

Medway NHS Foundation Trust

Quality Report


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

Ratings

Overall rating for this trust

Inadequate 

Are services at this trust safe?

Inadequate 

Are services at this trust effective?

Requires improvement 

Are services at this trust caring?

Good 

Are services at this trust responsive?

Inadequate 

Are services at this trust well-led?

Inadequate 

Summary of findings

Letter from the Chief Inspector of Hospitals

Medway NHS Foundation Trust provides acute services to a population of 400,000 across Medway and Swale. It became a foundation trust in April 2008 and employs around 3,880 staff, supported by 700 volunteers. The trust has two registered locations registered with the Care Quality Commission including Medway Maritime Hospital, which is the main acute hospital site and Woodlands Special Needs Nursery, which did not form part of the inspection.

The Medway Maritime Hospital site is home to a Macmillan Cancer Care unit, the West Kent Vascular Centre, an obstetrics theatre suite, a neonatal intensive care unit, a Foetal Medicine Centre, a dedicated stroke unit and the West Kent Centre for Urology.

We carried out this comprehensive inspection because Medway NHS Foundation Trust was rated as high risk in the CQC's intelligent monitoring system and the trust had been placed into 'special measures' in July 2013 following a Keogh review. The inspection took place between 23 and 25 April 2014 and an unannounced inspection visit took place on 1 May 2014.

Overall, this trust is inadequate. We rated it good for being caring, but improvement was required in providing effective care. The safety, responsiveness to patients' needs and leadership of the trust was rated inadequate.

Our key findings were as follows:

- A&E made insufficient progress since the last CQC inspection in December 2013; compared with the maternity department making significant progress since the last inspection in August 2013.
- Mandatory training compliance and associated records were insufficient, with significant inconsistencies between local and central records. In addition, there was inconsistent knowledge regarding the availability of training, in particular relating to Deprivation of Liberty training.
- Flow throughout the hospital was not efficient, with a particular lack of speciality pull from A&E combined with a lack of proactive discharge.
- Data quality throughout the hospital was poor, resulting in the trust board taking assurance from data that was inconsistent and, at times, unreliable.

- Governance processes were not robust or standardised, and consequently resulted in difficulty in clarifying whether the themes and trends from aggregated data were reliable.
- Junior medical staffing was insufficient and consultants were not providing a seven-day service.
- Nurse staffing was insufficient and, despite recent significant recruitment, there remained a significant reliance on agency staff, especially out of hours. There was also a significant reliance on medical locum doctors.
- While the culture within the hospital demonstrated the majority of the workforce were committed and took pride in their work, there was an evident presence of 'firefighting' and lack of objectivity, with a tendency to work locally in their 'own way'.
- The inconsistent leadership within the trust and recent instability in the trust's future was impacting on the hospital demonstrating collaborative and robust ward to board connection.

We saw some areas of good and outstanding practice including:

- Oliver Fisher Neonatal Intensive care Unit.
- Recent provision of the Bernard Dementia Unit.
- Improvements made by the maternity team since the last CQC inspection.
- WOW awards had been introduced, to enable patients and visitors to tell the trust about a member of staff who had delivered outstanding care.
- Use of 'Schwartz Rounds' to provide a forum for staff to debrief and explore some 'challenging' or emotional experiences that they have encountered when caring for patients.

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

Importantly, the trust must:

- Urgently address its poor data quality issues.
- Urgently review and standardise risk management and governance both at a local level and trust wide to ensure there are robust processes from board to ward.

