. They had leaflets and guidance on a range of subjects such as emotional, financial and therapy information.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, staff training compliance was below the trust's own target.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We spoke with staff and looked at records to confirm that staff had a good understanding of the principles of the Mental Capacity Act and when to carry out an assessment of capacity.

Nursing staff received with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Training in this was mandatory at Level 3 and the compliance rate was 69% across the teams, against the trust target of 85%. Post inspection the trust outlined plans to improve training compliance rates for all staff groups across the trust.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. An up-to-date policy was on the trust website and staff knew how to access it. The policy contained information about who to contact for advice.

End of life care

Is the service caring?

Good 

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We spoke with ward based staff who provided nursing, palliative and medical care to patients who were approaching the end of their life (EOL). They would make sure patients were comfortable, washed, and hydrated.

We observed the EOL team interacting with patients and their relatives in a respectful and considerate way. Staff took time with patients to ensure they felt supported. They introduced themselves and were compassionate to those who were experiencing pain, discomfort or distress.

Ward staff would always try to prioritise side rooms for patients who were receiving EOL care, however this was not always possible as other patients often needed to be isolated for infection control issues. Where this happened patients were nursed on a bay. We observed staff closing curtains around these patients beds during patient reviews.

Ward staff described how they would care for deceased patients before their transfer to the mortuary. This involved preparing the patient for transfer to the mortuary. Ward staff ensured the privacy and dignity of the patient was maintained until moved to the mortuary and ensured their spiritual and cultural wishes were respected.

Portering staff described how they would close all the windows and doors along a ward corridor before transferring the patient from the ward to the mortuary. They told us they did this to minimise any potential distress to other patients and visitors. Bereavement and mortuary staff provided bereavement care and support to relatives following a patient's death.

Emotional support

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

We observed staff demonstrating sensitive and supportive care and we heard of positive examples of when staff provided emotional support. For example, they arranged for relatives to receive parking permits and stay overnight when patients were cared for in side rooms, even if they had not been commenced on the EOL pathway. They would try and nurse the same patient to keep the continuity of care. They arranged a marriage service for a patient with terminal cancer.

The EOL team instigated the SWAN initiative to provide sensitive and emotional care to patients and their relatives. As part of the SWAN initiative we saw a range of items which had been donated from local charities. They used tote bags in which there were memory key-rings which could be given to patients or relatives especially children to provide comfort. There were also comfort packs containing self-care items such as a toothbrush and washing items for relatives who were staying overnight. It also included lip moisturiser if relatives wished to provide lip care to their loved ones.

End of life care

The EOL team reported the "feedback we have received since launching SWAN has been extremely positive from patients, relatives and staff".

Staff understood and respected the personal, cultural, social, and religious needs of patients and their relatives. The bereavement team knew about the promptness of burials for different religions.

The chapel was always open to offer spiritual or religious comfort to patients, relatives and staff. We saw various ways which prayers or messages could be dedicated to loved ones. For example, we saw relatives had written names of loved ones on a leaf and hung it on a specially constructed tree. We saw a poster displaying messages which had been written on colourful cut out butterfly shapes. There was a display cabinet showing an open prayer book displaying names of deceased children.

The bereavement staff were able to give us positive examples of when they delivered emotional care. They told us they were the main contact for relatives following the bereavement. Bereavement staff said that out of respect they would always call the deceased patient by their name or as a "patient" when speaking with relatives. They would request the deceased belongings from the ward so they could return these to the relatives to avoid relatives having to visit the ward.

We spoke with mortuary staff who provided positive examples of how they delivered emotional care to relatives of the deceased patient. They would spend time with relatives and gave them the time they needed. They encouraged relatives to take away comfort teddy bears, smooth coloured stones or would offer other physical memory aids such as hand or footprint castings. The staff said they would always put a handknitted teddy bear into babies and children's baskets.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff talked with patients and relatives in a way they could understand. They allowed patients and relatives the time to take on board the information provided and were encouraged to ask any questions.

The EOL team supported patients and relatives to be actively involved in making decisions about their care, treatment and support. They had implemented the SWAN initiative on most wards. The principles of the SWAN initiative were a simple way to highlight the importance of putting the patient and relatives at the heart of decision making when it comes to EOL care planning.

All staff were proud of the SWAN initiative. They were passionate about using it to deliver the best care possible. They gave teddy bears to anyone needing comfort especially younger relatives. There were story books for children to write their name inside to help them understand death and bereavement.

Is the service responsive?

Good ↑

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

End of life care

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. The SPCT had developed a strategy, launched in April 2022, with Kent and Medway system partners which addressed the needs of the local population for both acute and community services.

EOL care was delivered to patients in a system wide approach with the involvement of multidisciplinary teams. For example, emergency department staff and oncology healthcare professionals within the trust and GP's, hospices, community staff, local councils and other private providers within local area.

Ward staff had access to a palliative care advice and support telephone line. This was available outside of the normal working hours for the SCPT. Specialist EOL support was provided by specialist palliative care nurses and doctors from a local hospice.

Facilities and premises were appropriate for the services being delivered. We heard of positive examples when patients receiving EOL care were moved to side rooms on wards to ensure their privacy and dignity was maintained. Although these side rooms were limited, staff would always try and accommodate this for EOL patients.

Relatives were able to visit patients receiving EOL care at all times. Arrangements were made for relatives who wished to stay overnight.

There were parking permits available for relatives which meant they did not need to pay for car parking at the hospital. There were allocated car parking spaces reserved for relatives who were visiting the mortuary and these spaces were close to the mortuary entrance.

The chaplaincy staff were responsive to any request and would listen and support relatives or staff whether they had a faith or not. We were told the trust would pay for a hospital funeral if a deceased patient or relatives had limited funds.

The bereavement team ensured relatives received a bereavement pack once they had been notified of a death. They also provided practical advice regarding visits to the chapel of rest, collecting personal belongings and administration procedures such as registering the death and collecting the death certificate.

Meeting people's individual needs

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

The trust used a document called an Individualised Care Plan for the Dying Patient to record patient's preferences such as spiritual and religious wishes and patient's needs such as psychological and emotional needs. We reviewed the results of the latest National Audit of Care at End of Life (NACEL) from 2021/2022. This had identified the care plan was always not started early enough, and patient's personalised wishes and discussions were not recorded. This meant patient's wishes or needs, such as arranging their preferred place of death, were not always fulfilled.

The SPCT were developing an education plan for medical staff to address this shortfall and to raise awareness of early identification of a patient approaching end of life.

End of life care

During the SPCT virtual board round we observed meaningful discussions regarding patients and their individual circumstances and needs. There was a clear desire from the SPCT team to ensure that EOL patients had their needs met.

The SPCT had implemented the SWAN symbol across the trust. The addition of the symbol against a patient's record or name indicated they were end of life. This alerted all staff so they could modify their actions accordingly and be respectful of the patient's needs and those of their relatives.

The chaplaincy team could access the hospital computer system to identify EOL patients. They also received referrals from staff via phone calls. They had a message box outside the chapel for anyone to request a visit or phone call. Chaplaincy staff would visit the patient, relatives, or staffing looking after patient, and offer spiritual and religious support.

They were able to offer Christian and Anglican support within the team and had access to other faith leaders in the community.

There was a chapel and multifaith room which were open all the times and were well signposted within the hospital. These were accessible for the spiritual and religious needs of all patients, relatives and staff. We saw a diverse selection of religious books, information and posters available in languages spoken by the patients and local community.

