East Kent Hospitals University NHS Foundation Trust

Queen Elizabeth The Queen Mother Hospital

Quality Report

Queen Elizabeth The Queen Mother Hospital
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Date of inspection visit: 5th,6th 7th September 2016 and Unannounced 21st September 2016
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Good
Maternity and gynaecology	Requires improvement
End of life care	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Queen Elizabeth the Queen Mother Hospital (QEQM) is one of five hospitals that form part of East Kent University Hospitals NHS Foundation Trust (EKUFT). The Trust provides local services primarily for the people living in Kent. EKUHFT serves a population of approximately 759,000 and employs approximately 6,779 whole time equivalent staff.

The QEQM hospital has a total of 388 beds, providing a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric services.

Following our last inspection of the Trust in August 2015, we carried out an announced inspection between 5th and 7th September 2016, and an unannounced insection on 21st September 2016.

This is the third inspection of this hospital. This inspection was specifically designed to test the

requirement for the continued application of special measures to the trust. Prior to inspection we risk

assessed all services provided by the trust using national and local data and intelligence we received from a number of sources. That assessment has led us to include four services (emergency care, medical services, maternity and gynaecology and end of life care) in this inspection.

Overall we rated the Queen Elizabeth, the Queen Mother Hospital as Requires improvement

Our key findings were as follows:

Safe

We rated The Queen Elizabeth, Queen Mother Hospital as Requiring improvement for safe because:

- There was a shortage of junior grade doctors and consultants across the medical services at the hospital. This meant that consultants and junior staff were under pressure to deliver a safe and effective service, particularly out of hours and at night.
- The trust did not use a recognised acuity tool to assess the number of staff needed on a day-to-day-basis.
- In Maternity, a lack of staffing affected many areas of service planning and the care and treatment of women. This included not meeting national safe staffing guidelines, meaning 1 in 5 women did not receive 1:1 care in labour.
- We found poor records management in some areas. Staff did not always complete care records according to the best practice guidance.
- The trust did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance. The trust did not have adequate maintenance arrangements in place for the 483 medical devices used in maternity and gynaecology.
- Mandatory training rates for topics such as adult safeguarding and information governance were low.

However

- We saw robust systems in place for reporting and learning from incidents both locally and trust-wide.
- Ward and departmental staff wore clean uniforms and observed the trust's 'bare below the elbows' policy. Personal protective equipment (PPE) was available for use by staff in all clinical areas.
- The hospital was clean and met infection control standards.

Effective

Summary of findings

We rated The Queen Elizabeth, Queen Mother Hospital as Requiring improvement for effective because:

- Documents and records supporting the learning needs of staff were not always competed and there were gaps in the records of training achieved.
- The trust had not completed its audit programme. This meant the hospital was not robustly monitoring the quality of service provision
- Appraisial rates across the hospital needed to be improved.
- There was poor compliance in the use of the end of life documentation across the wards we visited which was reflected in the May 2016 documentation audit undertaken by the SPC team.

However,

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Comfort rounds had been performed and audited. These provided good assurance that pain assessments had been performed, analgesia administered.

Caring

We rated The Queen Elizabeth, Queen Mother Hospital as Good for caring because:

- Staff treated patients with kindness and compassion.
- Patients and relatives we spoke with were complimentary about the nursing and medical staff.
- Patients were given appropriate information and support regarding their care or treatment and understood the choices available to them.

Responsive

We rated The Queen Elizabeth, Queen Mother Hospital as requires improvement for responsive because:

- Performance indicators such as patients being seen within four hours in A&E remained below trust target and national averages.
- Delayed discharges remained a concern. However, as part of this response we observed an operational communications meeting, which showed the trust was addressing patient flow through the hospital.
- The hospital was not offering a full seven-day service. Constraints with capacity and staffing limited the responsiveness and effectiveness of the service the hospital was able to offer.
- Patients' access to prompt care and treatment was worse than the England average for a number of specialities. The trust had not met the 62-day cancer referral to treatment time since December 2014. Referral to treatment within 18 weeks was below the 90% standard as set out in the NHS Constitution and England average for six of the eight specialties from June 2015 to May 2016.
- Services did not always meet people's needs, for example, women had to divert to another hospital on 22 dates between January 2015 and June 2016. Also, the trust did not monitor the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour.

However,

- The trust employed specialist nurses to support the ward staff. This included dementia nurses and learning difficulty link nurses who provided support, training and had developed resource files for staff to reference. Wards also had 'champions' who acted as additional resources to promote best practice.

Well led

Summary of findings

We rated The Queen Elizabeth, Queen Mother Hospital as requires improvement for well led because:

- In some areas risk management and quality measurement were not always dealt with appropriately or in a timely way. Risks and issues described by staff did not correspond to those
- Where changes were made, appropriate processes were not always followed and the impact was not fully monitored in maternity and gynaecology services
- No separate risk register was available for palliative /end of life care. A separate risk register would allow the risks to this patient group be discussed regularly at the end of life board, and allow plans to be made to alleviate any identified risks.
- Changes in leadership in end of life care and maternity services had only recently been realised and as a result had yet to fully
- address the issues relating to these services

However

- The hospital had well-documented and publicised vision and values. Their vision was to provide 'Great healthcare from great people', with the mission statement 'together we care: Improving health and lives'. These were readily available for staff, patients and the public on the trust's internet pages, posters around the hospitals and on the trust's internal intranet.

We saw some outstanding practice including:

- Improvement and Innovation Hubs were an established forum to give staff the opportunity to learn about and to contribute to the trust's improvement journey.

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

Importantly, the trust must:

- Ensure the number of staff appraisals increase to meet the trust target. So that the hospital can assure itself that staff performance and development is being monitored and managed.
- Ensure the trust's agreed audit programme is completed and where audits identify deficiencies that clear action plans are developed that are subsequently managed within the trust governance framework. To have assurance that best practice is being followed.
- The trust must ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times. This includes medical, nursing and therapy staff.
- Ensure there are systems established to ensure there are accurate, complete and contemporaneous records are kept and held securely in respect of each patient.
- The trust must ensure that all staff have attended mandatory training.
- The trust must ensure that there are adequate maintenance arrangements in place for all of the medical devices in clinical use.
- The trust must take steps to ensure the 62-day referral to treatment times for cancer patients is addressed so patients are treated in a timely manner and their outcomes are improved.
- Ensure there are sufficient numbers of midwives to meet national safe staffing guidelines of 1:1 care in labour.
- Ensure maternity data is correctly collated and monitored to ensure that the department's governance is robust.

In addition the trust should:

Summary of findings

- Review the physical environment within maternity services to ensure it meets the needs of the patients. Specifically temperature control
- Ensure that the trust programme to improve overall culture also focuses on individual cases of bullying and harassment.
- Continue to reduce the number of bed moves patients experienced during their stay.
- Monitor ambient room temperatures where medication is stored.
- Review the maintenance of medical devises.
- Include venous thromboembolism data on the department dashboard.

There is no doubt that further improvements in the quality and safety of care have been made since our last inspection in July 2015. At that inspection there had been significant improvement since the inspection in March 2014 which led to the trust entering special measures. In addition, leadership is now stronger and there is a higher level of staff engagement in change. My assessment is that the trust is now ready to exit special measures on grounds of quality, However, significant further improvement is needed for the trust to achieve an overall rating of good.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated the urgent and emergency services provided at QEQM Hospital as requires improvement because: • Some systems and processes were not always reliable, such as monitoring training implementation. Mandatory training rates for topics such as adult safeguarding and information governance were low. • Major incident training rates were low although we acknowledge that another training session had been booked for later in September. • Staff appraisal rates, although better the other A&E locations, were still below the trust target. Lower completion rates make it difficult for the department to assure itself that staff performance and development is being monitored and given sufficient attention. • Auditing had improved since our last visit, although we found that action plans were not always submitted in a timely manner and where there was an action plan the actions were not always fully implemented or communicated throughout the department. This meant the department did not have full assurance that best practice was being followed or that problems were being identified quickly enough. • Delivery of performance indicators such as patients being seen within four hours remained below trust target and national averages. • Delayed discharges remained a concern due to the impact on the A&E. However, as part of this response we observed an operational communications meeting, which showed the trust was addressing patient flow through the hospital and monitoring closely for risks that affected beds available for receiving patients from the department. • A range of positive initiatives have been implemented in this department along with

Summary of findings

others we observed at similar sites in the trust. Further harmonisation and sharing of best practice between all A&E locations would benefit patients and staff.

However,

- We found ambulance handover breaches exceeding 60 minutes averaged 43 per month over the last four months (July – October 2016). This represented 2.4% of the total number of patient handovers and was better than the regional average of 3%.
- We saw significantly improved figures for children's safeguarding training for all staff groups, including doctors, and there were robust safeguarding systems in place for children.
- Apart from adult safeguarding and DoLs/MCA, the figures for mandatory training had improved since our last visit and were near or above trust targets for all staff groups, including doctors.
- We saw improvements in the way the department and the wider trust managed incident reporting and complaints. Lessons learned were widely communicated using a number of information systems.
- Patients' treatment and care was delivered in accordance with their individual needs. Patients told us they were treated with dignity and respect. People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.
- Medicines were stored safely and checks on emergency resuscitation equipment were performed. Incidents and adverse events were reported and investigated through robust quality and clinical governance systems. Lessons arising from these events were learned and improvements had been made when needed.
- The leadership, governance and culture within the departments were generally strong and we saw examples of good practice regarding visibility of supervisors, rounds and communication. Staff were supported by their managers and were actively encouraged to contribute to the development of the services.

Summary of findings

On this inspection we have maintained the rating as requires improvement since the last inspection.

Medical care (including older people's care)

Good

We found the medical services at the QEQM Hospital good because;

- The trust had a robust system for managing untoward incidents. Staff were encouraged to report incidents and there were processes in place to investigate and learn from any adverse events. The hospital measured and monitored incidents and avoidable patient harm and used the information to inform priorities and develop strategies for reducing harm.
- The trust prioritised staff training, which meant staff had access to training in order to provide safe care and treatment for patients.
- There were systems in place to maintain a clean and therapeutic environment. Staff effectively managed infection control and maintained the environment appropriately.
- Medical care was evidence based and adhered to national and best practice guidance. Management routinely monitored that care was of good quality and adhered to national guidance to improve quality and patient outcomes.
- Patients were supported through consultant led care and effective delivery of care through multidisciplinary teams and specialists. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- Staff treated patients with kindness and compassion.
- The trusts average length of stay for both elective and non-elective stays were better than the England average for the majority of medical specialities.
- There was good provision of care for those living with dementia and learning difficulties. There were support mechanisms and information available to take individual patients needs into account.
- The trust had clear corporate vision and strategy. The trust included the opinions of clinicians, staff

Summary of findings

and stakeholders when developing the strategy for medical services. Staff felt engaged with the direction of the trust and took pride in the progress they had made to date.

- The trust had clearly defined local and trust wide governance systems. There was well-established ward to board governance, with cross directorate working, developing standard practices and promoting effective leadership. The trust acknowledged they were on an improvement journey and involved all staff in moving the action plan forward.

However

- There was a shortage of junior grade doctors and consultants across the medical services at the QEQM Hospital. This meant that consultants and junior staff were under pressure to deliver a safe and effective service particularly out of hours and at night.
- We found there were nursing shortages across the medical services. The situation had improved due to the use of agency and bank staff. Although the trust had recruited overseas nurses, there remained staffing shortages on the wards.
- Staff did not always complete care records in accordance with best practice guidance from the Royal Colleges. We found gaps and omissions in the sample of records we reviewed. The trust did not have a robust system in place to audit, monitor and review care records to ensure they always gave a complete picture of the assessments and interventions undertaken.
- The trust did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance.
- The trust had not completed its audit programme. This meant the hospital was not robustly monitoring the quality of service provision. The hospital performed poorly in a number of national audits such as the stroke and diabetes services.

Summary of findings

- We found that the hospital was not offering a full seven-day service. Constraints with capacity and staffing limited the responsiveness and effectiveness of the service the hospital was able to offer.
- Patients' access to prompt care and treatment was worse than the England average for a number of specialities. The trust had not met the 62-day cancer referral to treatment time since December 2014. Referral to treatment within 18 weeks was below the 90% standard as set out in the NHS Constitution and England average for six of the eight specialties from June 2015 to May 2016.
- The hospital had improved the number of bed moves patients had during their stay. However, a fifth of all medical patients moved wards more than once during their stay. This meant the hospital transferred some patients several times before they had a bed on the right ward, which put additional pressures on the receiving wards.

At our last inspection, we rated medical services as Requires improvement. On this inspection we have changed the rating to good because of improvements in incident reporting, staff training, infection control, staff engagement and ward to board governance.

Maternity and gynaecology

Requires improvement

We rated this service as requires improvement because;

- Lack of staffing affected many areas of service planning and the care and treatment of women. This included not meeting national safe staffing guidelines, meaning 1 in 5 women did not receive 1:1 care in labour.
- The physical environment was not conducive to the safe care and treatment of women. The department was intolerably hot, with patients visibly struggling with the heat. The trust rated unworkable temperatures as 'low severity' when reported by staff.

Summary of findings

- Hospital management did not ensure robust governance, for example, hospital data of the number of surgical abortions was incorrect as figures included women who had miscarried and had a surgical evacuation.
- On our previous inspection, we found there was an ingrained bullying culture within women's services. This had since improved, however, the trust focused on overall culture rather than tackle individual cases.

However;

- Staff provided a caring, empathetic environment for women during their pregnancy and labour.
- Care and treatment was evidence based and patient outcomes were in line with other trusts in England.

On this inspection we have maintained the rating as requires improvement from the last inspection

End of life care

Requires improvement

Overall, we rated the end of life care services at the trust as requires improvement, because:

- The trust's Specialist Palliative Care (SPC) team demonstrated a high level of specialist knowledge. A strong senior management team who were visible and approachable led them. The SPC team provided individualised advice and support for patients with complex symptoms and supported staff on the wards across the hospital. However, the SPC team were small and there were concerns regarding the sustainability of the service. We noted the planned improvements and the implementation of the end of life strategy would be difficult to apply due to the current available resources.
- We found an array of service improvement initiates had been introduced across the trust since the last inspection. This included end of life care plan documentation, the appointment of an end of life facilitator, identification of end of life care link nurses, a decision making end of life board with a membership of healthcare professionals from a variety of specialties within the trust and external stake holders. There was a slot at QII hub to spread the work and raise the profile of end of life care. All service

improvements were based on national guidance. However, we found changes were recently implemented and more time was required to embed the changes into clinical practice, upskill staff and provide a robust training and education programme to ensure end of life care was delivered following national recommendations.