Summary of findings

- Continue to actively monitor its HSMR trends, including ensuring that consistent, robust, minuted mortality and morbidity meetings are being undertaken in all departments.
- Ensure that the Vanguard unit is not used as overnight accommodation for patients.
- Address its escalation policy within the A&E department to avoid the need to 'stack' patients; this should include formal agreement with specialities regarding expected professional standards.
- Ensure that the initial assessments of all patients (including children) are in line with national standards.
- Address the concerns regarding patient flow through the hospital, including improving discharge processes.
- Update its major incident policy in the A&E department and ensure that staff are trained appropriately.
- Ensure that there are a sufficient number of nurses with paediatric expertise in the A&E department.
- Ensure that all equipment is in date and is checked consistently.
- Ensure that all fire exits are accessible at all times.
- Ensure that mental capacity assessments (MCA) are undertaken where appropriate and staff are adequately trained in MCA and Deprivation of Liberty.
- Commence robust audit theatre utilisation to ensure clear allocation of elective and emergency lists.
- Improve the quality of cancellation of operations reporting.
- Ensure that all wards have appropriate equipment to meet peoples care needs.
- Ensure departments are sufficiently staffed by competent staff with the right skill mix, including out of hours.
- Review the current training matrix for mandatory training and improve the recording system so that there is a comprehensive record of compliance with training trust wide.
- Ensure all staff are aware of their roles and responsibilities to report incidents and that they have access to Datix. Feedback mechanisms and review processes need to be sufficiently robust to ensure that all staff groups are learning from incidents.
- Ensure that Consultant surgeons are undertaking ward rounds at weekends.
- Review the medical oversight of the medical high dependency unit and lack of regular input from critical care directorate.
- Review the current arrangement for protected consultant presence on the labour ward including the supervision of trainees performing elective caesarean sections.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Medway NHS Foundation Trust

Medway NHS Foundation Trust has been a foundation trust since 1 April 2008. It employs almost 4,000 staff and has 594 beds. The trust's turnover is £252million with a £10 million deficit in 2013/14, and a significantly higher deficit anticipated in 2014/15.

Medway NHS Foundation Trust was placed into 'special measures' in July 2013 by Monitor in order to improve and rectify failings in patient care and governance as identified in the review under Professor Sir Bruce Keogh. Monitor had subsequently taken further enforcement action and in February 2014 they used their powers to appoint an interim Chairman and Chief Executive.

At the time of this inspection the executive team comprised of four permanent executive positions and three interim executives. The finance director was in the process of handing over to his replacement and the

longest standing executive member had been in post since March 2013. The chairman was also an interim appointment following Monitor's urgent action. The significant number of interim appointments presented challenges for consistent leadership. The trust had adopted a clinically led model and they were in the transition from eight directorates to four divisions.

The Medway NHS Foundation Trust has two registered locations the Woodlands Special Needs Nursery and The Medway Maritime Hospital. The hospital site is home to a Macmillan Cancer Care unit, the West Kent Vascular Centre, a state-of-the-art obstetrics theatre suite, the neonatal intensive care unit, a Fetal Medicine Centre, a dedicated stroke unit and the West Kent Centre for Urology.

Our inspection team

Our inspection team was led by:

Chair: Professor Edward Baker, Deputy Chief Inspector of Hospitals, Care Quality Commission

Head of Hospital Inspections: Heidi Smoult, Care Quality Commission

The team of 31 included CQC senior managers, inspectors and analysts, doctors, nurses, pharmacist, patients and public representatives, experts by experience and senior NHS managers.

How we carried out this inspection

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

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

The inspection team inspected the following eight core services at the Medway Maritime Hospital:

- Accident and emergency
- Medical care (including older people's care)
- Surgery

- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), Monitor, NHS England, Local Area Team (LAT), Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

Summary of findings

We held a listening event, in Gillingham on 23 April 2014, when people shared their views and experiences of the Medway Maritime Hospital. As some people were unable to attend the listening events, they shared their experiences via email or telephone.

We carried out the announced inspection visit between 23 and 25 April 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out an unannounced inspection on 1 May 2014. We looked at how the hospital was run out of hours and, the levels and type of staff available and the care provided.