We saw several posters which displayed a welcome greeting in all languages, a multifaith calendar of religious events and chaplaincy contact numbers. We saw there was a submission box for messages requesting chaplaincy support or prayers. There was a quiet room which was neutrally decorated which was used by visitors from other faiths or with no faith for prayer or contemplation. There were prayers and leaflets that could be taken away. The facilities included an area for ritual washing and a place to safely store shoes. Prayer mats and scarfs were also available.

The bereavement staff explained how they delivered a seamless service to relatives and helped them organise paperwork and visits to the chapel of rest. Once a patient had passed away, relatives could liaise directly with the bereavement team for all their needs. This reduced the burden on the bereaved family at an often difficult time, as they only needed to contact one team within the trust.

Staff made sure patients and relatives could get help from interpreters or signers when needed.

All staff we spoke with gave positive examples of how they were aware of religious and cultural differences when caring for a deceased patient. For example, we heard staff helped with the religious washing and cleansing of deceased patients and had also arranged for a Buddhist faith leader to visit a patient.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were not always monitored.

The SPCT encouraged ward staff to recognise patients who were at EOL as soon as possible. The named consultant for the patient, in most cases, had the responsibility for making the final decision.

Ward based staff and the SPCT reported patients had not always been identified early enough to start on the EOL pathway. In some cases, the patient had deteriorated too quickly, or medical staff were waiting to see if there had been a response or a positive change in condition in response to treatment.

End of life care

The service had a formalised referral process to the SPCT and ward staff could access referral documentation through the trust's electronic patient record system. Referrals would be sent electronically to the SPCT.

We heard the EOL staff would access the computer system to identify patients who had been started on the EOL pathway by ward staff. They would aim to visit these patients the same day and ward staff confirmed they were very responsive.

Managers did not monitor waiting times but made sure patients could access services when they needed them. The trust said they did not specifically monitor whether patients received treatment within agreed timeframes, but they monitored complaints, patient feedback and incidents as an indicator of service performance in this area. The trust told us that staff could respond to urgent patients within 24 hours.

Staff supported patients when they were referred or transferred between services. One of the roles of the SPCT was to ensure patients could be supported to access and transfer between the different services involved in their journey. Staff gave us examples of how patients were supported to access a hospice at the weekend and how they supported patients from hospital to die in their chosen place.

We reviewed EOL dashboards which showed compliance against key performance indicators. This did not show data to measure the responsiveness, or the availability of the EOL team. In addition, there were no audits to measure the quality of the referrals.

The trust had a discharge policy to guide staff on how to fast track the discharge of patents who required palliative care. The EOL team had daily meetings with the local hospice who accepted admissions seven days a week. They told us local nursing homes would also accept admissions.

Ward staff told us the portering staff responded quickly when a request was placed to transfer a deceased patient from the ward to the mortuary.

The trust did not have a formalised referral process for the chaplaincy team. However, there were no reported issues or concerns about requesting a visit from the chaplaincy team.

Learning from complaints and concerns

People were able to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with relevant staff. However, we did not see where complaints relating to EOL were discussed at governance meetings.

Patients, relatives and carers could complain or raise concerns. We saw posters on the wards that provided information and details of how to make a complaint and the relevant contact details for the service if they needed to.

Staff understood the policy on complaints and knew how to handle them. We did not speak with any service users who had raised a complaint, but staff could describe how to handle complaints and had access to the trust's policy.

The SPCT said they would share feedback and learning from complaints to ward staff. They told us there had been fewer reported concerns and complaints since the introduction of the SWAN model. They also provided specific training with ward staff and worked collaboratively with partnership services such as hospices.

End of life care

However, we reviewed the March, April and May 2022 minutes "summary of actions" from the EOL steering group and did not see any associated escalations or actions relating to concerns or complaints. It was not clear how these were monitored in this group or how actions were cascaded back to the EOL team or to senior leaders.

Ward staff gave positive examples of when performance had improved as a direct result from complaints. For example, the introduction of SWAN bags and jewellery pouches had been developed due to feedback received regarding the lost property of a deceased patient's belongings.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

The EOL service sat within the Oncology directorate, which was a directorate within Cancer Services. The EOL team reported into a formal and recognised leadership structure within the trust divisions and directorate.

The EOL service had a palliative care lead clinician, who was a palliative care consultant, and a lead nurse of palliative and EOL services.

Leaders and managers in other departments relating to EOL, including the bereavement team, mortuary, chaplaincy and porters, were experienced in their roles. They were able to describe how their role complemented and enhanced the EOL service.

The EOL leaders had oversight of priorities and issues and were involved in the various meetings and task and finish projects.

Vision and Strategy

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

The trust vision was defined as:

- To deliver kind, compassionate and sustainable services for our community through being improvement driven and responsive to the needs of our patients and staff, making Maidstone and Tunbridge Wells NHS Trust a great trust to visit and work.

The EOL service vision was directly aligned to the vision of the trust and was defined as:

End of life care

- All patients dying within Maidstone and Tunbridge Wells NHS Trust will experience compassionate, high quality, responsive and individualised care that facilitates their preferences and addresses the physical, psychological, practical and social needs of the patient and those important to them.

The trust had a specific vision and strategy for end of life care for 2019 to 2022, which they had implemented across all the EOL and palliative care services the provider was responsible for.

The EOL service at the trust had worked with Kent and Medway system partners to develop and integrate their service provision further. As a result, they had together launched a system-wide EOL five-year strategy in April 2022.

This strategy was based on the six national ambitions and the priorities for EOL care were:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and well-being
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help.

In addition, the system-wide partnership had added an additional priority for Kent and Medway:

- Identifying an individual who is at the end of their life

Culture

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

Staff and managers we spoke with were focussed on the needs of patients and were motivated to deliver high quality care. The SPCT spoke highly of the support they provided each other despite being a small team. All staff were dedicated to their role. They encouraged ward staff to share personal experiences during EOL training sessions so that other staff could listen to real experiences.

The SPCT hoped to start training the new EOL ward champions and would incorporate additional time for them to receive appropriate supervision and have debrief opportunities. However this training was on hold due to staffing challenges within the SPCT. EOL ward champions were ward based nurses who received additional training and were a link between ward nurses and the SPCT.

The mortuary, bereavement and chaplaincy staff described a good working culture with each other and felt well supported in their role by colleagues, managers and senior leaders.

None of the patients we spoke with raised any concerns about the care they received from the SPCT, though they felt they could raise concerns with the trust if needed.

End of life care

Governance

Leaders operated an established governance process. Staff had opportunities to meet, discuss and learn from the performance of the service. However, there were missed opportunities to identify and share improvements.

The EOL service had a formalised governance structure which showed escalation pathways from SPCT to board and also dissemination routes from board to EOL team onto ward staff. This was defined in the SPCT Operational Policy, December 2022 to 2023. We saw evidence the SPCT were regular attendees at divisional meetingsEOL

We reviewed various EOL meeting minutes which showed learning had been shared with staff. However, we heard examples when incidents were not always reported. For example, when there were delays in identifying patients as EOL or delays to starting the EOL pathway. This meant there were potential missed opportunities for learning and improvement.

The SPCT held monthly EOL steering group meetings, chaired by the chief nurse, which were attended by a range of staff who delivered EOL care across the trust, as well as lead staff from patient experience teams, frailty teams, chaplaincy and mortuary. We were told this group would monitor the progress and improvements made within the EOL service over time. This meeting had standard agenda items which covered quality, safety and performance issues.

There were various projects within the SPCT that were reported in the steering group meeting. For example, the clinical leads for SPCT had commenced a piece of work about early discussion of EOL decisions during ward rounds. The goal for this work was to identify patients who were dying, in a timely way, so that the best care could be given and preferences identified and facilitated where able. Additionally, there had been a training programme across the trust prior to the rollout of a new syringe-driver. Also, the EOL were training volunteers to become specific EOL volunteers. Training was partnered with an existing charity who specialised in EOL services.