- Since the last inspection, we found the training of junior and speciality doctors had improved with the SPC team invited to divisional meetings to present and raise the profile of the importance of good end of life care conversations and symptom control. We saw clinical leads championed end of life care. However, further work was required to strengthen the collaboration of working with consultants.
- Staff told us that since the last inspection end of life care had a much higher profile across the trust. However, we found on the wards that ceiling of treatments were not generally documented, poor completion of nursing notes which made it difficult to access if patients were being reviewed regularly. There were no mental capacity assessments in place for vulnerable adults who lacked capacity. Where a patient was identified as dying it was often confusing for staff as in many cases interventions were still being delivered.
- End of life training was not part of the mandatory training programme. We found some nursing staff on the wards had received training whilst others had not. Wards struggled with staffing levels and there were no extra staff in place to support end of life care.
- 100 link nurses had been identified as leads on end of life care at ward level. By November 2016, training of the link nurses was expected to be complete. However, more time was required for the link nurses to settle into their new roles, to support their colleagues, and improve quality. We found the end of life resource folders were available on the wards. These folders contained the necessary documentation for staff, which was an improvement since the last inspection.
- The trust had access to the Medical Interoperability Gateway (MiG) system that

Summary of findings

enabled the trust to view, with consent, patients' GP records meant that this information was available 24/7.However, this system did not allow the trust to update records or input care plans. No electronic palliative care record system was in place where providers shared information.

- A fast track discharge process was in place. However, staff told us the process was not fast with some patients taking weeks to be discharged to their preferred place of care (PPC). Whilst work had been undertaken to improve the process since the last inspection, further work was required to ensure patients could be discharged within hours to their PPC.

On this inspection we have maintained a rating of requires improvement.

Queen Elizabeth The Queen Mother Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care);Maternity and gynaecology; End of life care;

Detailed findings

Contents

Background to Queen Elizabeth The Queen Mother Hospital

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assessed all services provided by the trust using national and local data and intelligence we received from a number of sources. That assessment has led us to include four services (emergency care, medical services, maternity and gynaecology and end of life care) in this inspection.

Our inspection team

Our inspection team was led by:

Chair: Sarah Faulkner, Director of Nursing, North West Ambulance Services NHS

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

The hospital was visited by a team of CQC inspectors,analysts and a variety of specialists including

consultants, nursing, midwives, radiographers, student nurse and junior doctor. We also included managers with board level experience and experts by experience (lay people

with care or patient experience).

How

Detailed findings

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?

Prior to inspection we risk assessed all services provided by the trust using national and local data and intelligence we received from a number of sources. That assessment has led us to include four services (emergency care,medical services, maternity and gynaecology and end of life care) in this inspection. The remaining services were not inspected as they had indicated strong improvement at our last inspection and our information review indicated that the level of service seen at our last inspection had been sustained. Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning groups, Monitor, Health Education England, General Medical Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records.

We held focus groups with a range of staff in the hospital, including doctors, nurses, allied health professionals, administration and other staff. We also interviewed senior members of hospital staff.

Facts and data about this tru

Facts and data about Queen Elizabeth The Queen Mother Hospital

East Kent Hospitals University NHS Foundation Trust is one of the largest hospital trusts in England, with five hospitals serving a local population of around 759,000 people. The trust has a national and international reputation for delivering high quality specialist care, particularly in cancer, kidney disease, stroke and vascular services. The trust serves the populations of the following districts and borough councils (figures in brackets indicate their deprivation quintile with 1 being the most deprived and 5 being the least deprived): Dover(2), Kent(4), Canterbury(3), Thanet(1), Ashford(3) and Shepway(2). The health of people in Kent is generally better than the England average. Deprivation is lower than average, however about 17.6% (48,300) children live in poverty. Life expectancy for both men and women is higher than the England average.

The total number of beds across the trust is 1,188 and the number of staff is staff: 7,086 of which there are 954 Medical staff, 2,114 Nurses and 4,018 other staff.

The Trust has revenue of £533,485,000 with full costs of £541,253,000 and deficit of £7,768,000 deficit at the time of the inspection.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

East Kent University Hospitals NHS Foundation Trust (EKHUFT) delivers a range of urgent and emergency services through five hospitals in the region. The urgent and long-term conditions directorate is responsible to the trust board for the management of these services and this report follows our inspection of the accident and emergency (A&E) department at Queen Elizabeth, The Queen Mother Hospital (QEQM).

The A&E department at QEQM provides emergency care to people living in Margate and Thanet in Kent and serves a mixed population. Some areas in the locality are within the top 20% most deprived areas in England. Attendances across all sites totalled 205,673 from April 2015 to March 2016, putting the trust into the top 25 of 154 acute NHS trusts for A&E attendances. This compares with 204,685 the year before. According to current trust data, around 600 people attend each day. Of this figure, about 206 come to QEQM.

On our previous inspection, we found the A&E services at QEQM required improvement. We had concerns about overcrowding and flow of patients through the department and a lack of consultant cover out of hours. Incident reporting and complaint handling were poor. There were gaps in training, record keeping and a number of clinical guidelines and policies were out of date. Decisions taken at a senior level did not appear to relate to the experience of frontline staff. Since then, the trust has new chief executive and received support from NHS Improvement including the emergency care improvement programme (ECIP). The trust identified the five top risks, which were emergency care, staffing, clinical governance, planned care and finances.

We conducted this inspection to follow up on these issues and assess the progress of the trust against the action plans that were in place. The inspection took place over three days, 5 – 7 September, during which we visited emergency departments across the three main hospital sites. We spent one day in the A&E department at QEQM and during this time, we spoke with 15 members of staff. These included doctors and nurses at varying levels of seniority, allied healthcare professionals, managers, health care assistants, play assistants (paediatric area) and administrative staff. We also spoke with two ambulance crews and seven patients.

We reviewed documentary information supplied prior to our visit and provided on request during the inspection. In addition, we took into account feedback from discussion and written communications from stakeholders. During our visit, we made observations of activity levels and staff interaction with people using the service and made checks on the environment and equipment used by patients. We additionally observed a hospital-wide 'bed management' meeting held at the operational communications centre.

In addition to our main inspection, we undertook an unannounced visit on 21 September, in which we checked equipment and staffing levels, observed interactions between patients and staff, and reviewed care and treatment.

Urgent and emergency services

Summary of findings

We rated the urgent and emergency services provided at QEQM Hospital as requires improvement because:

- Some systems and processes were not always reliable, such as monitoring training implementation. Mandatory training rates for topics such as adult safeguarding and information governance were low.
- Major incident training rates were low although we acknowledge that another training session had been booked for later in September.
- Staff appraisal rates, were still below the trust target. Lower completion rates make it difficult for the department to assure itself that staff performance and development is being monitored and given sufficient attention.
- Auditing had improved since our last visit, although we found that action plans were not always submitted in a timely manner and where there was an action plan the actions were not always fully implemented or communicated throughout the department. This meant the department did not have full assurance that best practice was being followed or that problems were being identified quickly enough.
- Delivery of performance indicators such as patients being seen within four hours remained below trust target and national averages.
- Delayed discharges remained a concern due to the impact on the A&E. However, as part of this response we observed an operational communications meeting, which showed the trust was addressing patient flow through the hospital and monitoring closely for risks that affected beds available for receiving patients from the department.
- A range of positive initiatives have been implemented in this department along with others we observed at similar sites in the trust. Further harmonisation and sharing of best practice between all A&E locations would benefit patients and staff.

However,

- We found ambulance handover breaches exceeding 60 minutes averaged 43 per month over the last four months (July – October 2016). This represented 2.4% of the total number of patient handovers and was better than the regional average of 3%.
- We saw significantly improved figures for children's safeguarding training for all staff groups, including doctors, and there were robust safeguarding systems in place for children.
- Apart from adult safeguarding and DoLs/MCA, the figures for mandatory training had improved since our last visit and were near or above trust targets for all staff groups, including doctors.
- We saw improvements in the way the department and the wider trust managed incident reporting and complaints. Lessons learned were widely communicated using a number of information systems.
- Patients' treatment and care was delivered in accordance with their individual needs. Patients told us they were treated with dignity and respect. People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.
- Medicines were stored safely and checks on emergency resuscitation equipment were performed. Incidents and adverse events were reported and investigated through robust quality and clinical governance systems. Lessons arising from these events were learned and improvements had been made when needed.
- The leadership, governance and culture within the departments were generally strong and we saw examples of good practice regarding visibility of supervisors, rounds and communication. Staff were supported by their managers and were actively encouraged to contribute to the development of the services.

On this inspection we have maintained the rating as requires improvement since the last inspection.

Urgent and emergency services

Are urgent and emergency services safe?

Good

We rated the urgent and emergency department as good for safety, because:

- We saw robust systems in place for reporting and learning from incidents both locally and trust-wide. In addition to departmental meetings and reviews, learning strategies included newsletters and email alerts.
- Our observations indicated that cleanliness in the department had improved and this was supported by the Patient Led Assessment of the Care Environment (PLACE) audit for 2016, which showed that A&E at QEQM scored 99.6% for cleanliness. This was better than last year and higher than the England average.
- The most recent 'Bare below the elbows' audit (April 2016) showed 100% compliance by support staff, 99% for nurses and 92% for medical staff. During our visit, all staff followed bare below the elbows policy.
- We found the department had safe systems for ordering, storage and the administration of medicines. We saw that local and organisation-wide audits were completed, which showed the department complied with the current policy.
- There were local auditing processes in place to help ensure patient records were up to date and accurately completed. We saw that matron checked the quality of record keeping for each patient during 'rounds' of the department.
- We saw significantly improved figures for children's safeguarding training for all staff groups, including doctors, and there were robust safeguarding systems in place for children.
- Apart from adult safeguarding and DoLs/MCA, the figures for mandatory training had improved since our last visit and were near or above trust targets for all staff groups, including doctors.
- We saw sufficient staff on duty to meet diagnostic and care needs and on reviewing rosters noted that planned staffing levels matched actual numbers present.
- Ambulance handover breaches exceeding 60 minutes averaged 43 per month over the last four months (July – October 2016). This represented 2.4% of the total number of patient handovers and was better than the regional average of 3%.

However,

- Some systems and processes were not always reliable, such as monitoring training implementation.
- Mandatory training rates for topics such as adult safeguarding and information governance were low.
- Major incident training rates were the lowest of all the locations we inspected, although we acknowledge that another training session had been booked for later in September.

At our last inspection, we rated the service as inadequate for safety. On this inspection, we have changed this to good, as we have seen improvements in key areas such as staffing levels and the way incidents and complaints are reported, lessons learned and changes made when needed.

Incidents

- There have been no never events and 10 serious incidents (SI) reported across the directorate between July 2015 and June 2016. Nearly all of the SIs related to treatment delays. One was a reported delay in diagnosis, another an allegation of abuse by staff and one a pressure ulcer meeting the SI criteria. Never events are serious, preventable patient safety incidents that should not occur if healthcare providers had implemented existing national guidance or safety recommendations. The occurrence of never events may highlight potential weaknesses in how an organisation manages fundamental safety processes.
- Staff we spoke to knew about of the DoC legislation. The Duty of Candour (DoC) requires healthcare providers to disclose safety incidents that result in moderate or severe harm or death to patients or any other relevant person.
- Staff reported incidents on an electronic reporting system and said they felt confident about using the system, the type of incidents reported and to whom incidents should be reported to. We saw meeting minutes that showed staff discussed incidents and shared lessons learned. We also saw an example of the trust's clinical safety newsletter called 'Risk Wise'

(Summer 2016) which detailed case studies along with advice and guidance. Helpful facilities provided to staff included a link to an electronic system that automatically sent email safety alerts to their mobile phones.

- The trust provided copies of the A&E Clinical Governance meetings minutes for January, March and May 2016. They explained that due to operational demands, the meetings in February and April were cancelled. We saw that mortality and morbidity summaries were missing from the minutes. This omission was identified by the trust, but it meant that managers were not always in possession of timely information affecting safety.
- The reporting of mandatory training had also been deferred from the minutes and then omitted. This meant that managers and senior staff could not assure themselves that training shortfalls had been consistently identified or addressed.
- Some staff told us that security arrangements at the site caused them concern. While the patients we spoke to said they felt safe, some staff did not. One security guard covered the hospital site and concerns were expressed to us about the ability of the guard to respond to incidents safely, deal with patients of either gender and cover a large site on their own. During the day of our unannounced visit, we learned that a member of staff had been assaulted. Security had responded and supported the department. We did not see security personnel at the time of the visit.
- We saw up-to-date quality scores displayed on notice boards in the department. This was part of the safety thermometer scheme, which is used nationally to monitor harm to patients. The display of this information helps inform patients and visitors about harm reduction priorities and strategies used in the department.

Cleanliness, infection control and hygiene

- There were no reported cases of MRSA, Clostridium difficile (C. diff) or Escherichia coli (E. coli) in the period April 2015 – March 2016. These serious infections have the potential to cause harm.
- We saw the last infection control audit showing 58% compliance, which was worse than the trust average of 87%. Non-compliances related to high dust traps, cleanliness in some areas and condition of fixtures and fittings. Others related the cleanliness of items such as commode chairs.
- At the time of our inspection, our observations indicated that cleanliness had improved. The areas we visited were tidy, visibly clean and uncluttered. Medical equipment and trolleys were also visibly clean.
- Our view was supported by the Patient Led Assessment of the Care Environment (PLACE) audit for 2016 showed that A&E at QEQM scored 99.6% for cleanliness, which was an improvement on last year and better than the England average of 98%.
- We saw disposable curtains fitted on rails between bays. Each had a label showing the date changed, which were within the last few weeks. According to HBN 00-09, frequently changed disposable curtains helps to reduce the chances of bacteria passing from one person or object to another.
- Hand washbasins were installed in clinical areas. These were medium or large integral back-outlet basins with mixer taps and no plugs. This complied with Health Building Note (00-10 (2013): Part C – Sanitary assemblies).
- We saw wall mounted dispensers for aprons and gloves and we noted hand-sanitising gel mounted on walls in each area. Accompanying wall posters were displayed which explained hand-washing technique in line with World Health Organisation guidance.
- The most recent 'Bare below the elbows' audit (April 2016) showed 100% compliance by support staff, 99% for nurses and 92% for medical staff. During our visit, all staff followed bare below the elbows policy.
- Staff separated waste into different coloured containers to show the different categories of waste ready for disposal. This was in accordance with the Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health (COSHH) and health and safety at work regulations.
- We saw sharps bins available in treatment areas and correctly used in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The bins were secure containers, clearly marked and placed close to work areas where medical sharps were used. The bin labels included clear instructions for staff on safe disposal.
- All single-use items we saw were in date, such as syringes and wound dressings. We saw these items

being used once and disposed afterwards. Correct storage and stock rotation ensured the sterility of items was maintained and risks of cross contamination reduced.
- We visited the paediatric reception and treatment area and reviewed the decontamination of toys checklist. We saw that staff had cleaned toys daily.

Environment and equipment

- Urgent and emergency services at QEQM comprised 10 cubicles designated as a 'majors' area, a resuscitation area of four bays, five paediatric cubicles, suture room and ophthalmic rooms and four observation beds.
- The Patient Led Assessments of the Care Environment (PLACE) for 2016 showed the hospital scored 98.8% for the condition, appearance and maintenance, which is another improvement on last year (91%) and better than the England average of 93%.
- We saw copies of a quarterly "Hygiene Code Environmental Audit" that demonstrated managers monitored the cleaning and responded to any deficiencies detected. The environmental audit results for the department (March 2016) that showed 58% compliance, which was lower than the other ED sites in the trust
- Staff knew about the process for reporting faulty equipment and none had concerns about equipment availability and if anything required repair it was fixed.
- We saw that trolleys, furniture and equipment were labelled with asset numbers and service or calibration dates. This helped to provide assurance that items were maintained in accordance with manufacturer recommendations.
- The Medicines and Healthcare Products Regulatory Agency's Managing Medical Devices (April 2015) states that healthcare organisations should risk assess to ensure that the safety checks carried out on portable electrical equipment are appropriate and reasonably practical. These include pre-use testing of new devices in addition to subsequent maintenance tests. We checked several devices in each of the areas we visited. These devices were labelled with the dates of the most recent electrical testing, which provided a visual check that they had been examined to ensure they were safe to use.
- We checked the adult and paediatric resuscitation trolleys. Both were locked and records showed the trolleys were checked daily. All drawers contained consumables and medicines in accordance with the checklist. We saw that consumables were in date and trolleys were clean and dust free. The automatic electrical defibrillator and suction equipment were in working order. This meant all items were ready for immediate use should an emergency occur.