What people who use the trust's services say

- We held a listening event where some people told us about us that they had good care at Medway Maritime Hospital. However, people had concerns about the long waiting times and care provided in the A&E department.
- In the Adult Inpatient Survey in 2012 Medway NHS Foundation Trust scored 'within expectations' in 9 of the 10 areas. The trust's performance had remained the same in seven areas but they had made improvements in three areas. Of the 60 questions asked the trust performed worse than other trust in seven questions.
- The results from the Friends and Family Test (FFT) between October 2013 to January 2014 show the trust has scored below the England average for all four of the months, achieving the lowest in November. Response rates fluctuated over the four months.
- The FFT A&E scores between October 2013 and January 2014 were notably worse than the national average for three of the four months. However, the response rate was poor.
- The Cancer Patient Experience Survey (CPES), Department of Health, 2012/13, showed that out of 69 questions, for which the trust had a sufficient number of survey respondents on which to base findings Medway NHS Foundation Trust was rated by patients in the bottom 20% of all trusts nationally for seven of the 69 questions.
- The CQC's Survey of Women's Experiences of Birth 2013 showed that under the 'Care during labour and birth' that the trust is performing the same as other trusts for all three areas of questioning.
- Between January 2013 and February 2014, Medway Maritime Hospital had 367 reviews from patients on the NHS Choices website. It scored 3 out of 5 stars overall, with 83 comments with a rating of 5 stars and 81 with a rating of one star. Comments and reviews via NHS Choices are mixed, they praise staff for being knowledgeable, providing outstanding care and treating patients with respect and dignity. However, waiting times, overcrowding, dirty wards and results being lost are highlighted areas of concern.
- Patient-Led Assessment of the Care Environment (PLACE) is self-assessments undertaken by teams focus NHS and independent healthcare staff and also the public and patients. In 2013, Medway NHS Foundation Trust scored between 73% and 93% for all four measures, with cleanliness scoring the highest at 93%.

Summary of findings

Facts and data about this trust

Context

- Foundation Trust since 1 April 2008
- 594 beds
- Serves a population of around 400,000
- Employs around 3,880 members of staff

Activity

- Inpatient admissions around 75,000 per annum including day case activity
- Outpatient attendances around 309,000 per annum
- Around 90,000 A&E attendances per annum
- Births around 5,730 per annum

Intelligent Monitoring – High risk (March 2014)

- Safe: Items = 8, Risks = 1, Elevated = 0, Score = 1
- Effective: Items = 32, Risks = 0, Elevated = 0, Score = 0
- Caring: Items = 10, Risks = 0, Elevated = 0, Score = 0
- Responsive: Items = 11, Risks = 2, Elevated = 0, Score = 2
- Well led: Items = 25, Risks = 2, Elevated = 1, Score = 4
- **Total:** Items = 86, Risks = 5, Elevated = 1, Score = 6

Key Intelligence Indicators

Safety

- 2 never events (1 surgical swab, 1 ureteric stent)
- STEIS 84 Serious Untoward Incidents (Dec 2012-Jan 2014)
- NRLS : Deaths = 18, Severe = 26, Abuse = 34, Moderate = 205
- Infections
 - C-difficile : 17 = within expectation
 - MRSA : 1 = within expectation

Effective

- HSMR = elevated

- Endocrinology mortality = elevated
- GI : mortality = elevated
- Respiratory : mortality = elevated
- SHMI = within expected range

Caring

- Friends and Family Test = Performing below the England average for the Inpatient tests
- Cancer Patient Experience = Of 69 the trust was in the top 20% nationally for 14 questions
- CQC Adult Inpatient Survey = Performed 'within expectations' for nine of the 10 questions

Responsive

- A+E 4 hour target = well below 95% in most of the previous 12 months
- A+E left without being seen = above national average

Well-led



- Staff survey 2013 = Areas that scored worse than average include:
 - Appraisals
 - Training
 - Incident reporting
 - Bullying
 - Communication
 - Staff recommending the trust.