Overall, patient feedback was positive and staff provided responsive care. Managers and staff had worked hard to improve the system across Kent and Medway so that patients' needs for specialist palliative care could be responded to more consistently, including out of hours.

Management of risk, issues and performance

Leaders and teams used limited systems to manage performance. We were not assured the service identified and escalated all relevant risks and issues.

There were governance processes in place to lead, manage, risk assess and sustain effective services. However, we found challenges with the sustainability of those processes, with some single points of failure within the service structure.

There were limited trust audits to measure the responsiveness and performance of the EOL service. The EOL service used the annual NACEL as a primary tool to measure performance and to benchmark its performance against similar NHS services. However, NACEL is currently paused during 2023 for a redesign, it is therefore unclear how the service will measure and report its own performance and subsequently drive improvement.

During the inspection we asked staff about the service risk register and any associated risks for the service that might be recorded. None of the staff were able to articulate their understanding of the risk register, what might be on the register or how to update the register should they identify a risk. We therefore requested the risk register for the EOL service post inspection. The trust provided the Cancer Service risk register, and associated documents, as EOLC sat within that division. The trust confirmed that there were no live risks associated with the EOLC service. There was executive oversight of the service as they chaired the EOLC committee.

However, we were not assured staff within the service appropriately identified and recorded risks relating to their service provision. Staffing issues described to us during the inspection had not been recorded and therefore were not formally visible to senior leaders within the trust. For example, there was one member of staff responsible for coordinating training for ward staff and EOL champions. At the time of the inspection this training was on hold as this member of staff was off work for extended period. This had not been identified as a risk to the service or recorded on the risk register.

At the time of the inspection, the EOLC service provided a 6 day a week on-site service and were working towards a 7 day on-site service. Staff within the hospital could access specialist clinical advice outside of EOLC working hours. There was a formal agreement with the local hospice and staff could access the haematology and oncology on-call consultant teams for advice.

We reviewed the results of the Human Tissue Authority (HTA) audit of the mortuary. We saw appropriate actions had been put in place to mitigate against identified risks on the audit.

Despite these current challenges, the service had made a number of improvements and there were clear plans for the service with defined trajectories. These provided assurances of the sustainability of the EOL service. We recognised the ambition to deliver a seamless provision of EOL care within Kent and Medway.

Information Management

The information systems were integrated and secure. The service collected data, however there was limited analysis and therefore limited opportunity to understand performance, make decisions and improvements.

The trust had implemented an electronic patient record system across all its services. At the time of the inspection the EOL were transitioning their record keeping and referral documentation onto the new system.

We heard and observed positive examples from staff regarding how the new system was being used to improve communication between teams of a patient's individual care. For example, we saw clinical staff could access patient records from both hospital sites. Patient information was able to be reviewed remotely during team handovers and virtual board rounds.

The service captured referral information and data which was, at the time of the inspection, via a manual process. However, there were limited audits or analysis of this data to measure the responsiveness and performance of the EOL team.

Service leads described plans were also in place to link the dataset to the new quality oversight software as part of the EOLC teams digital quality dashboard. It was hoped this would improve the quality and understanding of information captured.

Several partners such as hospices and local trusts within Kent and Medway system had been granted access rights for patient information stored within the trust computer system. The trust also had information sharing agreements in place with local safeguarding and council teams and community pain services.

Engagement

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

End of life care

The SPCT were well known on all the wards we visited. Ward staff reported they always gave positive feedback on how the SPCT helped them in their roles.

We observed how the SPCT successfully collaborated with ward staff and met with patients and relatives to help plan and manage the services.

We saw how they spoke with patients and relatives about the best ways to capture their preferences and needs. However, this was once a patient had been identified as EOL which did not always happen in a timely way.

We heard the different ways that the chaplaincy team reached out to engage with patients and staff and how they offered support and guidance.

The SPCT collaborated and worked well with providers within Kent and Medway. For example, they met with senior representatives from the local hospices, councils and other partners at the steering group meetings. The meeting minutes showed these representative attendees held delegated authority to deliver sustainable improvements in the system.

Learning, continuous improvement and innovation

The SPCT were committed to continually learning and improving services.

There was an ambition for the implementation of a robust seven-day EOL service across the region covered by this trust. We heard funding had recently been approved for the recruitment of consultants and clinical nurse specialists to support the provision of a seven-day service for both EOL and palliative care patients within the hospital, community and hospice settings.

The SPCT had designed and rolled out the SWAN initiative onto ward areas and patients and relatives reported positive experiences. This was an example of an innovative approach to engage everyone in the principles of delivering good quality EOL care.

The Tunbridge Wells Hospital at Pembury

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Pembury
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TN2 4QJ
Tel:

Description of this hospital

The Maidstone and Tunbridge Wells Specialist Palliative Care Team (SPCT) is a trust-wide service encompassing both hospital sites. The service provides care for patients with non-curative illnesses and also supports those closest to them. End of life care (EOLC) was not seen as the sole responsibility of the SPCT.

Although there is one team, this report relates to Tunbridge Wells Hospital. Please refer to a separate report for Maidstone Hospital.

The SPCT consist of 1.0 Whole Time Equivalent (WTE) palliative care consultant and 9.8 WTE clinical nurse specialists (CNS) and an EOLC facilitator (15 hours per week). The team works in association with their respective community palliative care teams and in partnership with local voluntary sector hospice providers. In addition, a trust chaplaincy team provided multi-faith support.

The SPCT were available six days per week, Monday to Saturday 9am to 5 pm. Outside these hours the SPCT service was covered by telephone support from the local hospice linked to the hospital.

During the inspection we visited wards and departments across both Tunbridge Wells Hospital and Maidstone Hospital where end of life care was provided and carried out. This included wards, mortuary, bereavement office and the chaplaincy to assess how EOLC was delivered.

We spoke with staff including palliative care leads, medical and nursing staff, patient liaison officers, porters, mortuary staff, and hospital chaplains.

We reviewed the medical records of 11 patients who were receiving EOLC at either this hospital or Maidstone Hospital and observed care provided by medical and nursing staff on the wards. We spoke with family members who's relative were receiving EOLC and we also spoke with 4 patients.

We reviewed performance information held about the trust.

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

Our findings

- EOL patients personalised needs and preferences were not always recorded. There was sometimes a delay with the recording of patient's needs and preferences. The EOL team was not available seven days a week.
- There was no available data to measure the responsiveness or availability of the EOL. The service did not always use effective systems to improve the awareness of risks and issues and manage performance.
- Not all staff involved in the delivery of EOL care were clear about their responsibilities and accountabilities. EOL staff did not always collect reliable data to understand performance, make decisions and improvements.

However:

- The service generally had enough staff to care for patients and keep them safe. Staff had training in key skills and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Most staff were clear about their roles and accountabilities.
- Leaders were experienced and ran services well and supported staff to develop their skills.

End of life care

Requires Improvement  

Is the service safe?

Good  

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

Mandatory training

The service provided mandatory training in key skills to all staff working in the Specialist Palliative Care Team and monitored compliance.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us they had been given protected time to complete this training. All staff had completed equality and diversity, information governance and data security and moving and handling training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Nursing staff received and kept up-to-date with their mandatory training. We reviewed the mandatory training compliance rates for staff working within the Specialist Palliative Care Team (SPCT). This showed an overall compliance rate of 100% for mandatory training and exceeded the trust target which was set at 85%.

The SPCT had specific role End of Life (EOL) mandatory training to complete. However, there was a shortfall with this compliance as two modules had recently been added to the mandatory training schedule. After the inspection the trust outlined plans to ensure staff became compliant, however this did not pose a patient safety concern.