Medicines

- We found the department had safe systems for ordering, storage and the administration of medicines. We saw that local and organisation-wide audits were completed, which showed the department complied with the current policy.
- There was evidence of daily controlled drugs stock checks in the controlled drug register. Staff were familiar with policies regarding the destruction of controlled drugs and we saw suitable drug destruction kits near the CD cupboard.
- We saw that medicines requiring storage in a temperature-controlled environment were held in designated drug fridges. These were locked and incorporated digital thermometers with an easily readable display that recorded temperature data. Staff performed daily checks daily and these were recorded on a standardised form. Staff described the process of dealing with out of range temperatures and showed us the policy explaining the process, which included reporting it as an incident on the electronic reporting system.

Records

- We saw the medical records of eight patients. The records were legible, dated and signed.
- The department used a combination of electronic records and paper files. We saw patient personal information and staff records managed safely and securely, in line with the Data Protection Act. When not in use, patients' notes were kept in a locked records cabinet.
- The records we reviewed were complete and up to date. Each patient had the appropriate care pathway documented.
- There were local auditing processes in place to help ensure patient records were up to date and accurately completed. We saw that matron checked the quality of record keeping for each patient during 'rounds' of the department.

Urgent and emergency services

Safeguarding

- According to the trust's adult safeguarding team (now called the people at risk team - PART), no safeguarding allegations had been made against the A&E department last year.
- The trust reported problems with the learning and development tracking system, which resulted in reporting delays. Figures obtained in May showed all areas were below the target of 85%.
- The urgent and long-term conditions directorate achieved 61% for level 1 training and 56% for level 2, compared to the trust average of 47%.
- The figures were significantly better children's safeguarding training and had improved since our last inspection. Broken into staff groups, compliances were:
  - Clinical services - 90.9%
  - Administrative and clerical - 94.7%
  - Nursing - 89.7%
  - Medical - 94.4%
- Staff had safeguarding training at the appropriate levels for their roles and all we spoke with were alert to any potential issues with adults or children.
- Staff showed us examples of the new screening management and reporting tool (SMART Plus) which was used to identify high-risk vulnerable adults. The tool was adapted by the trust in December 2015, in conjunction with a new policy. In addition, new flow-charts and forms were provided on the 'Staff Zone' hospital intranet.
- We saw posters showing safeguarding pathways for adults and children displayed on notice boards and we were shown that attendance cards for children were marked with an orange strip for easier identification. The safeguarding link sister explained that the attendance records for each paediatric case was checked daily by the safeguarding team, although this was due to be reduced to a weekly check.

Mandatory training

- Mandatory training was completed and recorded on the 'Staff Zone' intranet. Staff maintained individual electronic staff records and their managers had authority to access the record to monitor compliance. Safeguarding courses above level 1 were classroom-based.
- Apart from adult safeguarding and DoLs/MCA, the figures achieved had improved since our last visit and were above the trust target of 85%. Compliance with mandatory training for nurses and other staff groups at A&E were as follows:
  - Fire training - 100%
  - Moving and handling training - 87%
  - Health and Safety awareness - 100%
  - Infection control prevention - 87%
  - Equality and Diversity - 100%
  - Safeguarding adults - 46%
  - Information governance - 87%
- Completion figures for medical staff were good and either close to trust target of 85% or well above:
  - Fire Safety - 88.9%
  - Health and Safety Awareness - 94.4%
  - Information Governance - 88.9%
  - Moving and Handling - 83.3%
  - Safeguarding Children and Young People - 94.4%
  - Equality and Diversity - 94.4%
  - Infection Prevention and Control - 83.3%

Assessing and responding to patient risk

- Although 97% of patients were triaged within 15 minutes, only 42% had a clinician first assessment within one hour and 17% a decision to admit within two hours. Attendance by specialist doctor within 30 minutes following referral was only achieved 27% of the time.
- The hospital used the National Early Warning Score (NEWS) and escalation flow charts to identify patients whose condition was, or was at risk of, deteriorating. NEWS is a simple scoring system for physiological measurements, such as blood pressure and pulse, for patient monitoring.
- We were told by senior staff that other parts of the trust used an electronic system that monitored and analysed patients' vital signs to identify deteriorating conditions and provide risk scores to trigger the need for further care. This was due to be trialled in October, with the intention of extending the facility to both A&E departments.
- Observation of records showed NEWS scores were correctly calculated at the required frequency. We also noted the use of paediatric early warning scores (PEWS)

in the unit. This meant that children attending the department were being assessed so that any deterioration in their condition would be rapidly detected.

- Mental health and other vulnerable patients were risk assessed using the SMART Plus tool and their condition graded as red, amber, yellow or green. Staff explained that anyone graded amber or above had a nurse allocated to them for supervision purposes. We spoke to an agency mental health nurse who did regular shifts at the A&E in addition to her normal work in the community. The department had arranged specialist support in response to a higher number of patients attending with mental health issues. We observed the nurse providing one-to-one supervision to a patient during our visit.
- On our unannounced visit, we saw one patient waiting on a trolley for a bay to become available. We observed that the patient had a member of staff with them and preserved their dignity by the use of blankets. We saw that middle grade doctors were present in the department and the doctor in charge (who was easily identified by the wearing of an armband) quickly located the medical consultant who was present in the department triaging patients and working with the team.

Nursing staffing

- The adult department employed 93 staff including emergency nurse practitioners and children's nurses. The matron explained that two nurses were on maternity leave and she had three vacancies at band 5/6 level. Matron was confident the vacancies would be filled. She said that lately "people are asking to work here", which she attributed to improvements in the trust and her department in particular. According to trust data, and average of 21% agency staff were used to cover shortfalls at A&E over the last year.
- During both visits to the department, there appeared to be adequate staff in place on the adult section. Staff appeared busy but not rushing or stressed.
- In the paediatric section, there was one trained children's nurse on each occasion we visited. We saw a play specialist, who worked four days a week. The nurse confirmed that there were five trained staff including her for this department but felt this was inadequate when the area was busy or occupied by very ill children. We checked the roster for the month and saw that one nurse was rostered for each shift. We also checked incident reports for the area and saw occasions when overcrowding had been reported. When we spoke to managers, it was acknowledged that demand in the department could change rapidly. In this regard, patient acuity (the severity of their illness and care needs) was assessed using PEWS scores.
- We saw sufficient staff on duty to meet care needs and on reviewing rosters noted that planned staffing levels matched actual numbers present. We saw trust data from the last four months that showed actual staffing hours matched planned hours at rates of between 87% and 26% over requirement. Bank and agency staff were employed to make up any shortfall in numbers.
- We saw trust reports showing that staff turnover for the whole directorate was 10.7% and this figure had not changed over the last year. Vacancy rates for band 5 nurses at QEQM A&E was 19%. Managers stated that recruitment was ongoing and had included advertising in parts of Europe for nursing staff.
- Sickness absence had increased to 4.07%, although this was lower than other parts of the trust.

Medical staffing

- According to the Standards for Children and Young People in Emergency Care Settings (Royal College of Paediatrics and Child Health, 2012), all paediatric departments supporting an on-site emergency care setting seeing more than 16,000 children per year should aim to appoint a consultant with sub-specialty in children. Managers told us that a consultant had just been recruited with the appropriate speciality.
- Across the directorate, there were medical vacancies of 29.78 WTE at consultant grade and 21 WTE for speciality doctors. However, we learned that eight A&E Specialty Doctors had recently accepted offers of employment and another four were 'under negotiation'. All known gaps in the upcoming A&E and Medicine Junior Doctor rotations have been filled and staff expressed the view that having more substantive doctors on staff was an improvement over the earlier reliance on locum cover
- Consultant cover was provided from 8.00 am to 22.00 pm Monday to Friday, along with eight hours of consultant cover on weekend days. On call cover was arranged outside these hours. At QEQM, the weekend on

call roster was based on a 1:7 rotation filled by the three substantive consultants and a range of internal locums for the on call element and internal and external locums for the eight hours on weekend days.

- The clinical lead stated that although the rota was currently filled with only three substantive consultants, there was one internal locum who, along with the two agency locums, had been working with the department on a long term basis and there were "very few occasions" when the rota was not covered. This was supported by figures for locum cover for QEQM, which was higher than the other locations. QEQM averaged 42% last year, against 36% for WHH and 31% at UCC.
- The medical staffing skill mix showed the trust has a higher percentage of junior grade staff when compared to the England average, but the percentage of consultants is lower. Across the trust, 20% of medical staff were consultants compared to the England average of 26%, 17% were 'middle career' compared to 15% in England and 63% were registrar or below compared to 41% in the rest of the country.

Major incident awareness and training

- A new Emergency Planning Policy had been introduced since our last inspection (January 2016), which included a new online major incident awareness package as part of mandatory training.
- In addition, annual 'table top exercises' commenced along with a requirement for selected emergency staff to update their training and competence every year. Managers told us that training was monitored and provided by the emergency planning team and staff described participating in scenario-based training events.
- The policy provided assurance that frameworks existed within the trust that supported a high level of preparedness to any business-disrupting event or major incident, regardless of source. Staff were made aware of the trust's major incident plan, which was published on the trust's intranet.
- We checked the major incident stores and found a range of equipment and clothing neatly stacked in carry boxes ready for use. Items were clearly labelled with expiry dates where applicable. This indicated that emergency stores had been correctly maintained in a state of readiness for immediate use.
- Staff told us the next major incident training session at the department was programmed for later in September. This was expected to improve the figures for the department, which were acknowledged as poor: 44% of 'target staff' had received either DVD-based awareness training or completed the classroom-based course. This was worse than WHH (79%), UCC (56%) and the trust average of 62%. The trust target was 100%.
- Every two months the trust's resuscitation training officers conducted emergency exercises in the A&E to help ensure staff responded appropriately to emergencies.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated the urgent and emergency department at QEQM as requires improvement for effective, because:

- Documents and records supporting the learning needs of staff were not always competed and there were gaps in the records of training achieved. Some topics reported directorate-wide, such as DoLs and MCA were low.
- Staff appraisal rates were better than other A&E departments but remained below the average for the trust as a whole and less than target.
- Auditing had improved since our last visit, although action plans were not always submitted in a timely manner and where there was an action plan the actions were not always fully implemented or communicated widely throughout the department. This meant the department did not have full assurance that best practice was being followed.

However,

- Clinical audit results for bodies such as the such as the royal college of emergency medicine (RCEM) and national trauma audit & research network (TARN) were improved and in some cases better than other hospitals in the region.
- We saw evidence that comfort rounds had been performed and audited. These provided good assurance that pain assessments had been performed, analgesia

administered and comments on the effectiveness of the medication documented. In addition the rounds enabled the department to ensure that patients' hydration and dietary need were addressed.
- Induction arrangements for locum or agency staff appeared robust and we saw good examples of clinical and organisational information and advice made available on the staff intranet.

On this inspection we have maintained a rating of requires improvement since the last inspection.

Evidence-based care and treatment

- The trust provided staff with a range of easy to use guides and documents for recording information, such as the SMART Plus tool used to assess the health of patients being treated.
- The trust provided staff with intranet access to a range of care pathways that complied with the national institute for health and care excellence (NICE) and royal college of emergency medicine (RCEM) clinical standards.
- We saw evidence of recent updates and research references contained within the documents. This indicated that the pathways followed best practice.
- Pathways were supported by trust-wide audits and we saw examples of local audits such as the "stroke care bundle and pathway" completed by the hospital stroke team earlier this year.

Pain relief

- In the last CQC A&E survey, the results were about the same as other hospitals in England for the questions "staff did everything they could to help control your pain" (77%) and time taken to receive pain medication after requesting it (55%).
- We saw evidence of pain relief audits performed at least weekly by the Matron, who checked each adult area of the ED (Resus, Majors and Minors). These confirmed pain assessments had been performed at initial triage, analgesia administered and comments on the effectiveness of the medication documented. Other aspects audited included legibility of documentation and completeness of comfort rounds.

Nutrition and hydration

- In response to the question "Were you able to get suitable food or drinks when you were in the A&E Department", the trust scored about the same as other NHS hospitals in England (65%).
- We were shown evidence of a range of food items available to patients, including options suitable for people requiring gluten free diets or special preparations based on cultural or religious preferences.
- We saw a water fountain in the waiting area as well as a tea trolley 'round' to offer patients food and drinks if necessary.
- Nurses and support staff we spoke to understand the needs of patients they were caring for and the importance of ensuring they had adequate food and drink. Elderly or frail patients were assessed using the malnutrition universal screening tool (MUST), which helped staff identify patients at risk of poor nutrition and dehydration.
- We saw local monitoring of nutrition and hydration by the matron, who conducted and recorded the results of weekly audits of comfort rounds and documentation. Copies of completed updates were recorded and kept for auditing by senior nurses, along with records of the patient rounds conducted by the matron.

Patient outcomes

- According to royal college of emergency medicine (RCEM) audits for QEQM, the A&E department scored 100% for the initial management of the fitting child (between the upper and lower England quartiles); 72% for management of mental health in ED (between the upper and lower quartiles but worse than WHH) and 73% for assessing the cognitive impairment in older people (between the upper and lower quartiles but worse than the WHH).
- The rate of unplanned re-attendances (March to June 2016) for QEQM was 9.9%, which was worse than the other A&E sites over the same period. Lower figures can indicate that the care and treatment received is appropriate and effective for the patient's condition.
- Nurse practitioners undertook audits of their own practice and clinical decision-making and shared these at the emergency nurse practitioners (ENP) forum, which met every quarter. This enabled ENPs to share best practice and draw lessons from each other to improve the care they provided.

- Twenty four audits were progressed in the directorate during the 2015/16 Audit Programme. According to the trust summary, some action plans were not submitted in a timely manner and where there was action plan the actions are not always implemented.
- The trust participated in the national trauma audit & research network (TARN). TARN provides important information about the rates of survival for patients who have been injured and treated at different hospitals across England and Wales. It also provides information about the benefits of certain kinds of treatment.
- TARN results for QEQM (2015) showed the department scored 98.9% data completeness in key aspects of trauma care on 261 submissions. This score was better than other hospitals seeing comparable numbers of trauma victims in the region and was an improvement over the 2014 results (97%). This meant that senior clinicians and managers were able to benchmark results between seven regional NHS trusts and more easily determine areas of clinical practice requiring improvement.
- We saw examples of the "Emergency Department Observations Chart" introduced for use in A&E. The observation document was for all adult patients included a colour-coded observation record combined with NEWS scores and a tick-box Sepsis flow chart, in addition a "critically ill patient flow chart" printed on the reverse. Staff completing the document were given clear instruction on sepsis "red flags", which mean that all those delivering care had robust instruction on when blood tests were required and reporting concerns to the responsible doctor.
- The identification and management of sepsis had been placed on the directorate's risk register and plans were in place to improve processes. Among these were the trial to use an electronic NEWS "Track and Trigger" system, which automatically recorded patient observations.