Inspection history

- Inspection in August 2013 the trust was found to be in breach of regulations 10, 22 and 23 for Maternity Services
- Inspection in December 2013 the trust was found to be in breach of regulations 9 and 12 for the Accident and Emergency Department.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>Overall we rated the safety of services in the trust as ‘inadequate’. For specific information please refer to the report for Medway Maritime Hospital.</p> <p>Medway NHS Foundation Trust did not sufficiently protect patients from risks of avoidable harm or abuse.</p> <p>In the A&E department patients were being placed on trolleys overnight in the portable ‘Vanguard Unit’, without appropriate nursing assessments being made. Fire exits were found to be inaccessible. Some equipment was found to be out of date or damaged. A significant number of records in A&E were found to have incomplete documentation and in some cases medication was given without appropriate identification of the patient. Mental capacity assessments were not being undertaken appropriately.</p> <p>Incident reporting was not commonplace among all staff groups throughout the hospital and there was no consistent process in place for learning following incidents throughout the trust, with many staff members stating they do not receive feedback. Medical equipment checks were not consistently completed or recorded and staff reported difficulties in getting appropriate equipment to meet patient needs.</p> <p>Although there had been recent recruitment, nursing staffing levels were insufficient on many wards and there was a significant reliance on agency staff particularly out of hours. There was a shortage of junior medical staff, in particular out of hours and at weekends. Mandatory training compliance and records were insufficient with evident discrepancy in local and trust-wide data. Data quality was found to be poor throughout the trust.</p>	<p>Inadequate </p>
<p>Are services at this trust effective?</p> <p>Overall we rated the effectiveness of services in the trust as ‘requires improvement’. For specific information please refer to the report for Medway Maritime Hospital.</p> <p>There was insufficient evidence of adherence to either the National Institute for Health and Care Excellence (NICE) or the College of Emergency Medicine (CEM) guidelines within the A&E department, although there were areas within the trust were following national guidance. There were guidelines and protocols in place throughout the trust. However a significant proportion of these were out of their</p>	<p>Requires improvement </p>

Summary of findings

review date, and in some cases there were a limited number of guidelines or trust protocols for staff to use for commonly seen conditions. We were told that due to the IT system the guidelines were difficult to access, in particular for locum doctors out of hours.

While there was evidence of audits being done throughout the trust there was limited evidence to illustrate learning or changes in practice that occurred as a consequence. Timely pain relief provision was not consistent due to the workload of specialist pain control nurse and junior doctors.

Multidisciplinary working was evident in areas of the trust but it was not consistent trust wide. Seven day working was in place across all specialties and areas of the trust support services. Consultant ward rounds at the weekends were not in place for all specialties.

Are services at this trust caring?

Overall we rated the caring aspects of services in the trust as 'good'. For specific information please refer to the report for Medway Maritime Hospital.

Overall, patients received compassionate care and were treated with dignity and respect, with the exception of the A&E department where there were examples of patients not feeling they were treated with dignity and respect. In the majority of cases patients felt involved in their care and treatment decisions. While staff were often busy, they were committed the patients and aimed to put their needs and welfare first. The Bernard Dementia Unit had developed a 'buddy' programme for their patients to support patients living with dementia.

Good



Are services at this trust responsive?

Overall we rated the responsiveness of services in the trust as 'inadequate'. For specific information please refer to the report for Medway Maritime Hospital.

The trust faced significant capacity pressures. The A&E department was not consistently meeting the four-hour target for treatment, admission or discharge. The capacity within the A&E department was insufficient, with plan for a new build in the strategic plan. This resulted in patients being 'stacked' within the A&E department waiting to be seen, and in some cases, in the department for longer than 12 hours. The national average for the percentage of patients who leave A&E departments before being seen was between 2% and 3% and Medway Maritime Hospital A&E department had not dropped below 4%, and in July 2013 it was as high as 8% for the month.

Inadequate



Summary of findings

The flow throughout the trust was not robustly managed, with patients who were clinically fit for discharge not being discharged in a timely manner. There was a lack of specialty 'pull' of patients from the A&E department into appropriate wards. Medical patients were regularly 'outliers' on surgical wards and surgical patients often had their operations cancelled due to lack of available hospital bed.

Are services at this trust well-led?