Safeguarding

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

SPCT staff received training specific for their role on how to recognise and report abuse. We reviewed the safeguarding mandatory training compliance rates for the SPCT staff. This showed 100% of staff had completed training at level 3 for adults and children safeguarding level 2.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They knew how to identify adults and children at risk of, or suffering, significant harm, how to make a safeguarding referral and who to inform if they had concerns.

We heard of one example when a patient had disclosed information that raised concerns, and this was appropriately raised as a safeguarding concern.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

End of life care

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff using PPE such as gloves and aprons. We saw staff adhered to the 'bare below the elbow' infection prevention and control guidance.

We visited several areas in which EOL care was provided. This included hospital wards, the mortuary, multi-faith rooms and bereavement offices. All these areas appeared clean, tidy and well maintained. We saw personal protective equipment including gloves and aprons were readily available. There were appropriate handwashing and hand decontamination facilities in all areas.

Effective measures were in place to ensure the health and safety of everyone who came into contact with a deceased person's body. Staff we spoke with were knowledgeable about these infection, prevention and control (IPC) measures and could describe how they washed and prepared the body after death.

Portering staff were aware of the IPC measures to take when transporting patients and could describe training they had received. This included transporting patients with cultural or religious differences or who had an infectious disease.

We reviewed the mortuary area and saw it was visibly clean and followed IPC guidance. We reviewed cleaning records which were up to date and demonstrated areas had been cleaned regularly. Staff identified what had been cleaned and signed their name once it was completed.

Environment and equipment

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

We visited the mortuary, chapel, multifaith room, and bereavement room which were all suitable facilities to meet the needs of patients and their relatives. The mortuary had a viewing room that was appropriate for relatives visiting the deceased patient. All were appropriately signposted.

Access to the mortuary for authorised staff was via a secure key-card system. All other staff used an intercom system to request entry.

All access to the mortuary, including by authorised staff, was recorded in a visitor log which prompted visitors to sign in and out. All relevant areas within the mortuary were monitored by CCTV. During out of hours only trained portering staff had access to the mortuary. All access requirements were monitored and reviewed on a yearly basis.

The mortuary was clean and odour free. It had storage capacity for 100 deceased patients, including capacity for children and bariatric patients. There were also 5 deep freezers suitable for longer term storage of deceased persons, these were also suitable for bariatric patients.

We reviewed a Human Tissue Authority (HTA) audit which had been completed in February 2023 for the mortuary environment. The results showed some minor 'non-conformities' against HTA standards. The trust had developed an action plan to resolve or reduce the impact the issues raised. While it is the responsibility of the HTA to regulate the mortuary, we reviewed the action plan and saw some actions had been completed and others were in progress, with names of those responsible added to each action.

End of life care

Staff across the trust who delivered end of life (EOL) care said they had enough suitable equipment to help them to safely care for patients. For example, the service used specialist syringe drivers for patients who required a continuous infusion of medicine to control their symptoms. EOL patients were often nursed on an air mattress to limit pressure damage. Nursing teams did not report any issues and confirmed these items were readily available and were obtained from a trust wide central equipment library.

In the mortuary we saw there were suitable numbers of trolleys, including specialist trolleys, used to transport a deceased person from the wards to the mortuary. We saw all trolleys had suitable coverings to maintain dignity and privacy of the deceased person. New hoists had recently been delivered that would allow easier access to high and low fridge spaces.

Assessing and responding to patient risk

Ward staff provided care to patients requiring palliative and end of life (EOL) care. They completed risk assessments for patients who were deteriorating and in the last days or hours of their life. However, these were not always started in a timely manner.

Ward based staff used a nationally recognised tool to identify deteriorating patients. Staff described how they would escalate to medical staff if they had a concern or the tool indicated escalation was required.

Ward based staff were required to start an Individualised Care Plan for the Dying Patient when a patient was identified as EOL and placed on the EOL pathway. However, the SPCT team told us this document was not always started in a timely manner as patients were not always identified as being end of life. The SPCT team had identified there was a potential risk that patients approaching end of life might not be reviewed appropriately, or staff looking after them might not be given adequate support and guidance. The SCPT team had commenced a programme of education with medical staff to consider if a patient may be end of life when undertaking ward rounds.

Staff both on the wards and in the SPCT shared key information to keep patients safe when handing over their care to others. Staff across the trust could access pathways and escalation processes for the identification of patients approaching EOL. However, as staff did not always identify EOL patients early, the use of these pathways was not always effective.

Ward based staff knew about and dealt with any specific risk issues. However, when we looked at a sample of patient records, they indicated the SPCT had to sometimes intervene with ward based nursing teams to ensure appropriate care for patients with specific risk issues like pressure ulcers. Staff told us they completed pain assessments and ensured patients basic health care needs were met such as mouth care and washing.

Handovers included all necessary key information to keep patients safe. We attended one of the daily handover meetings and observed it followed a standard format and included information about safeguarding issues, incidents, and patients with urgent needs.

The mortuary staff showed us warning notices that alerted staff if patients had a pacemaker or implantable defibrillator. These were also used to highlight if there were patients with similar names to avoid identification errors.

Staffing

The service had generally enough specialist nursing and other support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

End of life care

Staff throughout the hospital delivered end of life and palliative care and were supported by the dedicated Specialist Palliative Care Team (SPCT). The SPCT were responsible for providing support and guidance to all staff who delivered care and treatment to patients who had been identified as EOL.

The SPCT was fully staffed, however they reported an increasing workload was putting increased strain and demand on its ability to fulfil their role. In addition, sickness levels within the team had impacted its ability to provide EOL training to ward based staff.

The mortuary team covered the mortuaries on both hospital sites on a rota basis. The managers and mortuary staff were experienced in their roles.

Chaplaincy and bereavement staff provided care and support to EOL patients and their relatives. The chaplaincy team were responsible for offering spiritual and religious support to patients, relatives and staff. They were able to offer Christian and Anglican support within the team and had access to other faith leaders in the community. The service had EOL volunteers supported by the chaplaincy team, and they were in the process of actively recruiting additional volunteers.

There were challenges within the chaplaincy team to provide sufficient cover. The two chaplains also supplied out of hours support on a rotational basis.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The EOL team had one consultant employed by the trust. They provided consultant cover across both hospital sites and were responsible for reviewing all patients who had been identified as EOL and had started on the EOL pathway. They were available for clinical advice, support and training and they provided support to patients, relatives and staff. All staff we spoke with gave positives examples of the level of support provided by this consultant.

However, with only one consultant employed by the service, this meant there was limited consultant cover across both trust sites during the day. The service could access the trust haematology and oncology consultant teams, who had received palliative care training, Monday to Friday.

Additionally on call consultant provision for evenings and weekends was provided through a service level agreement with the local hospice. The local hospice would also provide consultant cover on an informal basis for unplanned sickness or annual leave. The service did not routinely employ locums or trainee doctors to cover absences such as sickness or annual leave.

After the inspection we were advised a second palliative care consultant had been interviewed and appointed, with a start date to be agreed.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care. EOL care plans were not always started in a timely way, and there was limited audit of record keeping to promote learning or improvement.

End of life care

Patient notes were comprehensive, and all staff could access them easily. Staff used a combination of an electronic and paper records, which all staff had access to. In November 2021 the trust had transferred from paper records to an Electronic Patient Record system (EPR). Patient information was therefore recorded electronically. At the time of inspection, the specialised paperwork relating to EOL care was still paper-based. However, the trust were in the process of incorporating this paperwork into their EPR.