Competent staff

- The trust maintained employment policies, procedures and systems to ensure new staff were appropriately experienced, qualified and suitable for the post. We saw systems in place for departmental managers and human resources to monitor the status of registration for professionally qualified staff.
- We reviewed a sample of staff appraisals which were in date and completed. Trust data showed an average of 75% appraisals completed for A&E nursing, clinical and administrative staff groups (April 2015 to March 2016). This is similar to the same period and better than the other two locations we inspected and indicated that managers had generally monitored staff development and performance. The average appraisal rates across the entire trust for the reported period was 80%.
- We learned there was an induction process in place for agency staff and the department tried to use regular agency staff familiar with the department. We spoke to an agency nurse who confirmed this and described her induction and work experience in positive terms. She felt "valued" and was complimentary about the "friendly team".
- Registered nurses we spoke with told us they felt supported when preparing their revalidation. Staff we spoke with told us they had regular team meetings and supported with their continuous professional development.
- Three nurses from A&E at QEQM had successfully completed their advanced life support (ALS) qualification. This indicated the department had considered and addressed the need for advanced resuscitation training.

Multidisciplinary working

- Managers and staff gave examples of good multidisciplinary working at the department. For instance, concerns had arisen about the capacity of the local council to provide out of hours mental health services. This resulted in a series of meetings with external agencies such as the police, local ambulance service, county council and commissioners (CCG) to address the problems identified. Part of the hospital's response was the provision of 24 hour agency mental nurse cover to provide specialist care and support to the increased number of patients with mental illnesses presenting in crisis.
- In the children's area, we saw illustrated posters developed by the department in collaboration with the children's nurse in the operating theatres. This meant that children and their families had access to age-appropriate resources that helped to allay fears prior to urgent or emergency surgery.
- Staff from both hospital and local ambulance service emphasised the good relations between services and

staff also improved links with colleagues locally and the other emergency departments, which showed that effective channels for communication existed in the trust.

Seven-day services

- Consultant cover was provided on a seven-day basis between the hours of 8.00 am and 10.00 pm (Monday to Friday) and for eight hours a day on weekends. There were robust on-call arrangements out of these hours.
- Pharmacists were in the hospital from 8.00am until 1.00pm on weekends and out-of-hours cover was also provided for pharmacy, pathology, imaging and maintenance services. Registered mental health nurses were provided within the department.
- The trust had also responded to increasing demand by the introduction of referrals to a contracted 24-hour GP service.

Access to information

- A&E used a combination of computer software and paper notes to document care, treatment and observations. Other parts of the trust used an electronic system that monitored and analysed patients' vital signs to identify deteriorating conditions and provide risk scores to trigger the need for further care. We saw meeting notes confirming that this system was being introduced in A&E.
- We found there was no direct link between the software system used and other services in the community. For example, GP's had to wait for the discharge summary to be sent to them via post.
- We saw waiting times displayed in the reception area so patients knew how long they might have to wait. This information was replicated on the trust's website, which meant people with access to the internet at home or work could quickly obtain information on service status.
- Staff has access to clinical guidelines and policies via the "staff zone" intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that the trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details of the Mental Capacity Act 2005 (MCA) guidance and treatment checklists.
- Figures for training on consent and the Mental Capacity Act 2005 were low. Only 26% of band 6 and 7 nurses has completed the training. The trust had implemented revised DoLS training in the light of a recent Supreme Court ruling (2015) and its implications for the acute sector had proved challenging. The trust had adopted a package of tools developed by the association of directors of adult social services in England (ADASS) to assist the effective prioritisation of DoLS assessments and the trust continues to work to raise awareness about clinical restraint. In addition, the trust used a contracted service that provided specialist staff to support patients with challenging behaviours.
- Staff were aware of their responsibilities under the Mental Capacity Act 2005 and DoLS and were able to describe the arrangements in place should the legislation need to be applied.
- Staff explained that a new web page had been created on the trust intranet with hyperlinks to guide personnel through the safeguarding process (including female genital mutilation), the mental capacity act, Domestic abuse, DoLs and clinical restraint.
- Staff were confident with the consent process and could explain how consent to treatment was obtained.

Are urgent and emergency services caring?

Good

We rated caring at A&E QEQM as good because:

- Patients and relatives we spoke with were complimentary about the nursing and medical staff.
- Patients were given appropriate information and support regarding their care or treatment and understood the choices available to them. This was augmented by information leaflets and posters on display in the public areas of the department.
- We observed interactions which showed staff were welcoming, caring and supportive. Staff maintained patient privacy and dignity, including appropriate use of curtains.
- Staff expressed pride in their work and responded compassionately when patients needed help and supported them to meet their needs.

Urgent and emergency services

At this inspection we have maintained a rating of good since the last inspection.

Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. The latest results available for the A&E Friends and Family test showed the trust scored below the England average (June 2015 – May 2016). We saw that FFT information was displayed on notice boards in the department.
- The trust was rated as "about the same as other trusts" for all questions in the ED survey 2014.
- Patients and relatives we spoke with were complimentary about the nursing and medical staff. We observed care given was considerate and kind. We saw how the nurses assisted patients compassionately and respectfully.
- We observed the consistent use of curtains and blankets to help preserve patients' dignity at all times and patients had been given hospital gowns to wear if needed.
- Staff and doctors talked to patients in a low voice in an effort to maintain patients' privacy and we did not see any information on patient status boards that could be used to identify patients. Status boards and displays were sited in areas away from passing visitors, as were the computer terminals.

Understanding and involvement of patients and those close to them

- Patients and relatives said they felt involved and informed about their care and participated in decisions regarding their treatment.
- We observed clinical staff explain procedures and provide information and tactful reassurance to patients and their families.

Emotional support

- Staff knew of the need for emotional support to help patients and their relatives cope with their treatment and the department had arrangements in place to provide support when needed. This included the use of a 'quiet room' where relatives could be away from the main unit.
- We saw posters displayed with details of a variety of support groups or services such as domestic violence support, mental health support and community social support for elderly people.
- The hospital offered a 'take home and settle service', where patients were escorted home and helped to settle in. The service ensured that patients had a support network in place, a supply of everyday items such as milk and bread and that the home was suitable.
- Staff also described a hospital chaplaincy service, which provided spiritual, pastoral and religious support for patients, relatives, carers and staff. The service was contacted via the main hospital switchboard.
- Staff confirmed they had access to the end of life team and previous referrals had been acted upon promptly.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We rated A&E at QEQM as requires improvement for responsive, because:

- Delivery of performance indicators such as patients being seen within four hours remained below trust target and national averages. From March to June 2016, the department averaged 78% of patients seen within four hours. This was worse than the trust target of 95% and the England average of 88%- 95%. The percentage of unplanned re-attendances averaged 9.9% over the same period. This was worse than the trust target of 5% and the average for England.
- There was good information on the trust's public website about estimated waiting times, however this information was not readily available within the department.

However,

- Delayed discharges remained a concern due to the impact on ED. However, as part of this response we observed an operational communications meeting,

which showed the trust was addressing patient flow through the hospital and monitoring closely for risks that affected beds available for receiving patients from ED.
- The department was actively testing and trialling new ways of collaborative working to speed patient flow and take advantage of electronic technology. Early results were positive. We saw good examples of the department responding to patient's needs such as people with dementia and mental health conditions.

At our last inspection, we rated the service as inadequate for responsiveness. On this inspection, we have changed this to requires improvement, as we have seen improvements in key areas such as the meeting people's needs, access and flow and the way complaints are managed and lessons learned are disseminated to the department.

Service planning and delivery to meet the needs of local people

- March to June 2016, the department averaged 78% of patients seen within four hours. This was worse than the trust target of 95% and the England average of 88%-95%.
- The percentage of patients leaving before being seen was higher than the England average in the same period as was the total time spent in A&E.
- According to trust reports, delayed discharges remained a concern due to the impact on the department. We observed an operational communications meeting, held twice daily, which showed the trust was addressing identified factors related to patient flow through the hospital and monitoring beds available for admitting patients.
- The trust had also established integrated discharge teams to help speed the process. Other initiatives to support safer discharges had also been implemented, such as the 'Home First' scheme. Staff said these had a positive impact.

Meeting people's individual needs

- Staff told us that an interpreter service was available for those patients whose first language was not English. They said the service worked well and emphasised that staff or relatives were not asked to interpret.
- We saw a number of leaflets and useful information available on display to help patients and their relatives understand their conditions and the treatment options. The printed information was only available in the English language.
- Staff described examples of the frailty assessment in use and how the adjoining GP service supported patients, seeing them in the department if they lacked the mobility to get to the consulting room.
- A flagging system alerted the learning disabilities link nurse whenever a patient with learning disability was referred through the department for admission.
- We were shown 'distraction quilts' made by a hospital volunteer and used to help patients with dementia. Other dementia care initiative included the 'This is me' scheme and dementia champions within the department.
- Staff had access to a mental health liaison team to provide input to any patients who required mental health assessments.

Access and flow

- The trust as a whole failed to meet the emergency department four hour access targets between June 2015 and May 2016.
- The trust has developed business intelligence to support the implementation of its urgent care improvement plan. This data is site specific and provides a detailed breakdown of key performance indicators for access and flow. The trust provided data covering the period March – June 2016.
- For QEQM, the average performance against the 4 hour target was 78% for that time period. Whilst performance for minors patients was 92% (still below target) only 69% of majors patients were treated within 4 hours.
- However, across the trust the percentage of emergency admissions waiting 4 -12 hours from the decision to admit until being admitted was consistently lower (better) than the England average.
- The data reflects the continued issues relating to patient flow through the emergency pathway.
- The percentage of unplanned re-attendances averaged 7.2% over the same period. Lower percentages for unplanned attendances suggest that the care and treatment received is appropriate and effective for the patient's condition.
- Across the trust, the percentage of patients leaving before being seen was worse than the England average

(March 2015 to March 2016), as was the total time spent in A&E. In the last CQC A&E survey, the trust was rated about the same at other English hospitals for questions such as how long patients waited with the ambulance crew prior to being seen; or waiting to see a doctor or nurse.

- Patients who 'walked in' to the department were seen by a screening nurse in reception, who directed the patient to the next stage after making a visual and verbal assessment. As part of this triage process, QEQM had piloted the use of an A&E consultant and acute physician working together with nursing staff to assess and manage patients without onward referral to a specialist team. Staff said this had worked well so far and testing continued,
- During the main inspection and later on our unannounced visit, we observed the lead nurse and doctor keeping the department under review and making referrals. Both wore reflective armbands that were clearly marked as 'doctor in charge' and 'nurse in charge'. This meant that patients, staff and visitors could rapidly identify supervisors on duty, which improved communications and provided visible assurance that control was effective during busy periods.
- There did not appear to be any delays during our visits. We saw new patients arriving by ambulance being assessed on arrival with no apparent delay. We saw that patients who 'walked in' were seen in a few moments by a 'streaming nurse' located in the reception area. The nurse conducted a rapid verbal and visual assessment before directing the patient to the reception desk or another area of the department.
- On our unannounced visit, we saw patients requiring mental health referrals and noted an agency mental health nurses was attending. She spoke of how much she enjoyed working in the department and she would provide cover two to three days a week. She stated that there was twenty-four hour cover for the department and good links were maintained with the community psychiatric nursing service. Referrals could be made to appropriate place of safety for any patients once they had a medical assessment.
- We saw the mental health assessment room and learned that no patient is left alone in the room. The room was suitable for purpose and free from ligature points, which means it is a safer environment for patients with mental health conditions that may involve self-harm.
- In the last A&E survey, the trust was rated about the same at other English hospitals for questions about how long patients waited with the ambulance crew prior to being seen or waiting to see a doctor or nurse.
- We saw a new "care flow" project piloted at QEQM. This involved the use of phone or PC applications that provided an automated link from GP referral to A&E admission and then onward transfer to the appropriate ward. A&E managers and senior clinicians were able to view the process "live" on their phones or iPads and intervene if they detected any delays in the referral. We also learned that a new medical assessment pathway was being tested by a group led by a consultant physician. Although in "early stages" managers were positive that the new pathway would also enhance the flow of patients suffering from medical conditions.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy and coordinate by case managers from the patient experience team (PET). Complaints were acknowledged within three working days and the PET then worked to agreed timelines for investigation and response.
- Staff were aware of the complaints process and knew how to direct patients correctly. The complaints process was outlined in information leaflets, which were available in the department and in addition, contact details and 'on line' complaint forms were published on the trust website.
- Between June 2015 and June 2016, the department received 120 formal complaints. 69% of these complaints were about clinical treatment and admissions, discharge and transfer arrangements. 17% of the complaints were linked to patients being unhappy with their treatment.
- The matron monitored complaints and discussed these at departmental clinical governance meetings and briefings to ensure lessons learned were disseminated.
- We saw examples in the clinical governance minutes that confirmed this.
- In addition, a trust wide complaints newsletter was produced for disseminating the learning from complaints to staff in the Trust. The first issue was sent out in June 2015 and was also attached to the trust newsletter. The newsletter contained the complaints and compliments data for the quarter for each division and includes case studies identifying service improvements within the trust as a result.

Urgent and emergency services

Are urgent and emergency services well-led?

Requires improvement

We rated A&E at QEQM as requires improvement for well-led, because:

- Leadership last time was rated as inadequate because of lack of local organisation and decision-making and a lack of governance under reporting risks and inability to escalate risks; there was poor morale. This position is improving
- Although there had been progress, the trust acknowledged staffing and finance among the ongoing concerns which ultimately affect the patient experience.

However,

- We found the trust had clear vision and strategy for improvement and worked hard to engage staff in the department. Staff engagement was reflected in the developing strategy for emergency services where clinicians, staff and patients' opinions were taken into consideration.
- Managers at all levels were candid about the improvement challenges and staff were involved in progressing improvements. Departmental staff felt engaged with the direction of the trust and took pride in the progress they had made so far.
- The trust had improved and implemented clearly defined governance systems. There was a well-established governance structure, with cross-directorate working, developing standard practices and promoting effective leadership. Front line staff appreciated the highly visible and engaged approach of the chief executive and other senior leaders.
- A range of positive initiatives have been implemented in this department along with others we observed at similar sites in the trust. Further harmonisation and sharing of best practice between all A&E locations would benefit patients and staff.

At our last inspection, we rated well-led as inadequate. On this inspection, we have changed this to requires improvement, as we have seen improvements in key areas such as leadership and governance mentioned above.

Vision and strategy for this service

- The trust's vision was to provide 'Great healthcare from great people', with the mission statement 'together we care: Improving health and lives'. We saw various examples of the vision statement published on printed matter and posters around the hospital, which illustrated the board's intention to inform and promote the values to both service users and staff.
- The vison across A&E was stated as the provision of safe, effective and timely emergency care to meet the needs of the local population. Managers translated this into goals that included achieving the 4-hour emergency access standard, stronger partnership working and integration between the "emergency floor" which incorporated A&E and acute medical services, better site management linked to business continuity and emergency planning along with improved access to mental health services.
- The trust had well-documented and publicised vision and values. These were readily available for staff, patients and the public on the trust's internet pages, posters around the hospitals and on the trust's internal intranet. Managers told us of the trust's "improvement journey" and staff we spoke with knew and understood the terminology.
- Since the last inspection, the trust had a change of chief executive and support from outside agencies such as Monitor and the ECIP to implement improvement. The trust wide improvement plan identified 30 actions and this is reported monthly on their progress against the action plan to all relevant stakeholders.
- Although there had been progress, the trust acknowledged staffing and finance among the ongoing concerns which ultimately affect the patient experience.