The trust's leadership was rated as 'inadequate'. The executive team comprised of three recent interim appointments, one new appointee and four substantive members; with the longest standing executive in post since March 2013. The Chairman was also an interim appointment. At the time of the inspection, the Chief Executive (CEO) had been in post since 11 February 2014 and was on a 6 month interim contract. Similarly, the Chair commenced in post on 11 February 2014 and was a 12 month interim appointment. In view of these recent appointments, it was too early to evaluate their leadership specifically.

Since 2011 the trust's former leadership team had expended a significant amount of time strategically planning for a proposed merger with a neighbouring trust, which was abandoned in 2013 leaving Medway NHS Foundation Trust to establish a new sustainable strategic vision. Consequently, in 2013 leadership team developed a change programme for Medway, called "Transforming Medway". The programme set out a high level comprehensive set of objectives and proposals for a sustainable future for the trust. However, there was limited evidence to demonstrate that the trust had the required capacity and capability to successfully execute 'Transforming Medway'. However, there was evidence that some frontline clinical staff felt aligned with the content of the programme as the future strategy for the trust.

Since appointment, the new CEO and Chair (with the board) developed a focused 'Five Priorities' in order to address "getting the basics right". However these had not been communicated to staff trust wide and therefore it was difficult to evaluate whether staff were going to take ownership of these in the same way they had with the "Transforming Medway" programme. Furthermore, it was too early to assess how the two programmes would be strategically aligned. The 'Five Priorities' were emergent and did not, as yet, have a detailed timeline of plans underpinning them or clear lines of accountability.

Inadequate



Summary of findings

Many staff told us that they felt the new leadership were there to resolve financial constraints, which presented challenges for the executive team to gain staff confidence in them and the future of the trust. The majority of frontline staff stated that the executive team had not yet presented a clear vision.

As part of the “Transforming Medway” programme, the trust was in the process of restructuring from eight clinical directorates to four clinical divisions changing the lines of accountability from 1 May 2014 (as proposed by the former leadership team). During the inspection we spoke to the new appointees and members of the executive team regarding the new structure and there was lack of clarity regarding the proposed new senior team and who was taking responsibility for its success. The lines of accountability, job functions and connections between the leadership roles remained unclear despite implementation being imminent. Despite recognition that the new roles were going to be demanding clinical leadership roles, there was no comprehensive plan to ensure the four new appointees had clear objectives, personal development plans or training identified to ensure their success.

Risk management and governance processes from ward to board were not standardised or robust. Furthermore, There was a lack of a clear accountability framework for the directorate’s roles and responsibilities, with ineffective and inconsistent performance management arrangements trust-wide. The quality of data within the trust was a significant concern as the board were, in some cases, taking assurance from data that was unreliable.

This recent instability in leadership has resulted in front line staff feeling apprehensive about the future sustainability of the trust and unclear regarding the vision for the organisation. Staff did not feel the executive team were visible enough, although many staff told us that the Chief Nurse was visible and the CEO held open door sessions.

Vision and strategy for this service

- Between 2011 and 2013 the vision and strategy for the trust was associated with a proposed merger with a neighbouring trust, which was abandoned in 2013 leaving the trust to establish a new sustainable strategic vision.
- In 2013 the former leadership team developed a change programme for Medway, called “Transforming Medway”. The programme set out a high level comprehensive set of objectives and proposals for a sustainable future for the trust. However, there was limited evidence to demonstrate that the trust had the required capacity and capability to successfully execute the programme.

Summary of findings

- There was evidence that some frontline clinical staff felt aligned with the content of the 'Transforming Medway' programme as the future strategy for the trust.
- Since appointment in February 2014, the new CEO and Chair (with the board) developed a focused 'Five Priorities' in order to address "getting the basics right". However these had not been communicated to staff trust wide and therefore it was difficult to evaluate whether staff were going to take ownership of these in the same way they had with the "Transforming Medway" programme. Furthermore, it was too early to assess how the two programmes would be strategically aligned.
- At the time of the inspection, the 'Five Priorities' were emergent and did not, as yet, have a detailed timeline of plans underpinning them with clear lines of accountability.