Care records were completed by ward based staff and information was uploaded onto the EPR. SPCT had access to laptop computers for this purpose and could view patient records remotely.

The EPR was shared by other trust teams which meant no delays in staff accessing patient records. Staff, including consultants who were part of the Kent and Medway system, could also access this system.

Records, both paper based and electronic, were stored securely. Paper records were stored securely on wards and departments we visited. Each member of the team had a personal log-on to the EPR which was secure. Staff had to complete information governance training before they could use it.

We reviewed the results of the National Audit of Care at End of Life (NACEL) from 2021/2022 which found the Individualised Care Plan for the Dying Patient was always not started early enough, and patient's personalised wishes and discussions were not recorded. The service acknowledged this document was not always started, or completed fully, when the patient was started on the EOL pathway.

We reviewed the Individualised Care Plan for the Dying Patient which staff were required to commence when a patient was identified as EOL. This was a two part document consisting of a clinical review, and care plan, we saw this recorded the personalised needs and preferences of the patient.

We reviewed 11 of these documents within patient records and found the majority had been completed appropriately. However, there were incomplete sections within the care plan to detail the patient's preference for spiritual and/ or religious care, and any psychological and emotional needs. We spoke with ward staff who said it was not always clear who should complete each part of the document.

The SPCT did not complete any routine audit of EOL patient records outside of the annual NACEL return. This meant the service did not know how accurate their record keeping was and if any learning or improvement could be identified.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The specialist palliative care team worked with specialty and ward based staff to provide the management and administration of medication for palliative care patients with complex needs. The SPCT reported good links with the hospital pharmacy team. Medicines, including anticipatory medicines given at the end of life, were prescribed using an electronic prescribing system. This system mitigated against potential prescribing errors.

The SPCT had specially trained nurse prescribers and medicines management standard operating procedures to follow. The SPCT nurse prescribers were able to review patient medications and change prescriptions, as appropriate, to meet the specific needs of EOL patients.

End of life care

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw in care records that medicine was available for patients and regularly reviewed. We observed a daily handover meeting where staff met to discuss all the patients that were due to be seen that day, and this included a review of any medicines they were prescribed if needed. The patients and carers we spoke with told us staff provided them with appropriate medicines information and advice.

Staff completed medicines records accurately and kept them up to date. Staff completed records at the same time they saw patients on wards. Staff in the SPCT had laptops that enabled them to access records remotely.

Incidents

Staff recognised and reported incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. There were missed opportunities to report delays in identifying EOL patients.

The trust had an incident reporting policy. The SPCT and staff delivering care to EOL patients, told us they understood their responsibilities regarding the reporting of incidents and gave us examples when they had raised an incident. For example, they were encouraged to incident report when patient discharges were not activated.

The SPCT could easily identify incidents related to EOL from the addition of a tick box added onto the electronic database. They regularly reviewed and investigated all incidents that were graded as moderate or above harm.

Although both ward staff and SPCT staff knew how to report incidents, we heard examples when incidents were not always reported. For example, when there were delays in identifying patients or delays to starting the pathway.

The results of the most recent national audit of care at end of life (NACEL) 2021/2022 confirmed that 33% of trust staff strongly agreed, and 50% of trust staff agreed, they felt able to raise a concern about EOL care.

Is the service effective?

Requires Improvement  

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. However, audits showed some personalised preferences were not recorded in a timely way.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We looked at a range of policies and procedures, which were based on recognised End of Life (EOL) guidelines and quality standards, such as the National Institute for Health and Care Excellence, (NICE).

The service participated in the annual National Audit of Care at End of Life (NACEL). We reviewed results of the latest NACEL from 2021 to 2022. One of the metrics from the audit identified the Individualised Care Plan for the Dying Patient

was always not started early enough, and patient's personalised wishes and discussions were not recorded. Results showed that 77% of the time, the time from admission to recognition of dying was 48 hours or longer. This meant that staff were not always able to deliver care based on patient's individual needs or preferences because they had not been documented.

Patients had an individualised plan of care which reflected their personal needs. If the patient was at EOL this was supported by the individualised care and communication record for a person in the last days or hours of life. This was in line with national standards and guidelines. However, delays in filling out the Individualised Care Plan for the Dying Patient meant patient's personalised wishes and discussions were not always recorded in a timely way.

Ward staff delivering end of life care told us they were able to access policies on the trust intranet.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We shadowed staff and attended meetings with them and looked at care records, we saw staff placed great emphasis on supporting patients and their families with their emotions and feelings.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. However, once a patient was identified as EOL assessment was not always effective.

Staff on the wards used a nationally recognised screening tool to monitor patients at risk of malnutrition.

We reviewed 11 records for EOL patients. We found the malnutrition universal screening tool (MUST) had not always been used appropriately to identify and score nutritional and hydration requirements once a patient had moved onto the EOL pathway.

We saw evidence on the electronic patient record of mouth care for those patients unable to tolerate fluids and care plans for patient mouth care for patients who were unable to tolerate food or fluids.

We reviewed the 2021/22 results of the most recent national audit of care at end of life (NACEL). This showed that 71% of staff strongly agreed or agreed they were confident in their ability to discuss hydration options with patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Both ward staff and staff in the SPCT prescribed, administered and recorded pain relief accurately. Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Ward staff used the pain assessment charts on the electronic patient record.

We reviewed the 2021/22 results of the National Audit of Care at End of Life (NACEL). This confirmed that 74% of staff said they were confident in their ability to assess and manage pain and physical symptoms.

Patient outcomes

The service monitored the effectiveness of care and treatment. However, there was limited evidence to determine if findings were used effectively to make improvements and achieve good outcomes.

End of life care

The service had an annual programme of end of life audits which was predominately based on the NACEL programme. However, we did not see audits to measure referral times and the responsiveness of the SPCT.

The trust provided data that showed from April 2022 to September 2022, 78% of patients achieved their preferred place of death. However, although the data was recorded there was no narrative to say whether this had improved or declined over the years, or whether this met relevant standards. This meant there was only a moderate level of assurance that service standards, such as care after death, and information provided for bereaved people, were consistently being achieved.

Managers did not always share and make sure staff understood information from the audits. Many of the staff we spoke with in teams told us they did not know what audits had been carried out. However, they were aware of routine audits carried out within the service, such as infection control audits.

The SPCT monitored patient outcomes and safety performance data using the EOL specific dashboard. The reported compliance levels were 74% for the completion of the Individualised Care Plan for the Dying Patient, prescribing anticipatory medications and recording of preferred place of death. This was compared to 73% reported nationally. These issues were noted within the EOL improvement plan and action plans had been implemented to improve compliance rates.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

SPCT staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Most staff we spoke with had many years of experience working in EOL, and most of them were senior nurses. The SPCT had four nurses who had completed nurse prescriber training. We looked at data which confirmed nurse prescribers had completed an annual declaration to show they kept up to date with their competence and skills in this area.

Managers supported SPCT staff to develop through yearly, constructive appraisals of their work, and data provided by the trust showed 100% of staff had had an appraisal. This was against a trust target of 85%.

Managers made sure SPCT staff attended team meetings or had access to full notes when they could not attend. We looked at a sample of team meeting minutes to see that they were held regularly and documented adequately. However, both staff and managers confirmed workload pressures had meant team meetings had not always taken place as planned. The team had discussed this and had committed to hold meetings and had diarised future meetings.

SPCT staff had the opportunity through the appraisal process and supervision to discuss training needs and were supported to develop their skills and knowledge. Staff confirmed these conversations had taken place and described how they were supportive.

All ward staff received an introduction to EOL care as part of their induction and completed online courses which were related to EOL and palliative care.