Governance, risk management and quality measurement

- Governance in A&E had improved since our last inspection and a clearer line of accountability now existed up to board level. Department leaders worked through monthly "ED Department" meetings, which was mirrored by a Band 7 nursing meeting. These two

groups reported to the ED Business and Governance group which then reported to the trust wide UCLTC Quality and Management Board. This body worked with project groups responsible for initiatives such as the acute medical project at QEQM and reported to the Urgent Care Programme Board, which was a sub-group of the trust management board and chaired by the Chief Operating Officer.

- Directorate leaders had identified a number of risks to A&E, which it was addressing through the trust improvement program. These included overcrowding, which delayed patient care, inconsistent departmental and care process, poor leadership, workforce challenges and the built environment. The highest scored risks on the register related to finance, staffing and waiting times for patients. Dated actions indicated regular review and reporting, which was supported by comments in the governance board meeting notes.

Leadership of service

- The senior matron was on leave at the time of our visit. The matron, in post for two years, described a number of positive changes due to trust initiatives and locally through the ECIP program. She felt well supported by senior managers and rated her team as "friendly, supportive and caring". She gave the example of shared roles with more clarity (triumvirate working) as a valuable improvement and spoke about the successful introduction of early triage using senior doctors.
- 'Triumvirate working' had been introduced and was a structure designed to ensure both clinicians and managers were involved in the management and planning of hospital activities at every level. The triumvirate model consists of a lead clinician, a senior nurse and a manager.
- According to the matron, the environment "holds us back" and she was seeking funding to undertake improvements in layout and facilities such as the adult ophthalmology examination room adjoining the paediatric area.
- Ward and department governance meetings fed into divisional safety and quality meetings, which then reported to the executive safety and quality committee. Independent external reviews commissioned by the trust (July 2016) concluded that there was increased visibility of the senior managers and board; there was improved site management and safety, better staff engagement, stable divisional structures and strengthened leadership across the trust.
- We saw that the chief executive is highly visible and encouraged staff to call him by his first name. All staff spoke favourably about the visibility of the senior management team as a whole. They told us that the chief executive and chief nurse visited front line services at one or other of the sites on an almost daily basis.
- Staff felt free to raise any issues with them directly or through their line manager and in addition to local forums and meeting arranged in the department, told us about the monthly open forums led by the Chief Nurse where nursing issues could be discussed.

Culture within the service

- The trust had started a "great place to work" initiative after our last inspection. Actions in the program include an executive development programme, a "respecting each other" campaign and health and wellbeing group, which included a confidential report line. Staff we spoke with were positive about the project.
- The trust monitored workforce performance indicators in order to plan recruitment and monitor trends. The June 2016 staffing data indicated 11% vacancy rate, 10% turnover rate, 68% appraisal rate, sickness absence of 4% and mandatory training at 87%. This was similar to other NHS trusts. The staff survey action plan for the urgent care and long-term conditions division was working towards reducing sickness absence to 3.5%, improving the vacancy rate to 10%, the mandatory training and appraisal rates to 95%.
- Staff told us that the culture in the hospital was now moving towards being more inclusive and supportive. Relationships had improved as staff felt more "empowered and engaged" and we were given examples of senior clinicians "being re-energised" and newer individuals "a breath of fresh air".
- The June 2016 Family and Friends Test indicated that 80% of staff had never experienced bullying or harassment and the majority of staff would feel confident in reporting such issues. 96% of staff were aware of the trust's anti bullying initiatives.

Public engagement

- We saw the trust's website, which provided safety and quality performance reports and links to other web sites. This meant patients and the public had access to a wide range of information about the safety and governance of the hospital.
- The "hello my name is …" initiative was widely practiced by staff and during our visit and we heard examples of staff using this when talking with patients.
- The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups like the League of Friends and Healthwatch.
- We saw posters and leaflets about these initiatives on display in the department. This included posters about the CQC and reporting concerns.

Staff engagement

- Satisfaction surveys for staff at the trust were conducted in line with national policy. The latest published survey results demonstrated an improvement in communication (up 12%), decision making (up 11%) and managers acting on feedback (up 13%). The trust recorded the highest staff engagement score for five years.
- The trust recorded a positive staff friends and family test result with 57% of staff recommending the trust as a good place to work (up 8%) and 78% recommending the trust as a good place to receive treatment (up 4%).
- All the staff we spoke with assured us they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the staff noticeboards advising staff of the whistleblowing procedure. This indicated the trust had had developed an open culture in which staff could raise concerns without fear.

Innovation, improvement and sustainability

- Operational control centres had been established in each hospital and convened three times a day, involving key operational and clinical managers. The remit was broader than simple a bed state and focussed on key issues such as staffing and equipment failures. We saw new escalation protocols under development that were based on the Ipswich trigger tool. Staff had responded positively to these initiatives and stated it had led to a more proactive approach to escalation and response by colleagues in other areas of the hospital.
- At QEQM we saw examples of improved care processes, assessment and treatment of the deteriorating patient and improved dignity and privacy. We observed comfort rounds that included the timely administration analgesia and pain scores to help determine the effectiveness of the medication. The visibility of local clinical leaders had increased and improved staff levels had been achieved. Enhanced medical training had been implemented in the directorate, which included secondments to other specialities and weekly teaching and clinical supervision sessions.
- A practice development nurse had been appointed and paediatric nursing cover was now 24/7 at the two A&E sites. Approval had also been received to recruit 24-hour departmental clerk cover, which was considered a key support role.

Medical care (including older people's care)

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

Information about the service

The Queen Elizabeth the Queen Mother Hospital (QEQM) is a location of East Kent University Hospitals NHS Foundation Trust. The hospital is an acute hospital with 388 beds providing a range of medical care services. These include cardiology, gastroenterology, respiratory medicine, medical oncology, general medicine, nephrology, stroke and specialist rehabilitation services. The hospital also provides services to elderly patients.

Between March 2015 and February 2016, there were 21,546 medical admissions. Of these the majority were emergency (52%) with 5% elective, 43% admitted as day cases. The majority of admissions were for general medicine, with cardiology, geriatric medicine and other specialities accounting for the remainder.

On our previous inspection, we found the medical services at the QEQM Hospital required improvement because of we identified concerns with the environment, medical staffing, nursing staffing, especially at night, the availability of support therapies, arrangements to support patients whose condition was deteriorating, the storage and management of medicines, the management of patient records and shortfalls in infection control procedures. We had concerns that the hospital had admitted a large number of medical patients to non-specialty beds and staff had not managed discharge from the hospital in a timely manner.

We conducted this inspection to follow up on these issues and assess the progress of the trust against the action plans that were in place. In order to do this we reviewed information data supplied by the trust, visited The Clinical Decision Unit, Deal, Sandwich Bay, Fordwich, St. Augustine's and St. Margaret's Wards, the Coronary Care Unit and the Discharge Lounge. Staff spoke with us and we observed staff delivering care. The CQC held focus groups where staff could talk to inspectors and share their experiences of working at the hospital. We spoke with over 24 members of staff working in a wide variety of roles including divisional directors, the chief nurse, matrons, ward managers, nurses, health care assistants, therapy and domestic staff. We spoke with patients and their relatives. We reviewed 12 sets of patients' records as well as other documentation. We also received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection.

Medical care (including older people's care)

Summary of findings

We found the medical services at the QEQM Hospital good because;

- The trust had a robust system for managing untoward incidents. Staff were encouraged to report incidents and there were processes in place to investigate and learn from any adverse events. The hospital measured and monitored incidents and avoidable patient harm and used the information to inform priorities and develop strategies for reducing harm.
- The trust prioritised staff training, which meant staff had access to training in order to provide safe care and treatment for patients.
- There were systems in place to maintain a clean and therapeutic environment. Staff effectively managed infection control and maintained the environment appropriately.
- Medical care was evidence based and adhered to national and best practice guidance. Management routinely monitored that care was of good quality and adhered to national guidance to improve quality and patient outcomes.
- Patients were supported through consultant led care and effective delivery of care through multidisciplinary teams and specialists. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- Staff treated patients with kindness and compassion.
- The trusts average length of stay for both elective and non-elective stays were better than the England average for the majority of medical specialities.
- There was good provision of care for those living with dementia and learning difficulties. There were support mechanisms and information available to take individual patients needs into account.
- The trust had clear corporate vision and strategy. The trust included the opinions of clinicians, staff and stakeholders when developing the strategy for medical services. Staff felt engaged with the direction of the trust and took pride in the progress they had made to date.
- The trust had clearly defined local and trust wide governance systems. There was well-established ward to board governance, with cross directorate working, developing standard practices and promoting effective leadership. The trust acknowledged they were on an improvement journey and involved all staff in moving the action plan forward.

However

- There was a shortage of junior grade doctors and consultants across the medical services at the QEQM Hospital. This meant that consultants and junior staff were under pressure to deliver a safe and effective service particularly out of hours and at night.
- We found there were nursing shortages across the medical services. The situation had improved due to the use of agency and bank staff. Although the trust had recruited overseas nurses, there remained staffing shortages on the wards.
- Staff did not always complete care records in accordance with best practice guidance from the Royal Colleges. We found gaps and omissions in the sample of records we reviewed. The trust did not have a robust system in place to audit, monitor and review care records to ensure they always gave a complete picture of the assessments and interventions undertaken.
- The trust did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance.
- The trust had not completed its audit programme. This meant the hospital was not robustly monitoring the quality of service provision.
- We found that the hospital was not offering a full seven-day service. Constraints with capacity and staffing limited the responsiveness and effectiveness of the service the hospital was able to offer.
- Patients' access to prompt care and treatment was worse than the England average for a number of specialities. The trust had not met the 62-day cancer referral to treatment time since December 2014.

Medical care (including older people's care)

Referral to treatment within 18 weeks was below the 90% standard as set out in the NHS Constitution and England average for six of the eight specialties from June 2015 to May 2016.

- The hospital had improved the number of bed moves patients had during their stay. However, a fifth of all medical patients moved wards more than once during their stay. This meant the hospital transferred some patients several times before they had a bed on the right ward, which put additional pressures on the receiving wards.

At our last inspection, we rated medical services as Requires improvement. On this inspection we have changed the rating to good because of improvements in incident reporting, staff training, infection control, staff engagement and ward to board governance.

Are medical care services safe?

Requires improvement

We rated the hospital as requires improvement for safe because;

- The trust acknowledged there was a shortage of junior grade doctors and consultants across the medical services at the hospital. This meant that consultants and junior staff were under pressure to deliver a safe and effective service, particularly out of hours and at night.
- The trust had attempted to address staff shortages through the recruitment of overseas nurses, there remained staffing shortages on the wards covered by agency and bank staff.
- We found poor records management. Staff did not always complete care records according to the best practice guidance from the Royal Colleges. We found gaps and omissions in the sample of records we reviewed. The trust did not have a robust system in place to audit, monitor and review the care records to ensure they always gave a complete picture of the assessments and interventions undertaken.
- The trust did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance.

However;

- The trust had a robust system for managing untoward incidents. The trust's reporting performance between May 2015 and April 2016 was better than the national average. Staff were encouraged to report incidents and there were processes in place to investigate and learn from an adverse event.
- The hospital measured and monitored incidents and avoidable patient harm through the National Safety Thermometer scheme. This is a national improvement tool for monitoring the patients harm. Staff used information from the scheme to inform priorities and develop strategies for reducing harm.

- Staff training was prioritised, which meant staff had access to training in order to provide safe care and treatment for patients. Staff were aware of safeguarding principles and able to follow correct procedures.
- There were systems in place to maintain a clean and therapeutic environment. Staff effectively managed infection control and maintained the environment appropriately.

At our last inspection, we rated the medical services as Requires improvement for safe. On this inspection we have maintained a rating of requires improvement but have seen improvements in learning from incident reporting, staff training and infection control.

Incidents

- The trust reports all patient safety incidents through the National Reporting and Learning System (NRLS). When an incident is assessed as a serious incident, or a never event, it is reported through the Strategic Executive Information System (StEIS). NHS England describes a never event as "Serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers."
- The trust reported 13,137 incidents between May 2015 and April 2016. This was better (7 per 100 admissions) than the national average (8.6 per 100 admissions). The trust rated 98 percent of the incidents reported to NRLS as low or no harm. This indicated a good reporting culture.
- Between July 2015 and June 2016, the trust reported 75 serious incidents of which 13 related to medical services. Four of these were slips, trips or falls, which met the serious incident criteria; three were delayed treatment. The remaining six had various causes where no pattern was identified.
- The one never event which occurred in the medical services between January 2015 and January 2016, did not occur at the Queen Elizabeth the Queen Mother hospital.
- Following four never events that occurred in the trust between April 2011 and July 2015, there were concerns regarding the trusts compliance with national guidance in relation to the management of Patient Safety Alerts.

  In February 2016, the trust commissioned an external review of the systems and governance arrangements regarding the management of patient safety alerts. The review recommended that the trust put in place an escalation process and amend the management of safety alerts policy and procedures, to ensure stakeholder engagement together with robust management of alerts with effective oversight and scrutiny.
- Weekly quality meetings took place on the ward where all available staff met and discussed learning from incidents, complaints and quality issues. Minutes of the meetings were shared with those staff not on duty. The trust produced newsletters to disseminate good practice and highlight findings from investigations. We saw these were readily available to staff both on the intranet and pinned on staff notice boards.
- There was an incident reporting policy and procedure in place that was readily available to all staff on the trust's intranet. Staff we spoke with were aware of the policy and were confident in using the system to report incidents, this included bank and agency staff.
- Staff had access to training on incident reporting and this included 'Duty of candour' training. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of the duty of candour. One member of staff gave an example of how the governance lead had supported them when writing a letter to a patient under the duty of candour. Staff gave examples of supporting patients and relatives in accordance with the trust's duty of candour. The majority of staff we spoke with were aware of the duty of candour and their responsibilities.
- However, the trust had identified through reviewing the incident reporting system that staff did not always consider the duty of candour when investigating moderate or severe incidences. In response to this, the trust had provided additional training and support to improve the rate of reporting under the duty of candour.

- Regular mortality and morbidity meetings and case reviews took place across the medical services. We reviewed the minutes from a sample of these meetings and saw they were a forum for shared learning and development.