Governance, risk management and quality measurement

- There was an evident lack of standardised and robust governance processes adopted by staff trust-wide. Different clinical areas managed governance processes locally with a clear disparity from 'ward to board'.
- There was a lack of a clear accountability framework for the directorate's roles and responsibilities, with ineffective and inconsistent performance management arrangements trust-wide.
- Incident reporting culture was not embedded across all staff groups, with many staff stating they do not complete incident forms due to lack of feedback and limited learning as a consequence.
- The process for investigating incidents and sharing learning trust-wide was inconsistent.
- The data collection and quality was widely recognised as a concern; and evidence presented as part of the inspection demonstrated a clear lack of consistent and useable data sources.
- The data collection in A&E was a significant concern during the inspection due to accuracy.
- The inconsistency in data collection and reporting mechanism meant that the board may be taking assurance from poor data that does not present a true reflection.
- As a consequence of the poor data quality, wards were holding information locally that wasn't being shared or escalated.
- Escalation processes were not robust and, in some instances, not in place to ensure the board were made aware of appropriate risks throughout the organisation.

Summary of findings

- During the inspection the executive lead for A&E was not aware that patients had been staying overnight on trolleys in the 'Vanguard Unit' as there were no clear escalation routes for staff to follow to ensure an executive was made aware.
- During the inspection the referral to treatment data was discussed with the executive lead responsible to establish whether they were confident in the data being presented (given the recognised data quality issues), and they were not able to describe or evidence the any examples of when they had challenged or interrogated the data quality.

Leadership of service

- The executive team comprised of four substantive posts with the longest member appointed in March 2013. The substantive executive members were the Medical Director, Chief Nurse, Director of Strategy and Infrastructure and Director of Organisational Development and Communications.
- The four recent interim appointments included the Chairman, CEO, Director of Operations and Director of Transformation.
- The structure was imminently about the change with the clinical leadership changing from eight directorates to four clinical divisions, each with a Divisional Director having significant accountability for the performance of their directorate. These leadership posts were not clear in job functions and there was not clearly defined training plan to ensure they were sufficiently trained and developed in accordance with the new roles.
- Staff told us they did not feel the executive team were visible enough, although they did refer to the Chief Nurse being visible and the new CEO holding 'open sessions' to meet staff.
- Frontline staff were apprehensive about the recent changes in leadership with some groups of staff feeling the new team were purely aiming to improve the financial position as the trust had a legacy of financial challenge that was increasing.

Culture within the service

- Staff throughout the trust showed a sense of pride in their work and desire to improve the trust's quality and financial problems. However some staff felt 'helpless' in the trust's future and resigned to accepting the 'abnormal becoming the normal'.
- The overall culture was open and transparent

Public and staff engagement

- The results of the 2013 NHS Staff Survey are organised into 28 key findings. Four of the indicators show performance that is better than expected and placed within the top 20% of trusts

Summary of findings

nationally. However, 16 of the indicators were placed within the bottom 20% of trusts nationally, with one area of concern identified as the percentage of staff reporting good communication between senior management and staff. In addition, another area in the bottom 20% of trusts nationally was the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver.

- Since commenced in post the CEO had held open session with staff to meet them and gain feedback on their views and share experiences, as well as for the CEO to update staff.
- Many staff told us they did not feel fully involved in the decisions about changes within the trust.
- Patient feedback was not monitored or obtained in a consistent manner across the trust, although patients were encouraged to nominate staff for 'WOW' awards, where they received outstanding care and treatment.
- The trust had recently started taking a more active role in obtaining, collating and implementing changes based on improving patient experience. One of the new incentives being used to capture patient opinion was a text feedback service inviting patients to feedback their comments and concerns after discharge. Historically, complaints were written in a notebook (with no electronic record) and there had been a dedicated group working on complaints, engaging people and arranging to meet them set up.