The SPCT team delivered EOL specific training courses face to face in the form of workshops or ward visits to eligible staff. However, increasing workloads and staffing issues within the SPCT had affected the ability of the team to deliver this training effectively.

Porters received training to enable them to transport patients to the mortuary. There was specific training for portering staff to ensure they could access the mortuary out of hours in the event a patient had died. Access to the mortuary out of hours was reliant on this training being up to date. Training was provided and reviewed annually by the mortuary manager and access to the mortuary removed if the training had lapsed.

Volunteers had received recognised EOL training from a charity to enable them to support patients and their relatives.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss EOL patients and improve their care.

Ward staff told us the SPCT were visible on wards especially when delivering training such as the new SWAN (Signs, Words, Actions, Needs) initiative. The SWAN initiative was a mechanism for promoting person / family centred care and emphasising personhood after death. The service used a swan symbol to identify a patient as EOL, this ensured staff provided a sensitive and emotional approach to care for patients and their relatives.

We heard many positive examples when the SPCT worked collaboratively with other hospital staff including palliative and oncology nursing and medical staff. We observed good working relationships between staff who worked at different hospital sites such as the bereavement staff.

We saw excellent MDT working relationships between bereavement, chaplaincy and mortuary staff. In addition, we observed a patient discharge to the local hospice and saw coordinated and timely interactions between ward staff, patient discharge team members and portering staff.

There was a good uptake of EOL volunteers. These volunteers were drawn from the existing cohort of trust volunteers. They received additional training from a charity and provided emotional support to EOL patients and relatives if they wanted it.

There was a bi-monthly MDT EOL steering group meeting with an executive chair. This was regularly attended by staff, including the bereavement, mortuary and chaplaincy staff There were regular Kent and Medway EOL steering group meetings. These were regularly attended by the SPCT and other partner organisations across Kent.

The bereavement team described how they worked with medical staff, who completed death certificates, and with the registry office where deaths were reported.

Seven-day services

The SPCT team was not available seven days a week. However key services were available through established procedures to support timely patient care.

The EOL team provided an inpatient advisory service, Monday to Saturday (including Bank Holidays) between 9.00am and 5.00pm.

An out of hours palliative support telephone line was available and managed by palliative care nurse specialists. This was provided via a service level agreement with a local hospice. Out of hours consultant cover was also provided by the local hospice under the same agreement.

End of life care

The mortuary team did not routinely work at evenings or weekends. However, they would attend if assistance was needed for a transfer in or out of the mortuary.

Portering staff were available to transport patients when needed at all times. They were always available to support the transition of deceased patients from the wards to the mortuary. A limited number of porters received specific training and had access to the mortuary out of hours and weekends. Their access was monitored and reviewed annually. If their training went out of date their access to the mortuary was removed.

The bereavement team officers worked 30 hours during the day Monday to Friday and these hours were aligned to the local registrar's opening hours. There was no provision for out of hours or on call work.

The chaplaincy team were available during the day Monday to Friday. Out of hours cover was provided by the chaplaincy team on a rotational basis.

Health promotion

Staff gave patients practical support to help them live well until they died.

We saw relevant information promoting support on every ward. There were Macmillan support centres within the trust which were staffed by volunteers. They had leaflets and guidance on a range of subjects such as emotional, financial and therapy information.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, staff training compliance was below the trust's own target.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We spoke with staff and looked at records to confirm that staff had a good understanding of the principles of the Mental Capacity Act and when to carry out an assessment of capacity.

Nursing staff received with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Training in this was mandatory at Level 3 and the compliance rate was 69% across the teams, against the trust target of 85%. Post inspection the trust outlined plans to improve training compliance rates for all staff groups across the trust.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. An up-to-date policy was on the trust website and staff knew how to access it. The policy contained information about who to contact for advice.

Is the service caring?

Good 

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

End of life care

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We spoke with ward based staff who provided nursing, palliative and medical care to patients who were approaching the end of their life (EOL). They would make sure patients were comfortable, washed, and hydrated.

We observed the EOL team interacting with patients and their relatives in a respectful and considerate way. Staff took time with patients to ensure they felt supported. They introduced themselves and were compassionate to those who were experiencing pain, discomfort or distress.

Ward staff described how they would care for deceased patients before their transfer to the Mortuary. This involved preparing the patient for transfer to the Mortuary. Ward staff ensured the privacy and dignity of the patient was maintained until moved to the Mortuary and ensured their spiritual and cultural wishes were respected.

Portering staff described how they would close all the windows and doors along a ward corridor before transferring the patient from the ward to the Mortuary. They told us they did this to minimise any potential distress to other patients and visitors. Bereavement and mortuary staff provided bereavement care and support to relatives following a patient's death.

Emotional support

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

We observed staff demonstrating sensitive and supportive care and we heard of positive examples of when staff provided emotional support. For example, they arranged for relatives to receive parking permits and stay overnight when patients were cared for in side rooms, even if they had not been commenced on the EOL pathway. They would try and nurse the same patient to keep the continuity of care. They arranged a wedding for a patient with terminal cancer.

The EOL team instigated the SWAN initiative to provide sensitive and emotional care to patients and their relatives. As part of the SWAN initiative we saw a range of items which had been donated from local charities. They used tote bags in which there were memory keyrings which could be given to patients or relatives especially children to provide comfort. There were also comfort packs containing self-care items such as a toothbrush and washing items for relatives who were staying overnight. It also included lip moisturiser if relatives wished to provide lip care to their loved ones.

The EOL team reported the "feedback we have received since launching SWAN has been extremely positive from patients, relatives and staff".

Staff understood and respected the personal, cultural, social, and religious needs of patients and their relatives. The bereavement team knew about the promptness of burials for different religions.

The chapel was always open to offer spiritual or religious comfort to patients, relatives and staff. We saw various ways which prayers or messages could be dedicated to loved ones. For example, we saw relatives had written names of loved ones on a leaf and hung it on a specially constructed tree. We saw a poster displaying messages which had been written on colourful cut out butterfly shapes. There was a display cabinet showing an open prayer book displaying names of deceased children.

End of life care

The bereavement staff were able to give us positive examples of when they delivered emotional care. They told us they were the main contact for relatives following the bereavement. Bereavement staff said that out of respect they would always call the deceased patient by their name or as a "patient" when speaking with relatives. They would request the deceased belongings from the ward so they could return these to the relatives to avoid relatives having to visit the ward.

We spoke with mortuary staff who provided positive examples of how they delivered emotional care to relatives of the deceased patient. They would spend time with relatives and gave them the time they needed. They encouraged relatives to take away comfort teddy bears, smooth coloured stones or would offer other physical memory aids such as hand or footprint castings. The staff said they would always put a handknitted teddy bear into babies and children's baskets.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff talked with patients and relatives in a way they could understand. They allowed patients and relatives the time to take on board the information provided and were encouraged to ask any questions.

The EOL team supported patients and relatives to be actively involved in making decisions about their care, treatment and support. They had implemented the SWAN initiative on most wards. The principles of the SWAN initiative were a simple way to highlight the importance of putting the patient and relatives at the heart of decision making when it comes to EOL care planning.

All staff were proud of the SWAN initiative. They were passionate about using it to deliver the best care possible. They gave teddy bears to anyone needing comfort especially younger relatives. There were story books for children to write their name inside to help them understand death and bereavement.

Is the service responsive?

Good ↑

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. The SPCT had developed a strategy, launched in April 2022, with Kent and Medway system partners which addressed the needs of the local population for both acute and community services.

EOL care was delivered to patients in a system wide approach with the involvement of multidisciplinary teams. For example, emergency department staff and oncology healthcare professionals within the trust and GP's, hospices, community staff, local councils and other private providers within local area.