Safety thermometer

- The hospital used the NHS Safety Thermometer. This is a national improvement tool for measuring, monitoring and analysing harm and the proportion of patients that experience 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism.
- The medical wards we inspected displayed patient safety thermometer results on notice boards in public areas of the wards. This meant that up to date patient safety information was readily available for patients, visitors and staff.
- Pressure damage is localised, acute ischaemic damage to any part of the body caused by the application of external force (either shear, compression, or a combination of the two). Reports of pressure damage had remained stable across the trust between June 2015 and June 2016, although a slight increase was recorded trust wide in November 2015. The trust reported 44 pressure damage incidents over the past 12 months.
- Safety thermometer data for June 2015 to June 2016 demonstrated a decline in the number of pressure ulcers and falls and consistent catheter urinary tract infections (C.UTIs). The trust reported 45 falls between June 2015 and June 2016. The rate remained stable with slight increases noted in July and November 2015. Staff confirmed they were supported by the specialist falls prevention nurse who reviewed the falls risk assessments and any falls on the ward.
- There were 15 catheter urinary tract infections (C.UTIs) reported between June 2015 and June 2016. There were no reported C.UTI's reported in August 2015 or May 2016.
- The trust produced a monthly 'heat map'. This identified the number of safety thermometer incidents, together with other information such as staffing, friends and family test results and complaints. Staff displayed the results in an easy to access format, which was discussed at governance meetings and shared the information across the trust. This demonstrated that there were systems in place to monitor incidents of patient harm across the trust. Staff received feedback from investigation findings, which was used to inform practice and encourage improvement.

Cleanliness, infection control and hygiene

- The trust had infection prevention and control policies readily available for staff to access on the intranet. These included waste management policies, which staff monitored through regular environmental audits.
- The trust had arrangements in place to support the management of infection prevention and control. This included an infection prevention team with qualified infection control nurses and a doctor with infection control responsibilities. The team worked across the trust coordinating with other health-care professionals, patients and visitors to prevent and control infections.
- The teams' responsibilities included giving specialist infection control advice, providing education and training, monitoring infection rates and audit infection prevention and control practice. The Infection Prevention and Control Team submitted monthly reports to the board, which demonstrated that effective surveillance took place. For example in May 2016, the report identified that the team undertook post infection reviews to identify how any infection was acquired and if the action taken was effective. The report stated that there had been an overall decrease in ward-acquired MRSA cases across the trust.
- The infection control team regularly audited staff compliance to infection control policies. We reviewed a sample of audits and noted between 92% and 100% of staff in the urgent and long-term conditions division adhered to the bare below the elbows policy in April 2016, with 71 to 91% of staff adhering to the trusts hand washing policy. This was below the trusts targets. The medical staff were the lowest scoring staff group in both audits. Each of the medical wards and units we inspected displayed their infection prevention and control audit results.
- The safety thermometer Public Health observatory data for June 2015 to May 2016 reported low numbers (three) of MRSA for the trust compared to the number of MSSA

cases (28). There were 29 cases of C. Diff. The number of cases per 10,000 bed days was generally below the England average during this period with no trends identified.

- Infection prevention and control was included in the trust's mandatory training programme. Those staff we spoke with all confirmed they had completed this training.

Patient-led assessments of the care environment (PLACE) are a national initiative where teams of local people go into hospitals to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. The 2016 results for QEQM demonstrated an improvement from the 2015 results. The PLACE team rated cleanliness at QEQM at 99.6%, which was better than the national average of 98%. The Patient Experience Committee chaired by the chief nurse and Governors developed an annual action plan based on feedback from the report.

- The majority of areas we inspected where patients had access were visibly clean and tidy to the standard expected in the high-risk category of the National Specifications for Cleanliness in the NHS. For example, the linen cupboards were clean and tidy with bed linen managed in accordance with best practices. The sluices were clean, tidy and well ordered with little clutter. This made it easier for staff to keep the area clean. Patients told us that cleaners attended the ward twice a day and kept the ward clean. They told us that staff changed the bed linen daily.
- We spoke with domestic staff who explained their cleaning rotas. This included flushing all taps and water outlets twice a week as part of the programme to reduce the risk of legionnaire's disease. Staff completed daily checklists for each ward or area, which their manager then collected for monitoring. This demonstrated there were systems in place to maintain and monitor the cleanliness of the hospital.
- On all the wards and units we visited, we noted the moving and handling equipment was visibly clean and had "I am clean" labels in place. For example, on St Margaret's Ward, the majority of commodes in the sluice had "I am clean" stickers in place.
- We saw that clinical and domestic waste bins were available and clearly marked for appropriate disposal. Staff managed and disposed of sharps safely. On St Margaret's Ward, the sharps bins were kept closed and used correctly.
- We saw that personal protective equipment (PPE) such as disposable gloves and aprons were readily available for staff to use. There were hand-washing sinks with sanitising hand gel available. Staff followed infection control principles as demonstrated in the hospital's hand washing audits. At inspection, we observed staff washing their hands and using hand gel appropriately.
- Staff adhered to the hospital's 'Bare below the elbows' policy. We observed staff using PPE and saw they washed their hands in between patient contact. Patients confirmed that staff were always washing their hands or using hand gel.

Environment and equipment

- The 2016 PLACE rated the hospital at 97.8% for the facilities, which was higher than the England average of 90%. This score related to the condition, appearance and maintenance of the hospital, including the patient environments, décor, tidiness, signage, lighting, linen, access to car parking, waste management and the external appearance of buildings and grounds. The Patient Experience Committee chaired by the chief nurse and Governors developed an annual action plan based on feedback from the report . In addition, the Patient Experience and Investment Committee included the report findings and feedback into the annual refurbishment and improvement capital plans
- Sandwich Bay Ward provided a therapeutic environment to care for the medical specialities even though space was limited in the eight-bedded bays.. For example, each bed had piped oxygen and suction with two of the side rooms were fitted with negative pressure air conditioning. This meant that patients with a contagious disease could be safely cared for in that environment.
- St Margaret's Ward undertook a daily safety check and recorded this in a designated book. Staff took responsibility for completing the checklist and undertook any actions required.
- When we visited St. Augustine's Ward at the previous inspection we had concerns about the general

environment. At this inspection we found the ward had been recently refurbished and provided suitable environment to care for the patients receiving care and treatment there.

- We found that the corporate Control of substances hazardous to health (COSHH) risk assessments were available for all cleaning products used in clinical areas.
- In May 2016, the trust reported to the Quality Surveillance Group that the hospital adhered to the mixed sex accommodation policy. The 2016 PLACE assessment rated the hospital at 84.5 for privacy and dignity, which included changing facilities and appropriate separation of sleeping and bathroom/toilet facilities for single sex use. There were three areas in the hospital which were not compliant with single sex accommodation, this included day surgery, the Heart Centre and the ambulatoey care unit. Each area had been assessed and had plans in place to address the issues. The NHS Operating Framework expects all English NHS trusts to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, or reflects their personal choice.
- The trust had a planned preventative maintenance programme in place, which they monitored and risk assessed. The data supplied by the trust indicated there were a large number of medical devices not serviced or maintained within the designated time. The trust acknowledged they did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance. Achieving 95% planned maintenance compliance of all medical devices was included in the trust's Improvement Plan. At February 2016, the trust had 69% compliance with planned maintenance on the 20,611 devices that required planned maintenance.
- Staff reported there were no problems in obtaining stock or equipment. There was an equipment library on site and aids such as air mattresses, pressure relieving boots and air cushions were readily available. Staff on Sandwich Bay Ward reported that resources for reducing the risk of falls such as low beds and 'Sticky socks' (non-slip footwear) were easily obtained.
- We found there was adequate resuscitation equipment on each ward. We saw the documentary checks on each ward confirming that staff checked the resuscitation equipment daily. For example on St Augustine's wards we found staff had completed and appropriately documented all the daily checks of the resuscitation equipment.

Medicines

- The hospital had medicines management policies together with protocols for high-risk procedures involving medicines such as the intravenous administration of antibiotics. These were readily available for staff to access. Staff had access to relevant resources on medicines management such an electronic copy of the British National Formulary.
- We found the wards and units we visited handled medicines appropriately according to hospital policies and best practice guidance. This included patients own drugs, medicines requiring refrigeration and controlled drugs. On St Margaret's Ward, staff kept all medication locked and secured. The staff monitored the fridge temperatures daily.
- Each ward had an allocated pharmacist. Their role included undertaking regular audits and checking drug charts.
- We reviewed untoward incidents recorded over the past year and noted that staff reported medicine related incidents. The staff we spoke with understood how to recognise and report medicines related incidents.
- We undertook random medicine checks on the wards and units we inspected and found that in general medicine management met current best practice guidance. On Sandwich Bay Ward, staff ensured the two medicine trollies were locked when not in use and there were individual bedside drug lockers, which were kept locked. However, on the Cardiac Care Unit staff administered all medication from the treatment room. There was not a mobile medication trolley. This meant that the nurse in charge of each four-bedded bay prepared the medicine for their patients out of sight in the treatment room and brought the medicine across the unit to the patient. This increased the risk of drug errors rather than administering medication at the patient's bedside.
- We found that none of the medical wards routinely measured the ambient temperature of rooms where the

medications were stored. The majority of medicines have a maximum and minimum temperature, which they should be stored at; otherwise they may deteriorate more quickly or become ineffective.

Records

- We looked at a sample of records in each of the wards and units we inspected. We found that although both nursing and medical records provided a personalised record of each patients care and treatment there were gaps in the most of the records we reviewed.
- Medical notes were generally legible and completed in accordance with the General Medical Council guidance 'Keeping Records'. On St. Margarets Ward we found instances where staff had not signed the medical handover form and on Deal Ward we noted there was no indication as to the profession or seniority of the healthcare professional making the entry in the medical notes.
- The therapy documentation provided a clear assessment, plan of care and regularly updates. However, staff had not always completed the nursing records appropriately. For example on St Margarets Ward we looked at three sets of patient notes and found although staff had dated, timed and signed the entries, they had not added their designation. The paper-based records were not always in chronological order, which meant it was not always easy to find the most current entry. Staff had photocopied some of the forms so many times it affected the legibility of the document.
- The majority of records we reviewed had risk assessments such as falls, skin bundles and moving and handling in place. However, there were gaps where updates completed where indicated. For example, on St. Margarets Ward staff had completed one patient's skin care bundle for only three out of the past 11 days. On Deal ward Ward, several patients had not had their fluid charts completed or other risk assessments updated. This meant that patients may not have received the care they needed.
- We noted that staff had recorded allergies on medication records, but not always the patient's weight. This had implications for the amount of medication needed to be administered.
- Managers told us that regular nursing records audits took place. Staff told us a small sample of records were checked four times a year. We were later told that the audit team reviewed five sets of notes each week on each site. This was a small number in relation to the number of patients records completed each week. This meant there was inadequate oversight of the quality of record keeping.
- At the last inspection, we found records were not always stored securely. At this inspection, we noted an improvement in records management with records usually kept at the nursing station.
- We heard how there was easy access to GP records through a computer link.
- We noted that therapy notes were well documented and included in the doctor's medical notes.

Safeguarding

- The trust had a safeguarding vulnerable adults and children policy with guidelines readily available to staff on the intranet. We saw information on how to report safeguarding was available on the wards.
- There were safeguarding leads in the hospital that acted as a resource for staff and linked in with the trust's safeguarding team.
- All staff undertook safeguarding level one training at induction and had received appropriate information on identifying safeguarding concerns. However, not all staff who had regular contact with patients, their families, carers or the public had undertaken level two safeguarding training. To address this, in April 2016, the trust had introduced a half-day safeguarding course. This included the Mental Capacity Act, Deprivation of Liberty Safeguards, domestic abuse and Prevent (anti-radicalisation) training. The trust informed us that 54% of 2,309 identified staff had completed the required level two training, which meant they were below the national safeguarding training requirement of 85%. There was an action plan in place to improve this, with a review of safeguarding training needs across the trust.
- Staff we spoke with confirmed they had received level one safeguarding training as part of annual mandatory training. Staff were aware of the safeguarding policy and knew how to access it. They told us they would report their concerns to the nurse in charge and contact the safeguarding lead if needed.

- Staff gave examples of raising safeguarding alerts and confirmed the safeguarding team were on site for advice and support.

Mandatory training

- The trust had a mandatory training programme in place, which covered health and safety, manual handling, infection control, falls preventions and safeguarding children and young people.
- Staff on Sandwich Bay Ward told us that dementia training was mandatory; however, this was not the case on Birchington Ward, where staff told us they had not undertaken dementia training and relied on the dementia link nurses for support.
- The majority of mandatory training was undertaken electronically and staff now maintained individual electronic staff records. Managers and staff were able to access the staff records to monitor compliance. Staff told us there were issues with ensuring the electronic record was current and up to date but it generally was a better system.
- All staff including bank staff had access to on-line and face to face mandatory training. Managers could not verify that bank staff had undertaken their mandatory training updates as their training records were not held by the wards. All the staff we spoke with told us that accessing the annual mandatory training was not a problem although it was difficult to find the time.
- The integrated performance report stated that 87% of staff had completed their mandatory training by May 2016, which was slightly better than the trust target of 85%.

Assessing and responding to patient risk

- Staff recorded patient observations electronically. The results informed the deteriorating patient assessment. The hospital used the national early warning scoring system (EWS) to identify patients whose condition was deteriorating. We reviewed a sample of EWS observation charts across the wards we visited and found staff routinely used the charts and escalated patients appropriately.
- On the cardiac care and Sandwich Bay Ward, staff explained that although routine EWS scores were undertaken there was no specific score for escalation. This was because many of the patients with cardiac or respiratory disease had a high score even when stable. Staff told us they were always "Vigilant." The senior nurse carried a ward electronic tablet where the patients' observations were summarised. The information was used to inform ward rounds and the multidisciplinary care of the patients..
- The trust supported staff to identify deteriorating patients through the deteriorating patient programme. This group was overseen by the critical care steering group and monitored critical care outreach referrals, cardiac arrest data, electronic data recording and the mortality of ward patients admitted to intensive care beds. This information was analysed and had identified areas for improvement. The audits had identified that observations had improved with the electronic monitoring system. The trust had action plans in place to address the identified improvement work including patient handover information, raising staff awareness of the acutely ill patients, sepsis and acute kidney injury.
- Doctors supported staff on the wards when a patient's deterioration was sudden and resulted in an emergency. However, the response at night was slower because the doctors were so busy. Staff told us they felt well supported by the clinical outreach teams.
- There were individual risk assessments in all patient records we reviewed. These included assessing the risks of falling, pressure damage, nutrition and continence. However, not all were fully completed or updated appropriately.
- Venous Thromboembolism (VTE) was recorded as one of the trust's top five risks. Every patient should have a documented VTE risk assessment as part of nationally quality requirements. The latest data from July 2016 indicated that 85% of patients had a completed VTE risk assessment. This was worse than the national standard of 95%. The trust monitored individual consultant and divisional compliance monthly. The trust had an action plan in place to improve compliance. This included weekly consultant reports, including VTE compliance in consultants' appraisals, ensuring all patients leaving theatre or the clinical decision unit had been risk assessed and developing electronic support to remind practitioners and prompt appropriate actions to prevent VTE.