Innovation, improvement and sustainability

- Although there were areas where the staff worked locally to innovate and improve care provided, the consequence of staff working in an environment of 'fire-fighting' on a perpetual basis resulted in innovation and improvement not being commonplace throughout the trust due to work pressures. Furthermore, the reliance on agency and locum staff meant that substantive staff had limited time to innovate and make improvements to patient care.
- The new clinical model proposed with four divisions was about to be implemented immediately following the inspection but there were not clear plans around how innovation and improvements in care delivery would be improved. Furthermore, it was not clear how learning and innovation would be shared across the four divisions to ensure trust wide learning was achieved.
- The financial sustainability of the trust was a particular concern with a deficit of £10million in 2013/14, with a significantly higher deficit forecast for 2014/15.

Summary of findings

- The overall stability of the trust was a particular concern with a significant proportion of the leadership team made up of interim appointments, with further interim appointments planned. The CEO and Chairman were in six month and twelve month posts respectively, which presented concerns regarding the stability of leadership to deliver the changes and improvements required.

Overview of ratings

Our ratings for Medway Maritime Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Inadequate	Not rated	Requires improvement	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Inadequate	Requires improvement	Inadequate
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity & Family planning	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Children & young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Inadequate	Requires improvement	Inadequate

Our ratings for Medway NHS Foundation Trust

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.

Outstanding practice and areas for improvement

Outstanding practice

We saw some areas of good and outstanding practice including:

- Oliver Fisher Neonatal Intensive care Unit.
- Recent provision of the Bernard Dementia Unit.
- Improvements made by the maternity team since the last CQC inspection.

- WOW awards had been introduced, to enable patients and visitors to tell the trust about a member of staff who had delivered outstanding care.
- Use of 'Schwartz Rounds' to provide a forum for staff to debrief and explore some 'challenging' or emotional experiences that they have encountered when caring for patients.

Areas for improvement

Action the trust **MUST** take to improve

Importantly, the trust must:

- Urgently address its poor data quality issues.
- Urgently review and standardise risk management and governance both at a local level and trust wide to ensure there are robust processes from board to ward.
- Continue to actively monitor its HSMR trends, including ensuring that consistent, robust, minuted mortality and morbidity meetings are being undertaken in all departments.
- Ensure that the Vanguard unit is not used as overnight accommodation for patients.
- Address its escalation policy within the A&E department to avoid the need to 'stack' patients; this should include formal agreement with specialities regarding expected professional standards.
- Ensure that the initial assessments of all patients (including children) are in line with national standards.
- Address the concerns regarding patient flow through the hospital, including improving discharge processes.
- Update its major incident policy in the A&E department and ensure that staff are trained appropriately.
- Ensure that there are a sufficient number of nurses with paediatric expertise in the A&E department.
- Ensure that all equipment is in date and is checked consistently.
- Ensure that all fire exits are accessible at all times.
- Ensure that mental capacity assessments (MCA) are undertaken where appropriate and staff are adequately trained in MCA and Deprivation of Liberty.

- Commence robust audit theatre utilisation to ensure clear allocation of elective and emergency lists.
- Improve the quality of cancellation of operations reporting.
- Ensure that all wards have appropriate equipment to meet peoples care needs.
- Ensure departments are sufficiently staffed by competent staff with the right skill mix, including out of hours.
- Review the current training matrix for mandatory training and improve the recording system so that there is a comprehensive record of compliance with training trust wide.
- Ensure all staff are aware of their roles and responsibilities to report incidents and that they have access to Datix. Feedback mechanisms and review processes need to be sufficiently robust to ensure that all staff groups are learning from incidents.
- Ensure that Consultant surgeons are undertaking ward rounds at weekends.
- Review the medical oversight of the medical high dependency unit and lack of regular input from critical care directorate.
- Review the current arrangement for protected consultant presence on the labour ward including the supervision of trainees performing elective caesarean sections.

Please refer to the location reports for Medway Maritime Hospital for details of areas where the trust **SHOULD make improvements.**