End of life care

Ward staff had access to a palliative care advice and support telephone line. This was available outside of the normal working hours for the SCPT. Specialist EOL support was provided by specialist palliative care nurses and doctors from a local hospice.

Facilities and premises were appropriate for the services being delivered. We heard of positive examples when patients receiving EOL care were moved to side rooms on wards to ensure their privacy and dignity was maintained. Although these side rooms were limited, staff would always try and accommodate this for EOL patients.

Relatives were able to visit patients receiving EOL care at all times. Arrangements were made for relatives who wished to stay overnight.

There were parking permits available for relatives which meant they did not need to pay for car parking at the hospital. There were allocated car parking spaces reserved for relatives who were visiting the mortuary and these spaces were close to the mortuary entrance.

The chaplaincy staff were responsive to any request and would listen and support relatives or staff whether they had a faith or not. We were told the trust would pay for a hospital funeral if a deceased patient or relatives had limited funds.

The bereavement team ensured relatives received a bereavement pack once they had been notified of a death. They also provided practical advice regarding visits to the chapel of rest, collecting personal belongings and administration procedures such as registering the death and collecting the death certificate.

Meeting people's individual needs

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

The trust used a document called an Individualised Care Plan for the Dying Patient to record patient's preferences such as spiritual and religious wishes and patient's needs such as psychological and emotional needs. We reviewed the results of the latest National Audit of Care at End of Life (NACEL) from 2021/2022. This had identified the care plan was always not started early enough, and patient's personalised wishes and discussions were not recorded. This meant patient's wishes or needs, such as arranging their preferred place of death, were not always fulfilled.

The SPCT were developing an education plan for medical staff to address this shortfall and to raise awareness of early identification of a patient approaching end of life.

During the SPCT virtual board round we observed meaningful discussions regarding patients and their individual circumstances and needs. There was a clear desire from the SPCT team to ensure that EOL patients had their needs met.

The SPCT had implemented the SWAN symbol across the trust. The addition of the symbol against a patient's record or name indicated they were end of life. This alerted all staff so they could modify their actions accordingly and be respectful of the patient's needs and those of their relatives.

The chaplaincy team could access the hospital computer system to identify EOL patients. They also received referrals from staff via phone calls. They had a message box outside the chapel for anyone to request a visit or phone call. Chaplaincy staff would visit the patient, relatives, or staffing looking after patient, and offer spiritual and religious support.

They were able to offer Christian and Anglican support within the team and had access to other faith leaders in the community.

There was a chapel and multifaith room which were open all the times and were well signposted within the hospital. These were accessible for the spiritual and religious needs of all patients, relatives and staff. We saw a diverse selection of religious books, information and posters available in languages spoken by the patients and local community.

We saw several posters which displayed a welcome greeting in all languages, a multifaith calendar of religious events and chaplaincy contact numbers. We saw there was a submission box for messages requesting chaplaincy support or prayers. There was a quiet room which was neutrally decorated which was used by visitors from other faiths or with no faith for prayer or contemplation. There were prayers and leaflets that could be taken away. The facilities included an area for ritual washing and a place to safely store shoes. Prayer mats and scarfs were also available.

The bereavement staff explained how they delivered a seamless service to relatives and helped them organise paperwork and visits to the chapel of rest. Once a patient had passed away, relatives could liaise directly with the bereavement team for all their needs. This reduced the burden on the bereaved family at an often difficult time, as they only needed to contact one team within the trust.

Staff made sure patients and relatives could get help from interpreters or signers when needed.

All staff we spoke with gave positive examples of how they were aware of religious and cultural differences when caring for a deceased patient. For example, we heard staff helped with the religious washing and cleansing of deceased patients and had also arranged for a Buddhist faith leader to visit a patient.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were not always monitored.

The SPCT encouraged ward staff to recognise patients who were at EOL as soon as possible. The named consultant for the patient, in most cases, had the responsibility for making the final decision.

Ward based staff and the SPCT reported patients had not always been identified early enough to start on the EOL pathway. In some cases, the patient had deteriorated too quickly, or medical staff were waiting to see if there had been a response or a positive change in condition in response to treatment.

The service had a formalised referral process to the SPCT and ward staff could access referral documentation through the trust's electronic patient record system. Referrals would be sent electronically to the SPCT.

We heard the EOL staff would access the computer system to identify patients who had been started on the EOL pathway by ward staff. They would aim to visit these patients the same day and ward staff confirmed they were very responsive.

Managers did not monitor waiting times but made sure patients could access services when they needed them. The trust said they did not specifically monitor whether patients received treatment within agreed timeframes, but they monitored complaints, patient feedback and incidents as an indicator of service performance in this area. The trust told us that staff could respond to urgent patients within 24 hours.

End of life care

Staff supported patients when they were referred or transferred between services. One of the roles of the SPCT was to ensure patients could be supported to access and transfer between the different services involved in their journey. Staff gave us examples of how patients were supported to access a hospice at the weekend and how they supported patients from hospital to die in their chosen place.

We reviewed EOL dashboards which showed compliance against key performance indicators. This did not show data to measure the responsiveness, or the availability of the EOL team. In addition, there were no audits to measure the quality of the referrals.

The trust had a discharge policy to guide staff on how to fast track the discharge of patents who required palliative care. The EOL team had daily meetings with the local hospice who accepted admissions seven days a week. They told us local nursing homes would also accept admissions.

Ward staff told us the portering staff responded quickly when a request was placed to transfer a deceased patient from the ward to the mortuary.

The trust did not have a formalised referral process for the chaplaincy team. However, there were no reported issues or concerns about requesting a visit from the chaplaincy team.

Learning from complaints and concerns

People were able to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with relevant staff. However, we did not see where complaints relating to EOL were discussed at governance meetings.

Patients, relatives and carers could complain or raise concerns. We saw posters on the wards that provided information and details of how to make a complaint and the relevant contact details for the service if they needed to.

Staff understood the policy on complaints and knew how to handle them. We did not speak with any service users who had raised a complaint, but staff could describe how to handle complaints and had access to the trust's policy.

The SPCT said they would share feedback and learning from complaints to ward staff. They told us there had been fewer reported concerns and complaints since the introduction of the SWAN model. They also provided specific training with ward staff and worked collaboratively with partnership services such as hospices.

However, we reviewed the March, April and May 2022 minutes "summary of actions" from the EOL steering group and did not see any associated escalations or actions relating to concerns or complaints. It was not clear how these were monitored in this group or how actions were cascaded back to the EOL team or to senior leaders.

Ward staff gave positive examples of when performance had improved as a direct result from complaints. For example, the introduction of SWAN bags and jewellery pouches had been developed due to feedback received regarding the lost property of a deceased patient's belongings.

Is the service well-led?

Requires Improvement 

End of life care

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

The EOL service sat within the Oncology directorate, which was a directorate within Cancer Services. The EOL team reported into a formal and recognised leadership structure within the trust divisions and directorate.

The EOL service had a palliative care lead clinician, who was a palliative care consultant, and a lead nurse of palliative and EOL services.

Leaders and managers in other departments relating to EOL, including the bereavement team, mortuary, chaplaincy and porters, were experienced in their roles. They were able to describe how their role complemented and enhanced the EOL service.

The EOL leaders had oversight of priorities and issues and were involved in the various meetings and task and finish projects.

Vision and Strategy

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

The trust vision was defined as:

- To deliver kind, compassionate and sustainable services for our community through being improvement driven and responsive to the needs of our patients and staff, making Maidstone and Tunbridge Wells NHS Trust a great trust to visit and work.