Medical care (including older people's care)

Nursing staffing

- Nurse staffing was a concern raised at the two previous inspections in 2014 and 2015. Staffing concerns across the medical services was included on the divisional risk register. There were actions in place to reduce the risk, however staffing remained a concern. Managers we spoke with told us they regularly conducted interviews for new staff. One manager told us they had seven interviews the following week with two staff appointed awaiting a start date.
- The trust had taken action to address the shortfall in staffing such as recruiting overseas nurses and implementing a retention plan. A recruitment and retention strategy was in place, which addressed staffing shortfall action. However, we found that although there was an increased staff headcount, there remained a large number of vacancies covered by agency staff.
- Staff reported that there was no problem in requesting agency nurses when needed however they were not always available. They told us it was more of a problem in finding cover for the day shifts as agency nurses preferred working at night. This led to shifts not being filled. On some wards such as Minster Ward this was a particular problem.
- The trust supported overseas nurses until they had adjusted to nursing in England. This included a period of supernumerary nursing, a mentorship programme and competency support. We spoke with overseas nurses who were full of praise for the support they had in learning basic English and adapting to the British nursing model of care.
- On medical wards staffing numbers have been increased and the trust monitors safe staffing levels. However, there was a lack clarity amongst staff about the acuity based tool (to assess appropriate staffing for the complexity of patients cared for) and leaves staff convinced that there is still insufficient staff on duty for many shifts.
- The most recent review in July 2016 reflected that there had been a substantial financial investment in staffing due to the escalation wards. The review reported a 78% uptake in newly qualified staff joining the trust and the positive impact of appointing the overseas nurses.
- The actual staffing versus planned staffing was reported monthly. The trust reported a 95% vacancy fill rate and concluded that ward-staffing levels were satisfactory overall.
- Staff told us that staffing levels remained the main challenge and although they had improved, the increasing acuity of the patients meant that it always felt short staffed. Staff told us that caring for patients who required constant supervision or were at risk of deteriorating meant they always felt under pressure.
- The ward used a three shift pattern, which meant there were periods of overlap which was used by staff to complete nursing records, administrative tasks and training.
- There was administrative staff available to support ward managers. Managers we spoke with valued this resource. They told us it helped a lot and enabled them to concentrate on their leadership and management roles.
- On Fordwich Ward, staff confirmed that over the past 18 months the staffing situation had improved. For example, agency mental health nurses provided one to one care for stroke patients who were living with dementia when required. They told us that since the start of this initiative, falls had reduced on the ward.
- On Sandwich Bay Ward, we were told there were no staffing shortages. The ward manager told us that although four trained staff had left over the past year they had filled the posts. There was regular bank staff working on the ward. They told us there were no funding issues and additional staff were provided when needed for the acuity of patients.
- On St Margaret's Ward, staff reported that staffing levels were good. We noted the ward had three unfunded beds which although allocated for winter pressure beds were now always in use. The ward had two vacancies that agency and bank staff covered. The ward manager told us there was good retention on the ward and student nurses wanted to come back to work on the ward.
- However, on Minster Ward, staff told us they rarely operated on the planned four qualified staff. Although a number of new staff were waiting to take up their post, because of delays in their professional registration, staffing the ward remained a significant challenge. Staff

told us that two or three times a week, less than the required four qualified staff were on duty. This was confirmed by the duty rotas and a number of incident entries on the electronic incident reporting system.

- On the Cardiac Care Unit, the staff reported no staffing problems. Although there were two nursing vacancies, agency and bank staff were covering the posts.
- Managers discussed any staffing shortfalls at the daily operational meetings. Managers reallocated staff working on wards with extra capacity to other clinical areas to provide support. Staff regularly reported staffing shortfalls on the electronic incident reporting system.
- Patients told us staff answered the call bells promptly, although they did wait longer at night. One patient told us that it would be better if there were more staff so they could spend more time with the patients rather than rushing from one patient to the next.

Medical staffing

- The trust had a lower percentage of consultants and junior grade medical staff (4% lower) and a higher percentage of registrars than the England average. For example, the medical staffing percentage for registrars was 48%, higher than the national average of 36%. Junior doctors made up 16% of medical staff compared to an England average of 21%. This meant the trust's medical workforce was more reliant on registrars and middle grade doctors than the national average.
- There were two junior medical teams on duty, a 'Hot' team and a 'Cold' team. The Hot team consisted of a registrar, two senior house officers and a junior doctor. This team covered the emergency take, the clinical decision unit and the cardiac care unit. The Cold team consisted of two registrars and two junior doctors who covered the medical wards. At weekends, the Cold Team provided the medical cover. On Minster Ward, staff told us the weekend cover varied, although they did not know why. The minimum cover was one registrar and one junior doctor.
- The medical staff told us that the registrar rota was onerous with frequent nights on duty. They told us that the appointment of acute consultant physicians had made a big difference. Three consultant chest physicians covered Sandwich Bay Ward. Staff told us there was no respiratory consultant cover at the weekends.
- The Health Care of Older People (HCOOP) consultants cared for the elderly patients over 75 years of age. The three HCOOP consultants visited their patients every day. HCOOP patients were allocated to one of the specialist care of the elderly wards, to another medical speciality or to an outlier ward in the hospital.
- Minster Ward was a gastroenterology (GI) ward, which had five consultants. A fifth consultant was due to start in October. A designated GI consultant visited the ward each day and conducted a full round of every patient on Tuesdays and Fridays. The GI registrar saw every GI patient daily.
- There was a designated cardiology consultant each week, who carried out a full ward round every weekday starting at 8am. Staff told us that the management of heart failure differed between the four consultants, which was confusing for staff. In order to address this, a single protocol was being used for patients undergoing procedures in the cardiac catheter laboratory. Staff told us there should be three cardiology registrars to cover the ward, the caterer laboratory and the clinics. However, one was on annual leave, one had left and one was an unsuitable locum who left after three days. There were two junior doctors. We spoke with one of the junior doctors who told us they felt well supported by the consultants and nursing staff.
- Lack of medical cover was included on the divisional risk register. We noted that the medical staffing risks on the division risk register provided for inspection dated back to 2013. There were actions in place to reduce the risk, however medical staffing remained a concern.
- Staff recorded lack of medical cover as incidents on the trust's electronic reporting system. For example, in July 2015, lack of medical cover at night was raised as an incident by the consultant as the lack of medical cover caused a significant amount of stress and potentially compromised effective patients care.
- Staff told us the trust was aware of the gaps on the medical consultant staffing rota and told us "reorganisation is being considered."

Medical care (including older people's care)

Major incident awareness and training

- The trust had business continuity plans in place, which included major incidents, emergency preparedness, cold and hot weather plans, pandemic influenza plans and the patient flow and escalation policy.
- The trust made staff aware of these through both electronic and paper means. The current policy was available on the trust's intranet with hard copies on the wards.
- The high risk of a major incident was included on the divisional risk register. The main risks included the number of high-risk locations such as the Channel Tunnel, docks, nuclear power station, airports and motorway network. The trust had reviewed the major incident plan and identified a number of actions to ensure the safe management of any incident. This included the management of support services such as switchboards and reception.
- The QEQM Hospital would be a primary trauma centre in the event of a major incident. This meant that any local major incident would have a direct impact on the day-to-day activities of the hospital. The medical wards and services would usually be involved in a major incident through admitting patients from other areas and specialities to free up trauma beds in other areas.
- We found the hospital consistently worked at capacity and bed availability was a constant problem and pressure across the medical services. This may have an adverse impact on the trust's ability to respond in a timely fashion to any major incident.

Are medical care services effective?

Good

We rated the hospital's medical services as good for effective because;

- We found medical care was evidence based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. Staff routinely measured the care delivered to ensure quality and adherence to national guidance and to improve quality and patient outcomes.
- The medical wards had clinical pathways in place for the care of a range of medical conditions based on current best practice guidance and legislation.
- Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists. We found that staff training was good, with ongoing training and development opportunities available.
- There were suitable arrangements in place to ensure that further training and development was available for staff to enable them to improve their skills and develop their competencies. The majority of staff we spoke with told us they felt well supported and encouraged to develop.
- Throughout the medical services, we found effective multidisciplinary working. Medical and nursing staff as well as support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- The hospital scored better than the England average for both elective re-admissions and non- elective readmissions across the majority of medical services.
- The hospital performed well in the sentinel stroke national audit programme (SSNAP) with a level A across most areas. The hospital had increased from level C to level A and had remained at level A for the previous six months.

However;

- The 2015 Lung Cancer Audit report indicated only 25% of these patients were seen by a specialist nurse against the national average of 80%. Although the other results were only slightly lower than the England average, the lack of specialist nurse support was a concern.
- In the 2013/14 Heart failure audit, the hospital performed worse than the England average for the majority of in hospital care measures and similar to the England average for discharge care measures. The percentage of patients referred for cardiology follow up at 11% was significantly worse than the England average (54%).
- We found that the trusts audit programme was stretched due to staffing vacancies. Several local audits had not been completed or action plans implemented.

- We found that the hospital was not yet offering a full seven-day service. Management had not addressed constraints regarding capacity and staffing. Consultants and support services such as therapies operated an on-call system over the weekend and out of hours. This limited the responsiveness and effectiveness of the service the hospital was able to offer.

At our last inspection, we rated the medical services as Requires improvement for effective. On this inspection we have maintained a rating of requires improvement but have seen improvements in updated policies and staff training and professional development.

Evidence-based care and treatment

- The emergency care and long-term conditions division used guidance and policies based on National Institute for Health and Care Excellence (NICE) and the Royal Colleges' best practice guidelines. New and updated guidance was evaluated and shared with staff. The trust had strengthened the methodology surrounding this process following a clinical incident in 2014.
- Staff were able to access national and local guidelines through the trust's intranet. This was readily available to all staff. Staff demonstrated how they could access the system to look for the current trust guidelines. We noted there were appropriate links in place to access national guidelines if needed.
- The standardised care pathways were based on current best practice and NICE guidance. For example, the acute heart failure pathway and stroke pathways incorporated NICE guidance.
- The trust routinely reviewed the effectiveness of care and treatment by using performance dashboards, local and national audits. Although there was a good programme of regular audit meetings, the audit programme was limited by vacancies in the Audit Department. The Clinical Audit & Effectiveness Committee documented in May 2016 that although national audits had the best completion rates, the overall audit completion rates were low. Management had revised the local audit schedule in order for staff to concentrate on successfully completing a smaller number of audits.
- The clinical audit summary report for 2015/16 identified that the medical specialties had been over ambitious with the number of audits to be undertaken during 2015/16. The report identified that staff were not always submitting action plans in a timely manner and that actions were not always implemented. The neurology specialty had not had an audit lead for the past six months. Fourteen audits were planned for the 2016/17 audit cycle. The audit programme had been reduced to enable staff to complete the program.
- The minutes from various departmental and divisional meetings showed that audit results were discussed and plans put in place to address any issues. For example, the minutes from the heart failure meeting in January 2016 documented that staff monitored and discussed the recent heart failure audit results.
- The trust participated in 27 of the 35 medical national clinical audit programmes. We reviewed a sample of local audits such as the venous thrombolysis (VTE) and nasogastric tube audits. The trust used audits to inform practice and improve the quality of care provided. For example, the trust set up a board level falls steering group with a multidisciplinary working group, following the National Falls Audit. All falls that resulted in moderate or severe harm or death had a critical incident review undertaken and were reported to the board through the quality and risk committees.

Pain relief

- The trust had a pain management policy in place that was available to staff on the trust's intranet.
- The care assessment charts included space for recording patients' perception of pain. Staff attended patients at set intervals during 'intentional rounding' to check if they were comfortable and assess pain. In the June 2016 Executive Performance report, the trust raised the issue of compatibility of the electronic devices when assessing pain.
- The trust had a specialist pain team available to support staff and staff knew how to contact them.
- The trust had a person centred pain tool in place for patients with communication difficulties. Staff used this tool when undertaking pain assessments for patients living with dementia, confusion, learning disabilities or stroke.

- Patients told us there was no problem with obtaining pain relief. One patient on St Margaret's Ward told us staff had managed their pain very well. They had been unable to swallow a tablet and staff had quickly arranged for a different kind of painkiller.

Nutrition and hydration

- The trust used a nationally recognised tool to assess patients' nutrition and hydration. We reviewed a sample of risk assessments on each of the wards we visited which included nutritional assessments.
- We found that in general, the nutritional risk assessments were documented on admission and additional support from the dietician service was available when needed. However, in the sample of 12 notes we reviewed, not all were updated appropriately and patients were not always weighed which affected the risk assessment score.
- Dieticians monitored patients who received nutrition through a nasogastric or parenteral feeding tube. They reviewed the patients' individual needs and wrote a plan of care. Dieticians reviewed the plan after three days and then weekly.
- The 2016 patient-led assessment of the care environment (PLACE) survey showed the trust scored 83%, which was worse than the England average (88%) for the quality of food.
- Staff provided patients with three main meals and snacks were available if needed. There was a choice of food available and the hospital was able to cater for specialist diets if required.

Patient outcomes

- Mortality and morbidity trends were monitored monthly through Summary Hospital-level Mortality Indicator (SHIMI). The SHMI score of 84.36 in March 2016 indicated that the trust had reduced the number of deaths from August 2015 when a rate of 91.14 was recorded. Over the past year, there had been a month-by-month improvement in the SHMI score. Reviews of mortality and morbidity took place at local, speciality and directorate level within a quality dashboard framework to highlight concerns and actions to resolve issues. We reviewed the minutes of the mortality and morbidity meetings and reviewed the presentations into the investigations to share learning.
- The hospital episode statistics (HES) covering the period February 2015 to January 2016 showed the overall standardised relative risk of readmission at QEQM Hospital was better than the England average.
- The hospital scored better than the England average for both elective re-admissions and non- elective readmissions across the majority of medical services. The outlier was geriatric medicine, which scored worse than the England average for elective readmissions.
- The Hospital performed well in the sentinel stroke national audit programme (SSNAP) with a level A across most areas. A is the highest and E the lowest level of attainment. The hospital increased from level C to level A and remained at level A for the previous six months.
- Although there was a common stroke care pathway across the trust, differences in SSNAP ratings between the three hospitals occurred because of different levels of therapist input. We noted at the QEQM Hospital, there was a good provision of speech and language therapists, physiotherapy and occupational therapists.
- In the 2013/14 Heart failure audit, QEQM Hospital performed worse than the England average for the majority of in hospital care measures and similar to the England average for discharge care measures. The percentage of patients referred for cardiology follow up at 11% was significantly worse than the England average (54%).
- The 2013/2014 National Heart failure audit data indicated less input from a consultant cardiologist although more input from other specialists. There was also a slight delay in inpatients receiving an echocardiogram. An echocardiogram is a sound measurement of the heart which produces an image used in diagnostic investigations.
- On discharge, more patients received ACEi, which is an important medicine for managing heart failure. but less received discharge planning or were referred to a heart failure liaison service than the England average.
- The Myocardial Ischaemia National Audit Project (MINAP) 2013/2014 scores at the hospital for the care of patients with non-ST elevation infarction (nSTEMI) were lower for two of the three measures compared the England average. However, the scores had improved

since the 2012/2013 audit and the number of nSTEMI patients admitted to a cardiac ward was higher than the England average. The data indicated that the non-STEMI angiography rate was low.

- Scores in the National Diabetes Inpatient Audit 2015 at the hospital were better than the England average for 13 of the 17 measures audited and worse for four of measures since the 2013 audit. This indicated an improvement in the diabetic services undertaken at the hospital.
- The 2015 Lung Cancer Audit showed the trust was below the level suggested for three of the four indicators for process, imaging and nursing measures. Staff reviewed 89% of these patients at a multidisciplinary team meeting compared with the national average of 94%. Sixty-two percent had a pathological diagnosis against the national average of 69%. The NSCLC NOS rate was 13.9% against the England average of 11% and only 25% of these patients were seen by a specialist nurse compared with the national average of 80%. Although the results were only slightly lower than the England average, the lack of specialist nurse support was a concern.
- The endoscopy suite was currently not Joint Advisory Group (JAG) accredited. JAG accreditation demonstrates that the endoscopy service has met nationally recognised endoscopy standards. The endoscopy manager told us that there were plans in place to achieve JAG accreditation by the end of the year. Staff explained the loss of JAG accreditation was due to waiting times. The lack of endoscopy capacity was included on the divisional risk register. The trust had plans in place to address this through the appointment of additional gastroenterologists and nurse endoscopists. These were due to start in October 2016.