The EOL service vision was directly aligned to the vision of the trust and was defined as:

- All patients dying within Maidstone and Tunbridge Wells NHS Trust will experience compassionate, high quality, responsive and individualised care that facilitates their preferences and addresses the physical, psychological, practical and social needs of the patient and those important to them.

The trust had a specific vision and strategy for end of life care for 2019 to 2022, which they had implemented across all the EOL and palliative care services the provider was responsible for.

The EOL service at the trust had worked with Kent and Medway system partners to develop and integrate their service provision further. As a result, they had together launched a system-wide EOL five-year strategy in April 2022.

This strategy was based on the six national ambitions and the priorities for EOL care were:

- Each person is seen as an individual
- Each person gets fair access to care

End of life care

- Maximising comfort and well-being
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help.

In addition, the system-wide partnership had added an additional priority for Kent and Medway:

- Identifying an individual who is at the end of their life

Culture

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

Staff and managers, we spoke with were focussed on the needs of patients and were motivated to deliver high quality care. The SPCT spoke highly of the support they provided each other despite being a small team. All staff were dedicated to their role. They encouraged ward staff to share personal experiences during EOL training sessions so that other staff could listen to real experiences.

The SPCT hoped to start training the new EOL ward champions and would incorporate additional time for them to receive appropriate supervision and have debrief opportunities. However this training was on hold due to staffing challenges within the SPCT. EOL ward champions were ward based nurses who received additional training and were a link between ward nurses and the SPCT.

The mortuary, bereavement and chaplaincy staff described a good working culture with each other and felt well supported in their role by colleagues, managers and senior leaders.

None of the patients we spoke with raised any concerns about the care they received from the SPCT, though they felt they could raise concerns with the trust if needed.

Governance

Leaders operated an established governance process. Staff had opportunities to meet, discuss and learn from the performance of the service. However, there were missed opportunities to identify and share improvements.

The EOL service had a formalised governance structure which showed escalation pathways from SPCT to board and also dissemination routes from board to EOL team onto ward staff. This was defined in the SPCT Operational Policy, December 2022 to 2023. We saw evidence the SPCT were regular attendees at divisional meetings.

We reviewed various EOL meeting minutes which showed learning had been shared with staff. However, we heard examples when incidents were not always reported. For example, when there were delays in identifying patients as EOL or delays to starting the EOL pathway. This meant there were potential missed opportunities for learning and improvement.

End of life care

The SPCT held monthly EOL steering group meetings, chaired by the chief nurse, which were attended by a range of staff who delivered EOL care across the trust, as well as lead staff from patient experience teams, frailty teams, chaplaincy and mortuary. We were told this group would monitor the progress and improvements made within the EOL service over time. This meeting had standard agenda items which covered quality, safety and performance issues.

There were various projects within the SPCT that were reported in the steering group meeting. For example, the clinical leads for SPCT had commenced a piece of work about early discussion of EOL decisions during ward rounds. The goal for this work was to identify patients who were dying, in a timely way, so that the best care could be given and preferences identified and facilitated where able. Additionally, there had been a training programme across the trust prior to the rollout of a new syringe-driver. Also, the EOL were training volunteers to become specific EOL volunteers. Training was partnered with an existing charity who specialised in EOL services.

Overall, patient feedback was positive and staff provided responsive care. Managers and staff had worked hard to improve the system across Kent and Medway so that patients' needs for specialist palliative care could be responded to more consistently, including out of hours.

Management of risk, issues and performance

Leaders and teams used limited systems to manage performance. We were not assured the service identified and escalated all relevant risks and issues.

There were governance processes in place to lead, manage, risk assess and sustain effective services. However, we found challenges with the sustainability of those processes, with some single points of failure within the service structure.

There were limited trust audits to measure the responsiveness and performance of the EOL service. The EOL service used the annual NACEL as a primary tool to measure performance and to benchmark its performance against similar NHS services. However, NACEL is currently paused during 2023 for a redesign, it is therefore unclear how the service will measure and report its own performance and subsequently drive improvement.

During the inspection we asked staff about the service risk register and any associated risks for the service that might be recorded. None of the staff were able to articulate their understanding of the risk register, what might be on the register or how to update the register should they identify a risk. We therefore requested the risk register for the EOL service post inspection. The trust provided the Cancer Service risk register, and associated documents, as EOLC sat within that division. The trust confirmed that there were no live risks associated with the EOLC service. There was executive oversight of the service as they chaired the EOLC committee.

However, we were not assured staff within the service appropriately identified and recorded risks relating to their service provision. Staffing issues described to us during the inspection had not been recorded and therefore were not formally visible to senior leaders within the trust. For example, there was one member of staff responsible for coordinating training for ward staff and EOL champions. At the time of the inspection this training was on hold as this member of staff was off work for extended period. This had not been identified as a risk to the service or recorded on the risk register.

At the time of the inspection, the EOLC service provided a 6 day a week on-site service and were working towards a 7 day on-site service. Staff within the hospital could access specialist clinical advice outside of EOLC working hours. There was a formal agreement with the local hospice and staff could access the haematology and oncology on-call consultant teams for advice.

End of life care

We reviewed the results of the Human Tissue Authority (HTA) audit of the mortuary. We saw appropriate actions had been put in place to mitigate against identified risks on the audit.

Despite these current challenges, the service had made a number of improvements and there were clear plans for the service with defined trajectories. These provided assurances of the sustainability of the EOL service. We recognised the ambition to deliver a seamless provision of EOL care within Kent and Medway.

Information Management

The information systems were integrated and secure. The service collected data, however there was limited analysis and therefore limited opportunity to understand performance, make decisions and improvements.

The trust had implemented an electronic patient record system across all its services. At the time of the inspection the EOL were transitioning their record keeping and referral documentation onto the new system.

We heard and observed positive examples from staff regarding how the new system was being used to improve communication between teams of a patient's individual care. For example, we saw clinical staff could access patient records from both hospital sites. Patient information was able to be reviewed remotely during team handovers and virtual board rounds.

The service captured referral information and data which was, at the time of the inspection, via a manual process. However, there were limited audits or analysis of this data to measure the responsiveness and performance of the EOL team.

Service leads described plans were also in place to link the dataset to the new quality oversight software as part of the EOLC teams digital quality dashboard. It was hoped this would improve the quality and understanding of information captured.

Several partners such as hospices and local trusts within Kent and Medway system had been granted access rights for patient information stored within the trust computer system. The trust also had information sharing agreements in place with local safeguarding and council teams and community pain services.

Engagement

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

The SPCT were well known on all the wards we visited. Ward staff reported they always gave positive feedback on how the SPCT helped them in their roles.

We observed how the SPCT successfully collaborated with ward staff and met with patients and relatives to help plan and manage the services.

We saw how they spoke with patients and relatives about the best ways to capture their preferences and needs. However, this was once a patient had been identified as EOL which did not always happen in a timely way.

End of life care

We heard the different ways that the chaplaincy team reached out to engage with patients and staff and how they offered support and guidance.The SPCT collaborated and worked well with providers within Kent and Medway. For example, they met with senior representatives from the local hospices, councils and other partners at the steering group meetings. The meeting minutes showed these representative attendees held delegated authority to deliver sustainable improvements in the system.

Learning, continuous improvement and innovation

The SPCT were committed to continually learning and improving services.

There was an ambition for the implementation of a robust seven-day EOL service across the region covered by this trust. We heard funding had recently been approved for the recruitment of consultants and clinical nurse specialists to support the provision of a seven-day service for both EOL and palliative care patients within the hospital, community and hospice settings.

The SPCT had designed and rolled out the SWAN initiative onto ward areas and patients and relatives reported positive experiences. This was an example of an innovative approach to engage everyone in the principles of delivering good quality EOL care.