Competent staff

- The trust had in place recruitment and employment policies and procedures together with job descriptions. Recruitment checks were made to ensure new staff were appropriately experienced, qualified, competent and suitable for the post.
- On-going checks took place to ensure continuing registration with professional bodies. Registered nurses we spoke with told us the trust supported them in preparing for revalidation. Revalidation is the process that all nurses and midwives need to go through in order to renew and maintain their registration with the nursing and midwifery council (NMC). Nurses and midwives must be registered with the NMC to legally practice in the UK.
- All new employees undertook both corporate and local induction with additional support and training when required. The staff we spoke with confirmed they had received an adequate induction.
- The trust recorded all training undertaken on a central electronic training record. Staff had the appropriate skills and training. Management regularly monitored competencies through clinical supervision and the staff appraisal process. Management identified learning and development needs during the appraisal process. The staff we spoke with all told us they had had an appraisal within the last year.
- Staff throughout the medical services told us of the additional training and development they undertook to improve their skills and develop their competencies. For example on Sandwich Bay Ward, all qualified staff had intermediate life support training and were able to carry out arterial blood sampling.
- A wide range of specialist nurses supported the nurses on the ward, for example, the dementia care team, palliative care team, safeguarding leads, diabetes care team and discharge co-ordinators. The link nurses attended regular link meetings and a study day to ensure they kept their practice current.
- The medical staff praised the nurses, especially the specialist nurses and nurse consultants. They told us they were "Brilliant" and a valuable asset to the team.
- Consultants participated with appraisals and there were systems in place to support their revalidation with the General Medical Council (GMC) registration.

Multidisciplinary working

- Throughout the medical services, we found effective multidisciplinary working. This included effective working relations with speciality doctors, nurses, therapists, specialist nurses, community services and GPs. Medical and nursing staff, and support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.

Medical care (including older people's care)

- We observed positive and proactive engagement between all members of the multidisciplinary team (MDT). We found that ward rounds were well organised and well attended by all members of the multidisciplinary team.
- Medical, nursing and therapy staff of all grades described good working relationships between staff and directorates.
- Each ward held a daily MDT board round. On Fordwich Ward, staff held an extra-long multidisciplinary meeting every Wednesday. This meeting involved all three consultants, the community stroke nurse, therapists and the early discharge team. Staff described this MDT meeting as a "Think tank" to explore all the options regarding a patients care and treatment.
- The wards used integrated patient records, which were shared by doctors, nurses and other healthcare professionals. This improved communication and meant that care was generally well co-ordinated between healthcare professionals.
- The lack of mental healthcare professionals was included on the divisional risk register. Although staff could access mental health support, their response was not timely due to lack of capacity. Mental health services were provided on a Kent wide basis by the local community mental health trust under a service level agreement.

Seven-day services

- Seven-day cover was not available for all of the support services such as psychiatric support, pharmacy and therapy services. Pharmacy services were only available until midday at weekends. Staff told us there was limited pharmacy support at weekends and this affected discharges.
- There was no access to dieticians or speech and language therapists (SALT) at weekends. This had an impact on the care of patients particularly on the stroke ward.
- The weekend and out of hours services were provided by on-call, agency or locum staff supplementing the permanent members of staff. Staff stated there were challenges related to capacity, staffing and the financial implications of providing additional seven-day services.
- General and specialist medical consultant cover was available every day including weekends, with on-call arrangements for out of hours and ad-hoc cover on bank holidays.
- The trust provided a seven day service for the stoke unit. There was a consultant vacancy in the stroke service. The trust told us that the current on call arrangements placed significant pressure on the individual consultant teams and was affecting recruitment.
- Diagnostic services were available throughout the seven-day period. Staff did not report any issues with obtaining diagnostic results out of hours. The exception to this was diagnostic ultrasound and echocardiograms. The trust was outsourcing this to ensure there were no delays in patients receiving a diagnosis and starting appropriate treatment.
- The discharge lounge was open between 8am and 8pm Monday to Friday. It was not open at weekends when patients were discharged direct from the wards.

Access to information

- The hospital used mainly paper-based records. This meant there were sometimes delays when sharing information between hospitals and with other providers who used electronic records and means of communication.
- In general, the ward staff told us there was prompt access to the results from medical tests. Clinical staff who told us they had access to diagnostic results such as blood results and imaging to support them to care safely for patients. Staff retrieved patients' old notes from the hospital archives when required immediately.
- There were safe systems in place to transfer information when a patient moved between wards or hospitals.
- Site managers and senior staff routinely collected site data to inform the management of the hospital and the trust as a whole.
- All the staff we spoke with told us there was good communication and access to information between staff and between medical specialities. We observed staff handovers at the nurses' station and noted that

staff shared all relevant information quickly and effectively. Therefore, staff ensured continuity of care and important medical information was shared safely and efficiently.

- Staff held ward and departmental meetings on a regular basis. The minutes from these meetings confirmed that information was shared including clinical updates and lessons learnt from incidents and complaints.
- We saw that staff used whiteboards to give all healthcare professionals quick and easy access to relevant information. On St. Margaret's Ward, we saw staff constantly updated the white board with each patient's consultant and discharge dates. Any patient that was living with dementia had a flower beside their name to indicate their diagnosis.
- We saw that most clinical information and guidance was available on the intranet. Staff also had access to information and guidance from specialist nurses, such as the diabetic, stoma and tissue viability nurses and the link nurses for dementia care, infection control and safeguarding.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- Training on consent, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) was available and staff reported there was no problem with accessing the training. This training was to be incorporated with level two safeguarding training in the future and staff allocated a half-day training day.
- Staff obtained consent for invasive procedures such as endoscopy investigations and patients undergoing cardiology procedures in the cardiac catheter laboratories.
- Across the medical division, we saw that staff had a good awareness of the legislation and best practice regarding consent, the mental capacity act and DoLS.

The staff we spoke with on Fordwich Ward were clear about their responsibilities in relation to gaining consent from people, including patients who lacked capacity to consent to their care and treatment.

- MCA and DoLS checklists were available to staff on the intranet together with a 'delirium pathway' checklist. The checklists promoted staff to discuss with the patients' families and indicated when best interest meetings should take place.
- The patients we spoke with confirmed that staff always asked for consent when undertaking even the simplest of tasks or treatments. We observed a consultant on Fordwich Ward asking a patient for consent to undertake a clinical examination and for permission to share medical information with their relatives. This demonstrated that staff had a good understanding of consent; both written and verbal consent where consent was implied.

Are medical care services caring?

Good

We rated the hospital's medical services as good for caring because;

- During the inspection, we observed staff treating patients with compassion and saw evidence that patients' needs were usually anticipated and being met.
- Staff treated patients with dignity and respect and had their care needs met by caring and compassionate staff. Staff worked hard to ensure that, even when staffing levels were challenging, this did not affect the care and treatment patients received.
- We received positive feedback from patients who had been cared for at the QEQM Hospital over the past few months. This was reflected in the Family and Friends feedback and patient survey results.
- Patients reported they were involved in decisions about their treatment and care. There was access to emotional and psychological support, including a number of specialist nurses who provided emotional support to patients and made referrals to external services for support if necessary.

Medical care (including older people's care)

At our last inspection, we rated medical services good for caring. On this inspection, we have maintained the rating of good.

Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. The average response rate for the QEQM (31%) was better than the England average (26%) for the most recent data from May 2016.
- We saw that Friends and Family information displayed on notice boards around the wards and departments. Each ward and department collected the feedback monthly and then displayed the information for staff, patients and visitors to view. The overwhelming feedback was positive across all the medical wards. Patients and their relatives praised staff for their kindness and consideration in looking after them or their relative.
- A score above 50 is considered a positive indication that patients would recommend the hospital to family and friends. We saw that across the medical services the feedback was consistently positive with between 90% and 100% of patients happy to recommend the hospital to their family and friends from April 2015 to May 2016. The highest scoring wards were Sandwich Bay and Fordwich Stroke Unit, which both scored 100%. The lowest scoring were the Clinical Decision Unit (90%) and the cardiac catheter suite (93%). All the wards scored well but some wards scored particularly well, for example he Fordwich Stroke Unit achieved a score of 100% for eight out of the 12 months between June 2015 and May 2016.
- Staff treated patients in a sensitive and considerate manner. We observed this during our inspection and patients confirmed that were always thoughtful in maintaining their dignity especially when they were being washed or undergoing a procedure. The patients we spoke with told us the nurses were all kind and helpful.

Understanding and involvement of patients and those close to them

- We spoke with patients receiving medical care on most of the wards and units we inspected. Staff explained care and treatment plans and patients advised us staff provided them with up to date information. Staff provided adequate information about a patient's treatment and explained the risks, benefits and alternatives.
- During the inspection, we observed staff members introducing themselves to patients and relatives and explaining any treatment they would be receiving. We observed a good rapport between the consultant and patients on Fordwich ward. We observed the consultant introducing themselves to the patient during the daily board round and discussed their treatment options with them in depth. The consultant gave the patient a good explanation of their results and proposed treatment plan. The nurses offered further support with information booklets.
- The Francis report was a report on the inquiry into the failings at Mid-Staffordshire NHS Foundation Trust. The report contained many recommendations for both public bodies and the NHS on keeping patients safe and improving patient care. The Francis report in 2014, recommended that every hospital patient should have the name of the consultant and nurse responsible for their care above their bed. The report recommended this to ensure that patients had a clinician with overall responsibility for their care and a nurse who was directly available to provide information about their care.
- Each ward displayed staff photographs at the entrance to bays so patients could see who would be treating them. The patients we spoke with could name their consultant and the nurses and healthcare assistants who were caring for them in accordance with the NICE QS15 statement three: which states "Patients are introduced to all healthcare professionals involved in their care." This demonstrated the hospital complied with the recommendations in the Francis Report.
- On Fordwich Ward, staff told us that relatives could book 15-minute slots with the nurses or medical staff every afternoon. They could also book a consultant slot to ask questions and discuss their relatives care. Staff gave each patient a welcome pack on arrival on the stroke unit, which helped to answer questions and gave relevant information.

Emotional support

Medical care (including older people's care)

- Clinical staff provided emotional support in the first instance. The hospital had arrangements in place to provide emotional support to patients and their families when needed, which included support from clinical nurse specialists, such as the end of life team, diabetes nurses, and dementia specialist nurses.
- Patients also had access to physiotherapists and occupational therapists that provided practical support and encouragement for patients with both acute and long-term conditions. Patients spoke highly of the therapy staff and told us of the help and support they received from them.
- We saw there were many different ways the staff provided emotional support to patients and their relatives throughout the hospital. Patients and their families had written to staff expressing their gratitude of outstanding care and staff had displayed the many thank you notes and cards.
- There was a hospital chaplaincy service, which provided spiritual, pastoral and religious support for patients, relatives, carers and staff. Chaplains were available 24 hours a day throughout the week and were contactable by staff, relatives or carers through the hospital switchboard.

Are medical care services responsive?

Good

We rated the hospital's medical services as good for responsive because;

- The trust had plans in place to ensure that medical services across the county were sustainable and fit for purpose. The trust was engaging with all stakeholders to implement the changes.
- Where the trust had identified delays to the patient pathway, actions were taken to address the issues; such as rapid access clinics, rapid discharge team, the integrated discharge team and outsourcing diagnostic investigations.
- The average length of stay for all elective and non-elective stays was better than the England average.
- Elective stays in general medicine, cardiology and geriatric medicine were better than the England average.
- Non-elective stays in general medicine, geriatric medicine and rheumatology were better than the England average of 6.1 days.
- There was good provision of care for those living with dementia and staff took patients different needs into account.

However;

- Although the hospital had improved the number of bed moves patients experienced during their stay, a fifth of all medical patients moved wards more than once during their stay. This meant the hospital transferred some patients several times before they had a bed on the right ward and this put additional pressures on the receiving wards.

At our last inspection, we rated the medical services as requires improvement for responsive however following improvements in key areas we now rate the service as Good. We have seen improvements in the number of bed moves patients experienced during their stay and the actions taken to address patient flow through the hospital.

Service planning and delivery to meet the needs of local people

- The East Kent Hospitals University NHS Foundation Trust provides services to the population of Kent. Patients were admitted to the medical wards at the QEQM Hospital through direct referral from their GP or through the emergency department.
- The trust was in the process of redesigning the clinical strategy for delivering medical care across the trust. This involved reorganising the acute medical model, implementing an acute frailty pathway, improving discharge pathways and reorganising the acute medical units.
- The trust was working with commissioning bodies, staff and other stakeholders to ensure the new strategy was fit for purpose. The trust acknowledged that staff shortages, bed capacity and an inconsistent discharge process was affecting the patient experience, service planning and delivery.
- The flow of patients through the hospital and delayed discharges remained a concern. This was a complex

issue and reliant on both internal and external factors, including intake through the emergency department, GP referrals and lack of suitable beds or funding for support in the community on discharge.

- The trust had established an integrated discharge team. Staff reported this was having a positive impact. Staff monitored discharge information through the weekly safer dashboard and the daily board rounds. Various initiatives to support safer discharges were in place and supported both internally and externally for example 'Discharge to Assess' and the implementation of 'Home First'. The trust was working with consultants, commissioners, community staff and the voluntary sector to improve safer effective discharge procedures across the trust.
- Consultants at the hospital praised the transient ischaemic attack (TIA) service and the Integrated Discharge Team (IDT). The TIA Service is a rapid access service for patients who have experienced a TIA or "Mini-stroke". The IDT team included a physiotherapist and an occupational therapist. Staff usually saw new patients on the day of referral. We heard how the stroke consultants ran daily TIA clinics, Monday to Friday on all three sites across the trust and on one site at weekends. The consultants told us these services provided an excellent effective service to patients.

Access and flow

- In the 12 months from March 2015 to February 2016, the trust had over 80,000 admissions to medical services. This was higher than the majority of trusts in England. The QEQM Hospital had 31,546 admissions. Over half of the admissions were general medicine with gerontology, cardiology and other specialities making up the remainder.
- The average length of stay at the QEQM Hospital for all elective stays at 2.6 days was better than the England average of 3.9 days. The average length of stay at the hospital for non-elective stays, 6.1 days, was better than the England average of 6.7 days.
- Elective stays in general medicine (3.4 days) was better than the England average of 4.0 days. The elective stay in cardiology (1.4 days) was better than the England average of 1.9 days. The average length of stay for geriatric medicine (2.7 days) was significantly better than the England average of 10.9 days
- Non-elective stays in general medicine (4.1 days) was better than the England average of 6.2 days. Non-elective stays in geriatric medicine (9.3 days) was better than the England average of 9.8 days. Non-elective stays in rheumatology (5.5 days) was better than the England average of 6.1 days.
- As set out in the NHS Operating Framework and NHS Constitution, patients have a right to start consultant-led treatment within a maximum of 18 weeks. The hospital's referral to treatment times within 18 weeks was below the 90% standard and England average for six of the eight specialties from June 2015 to May 2016. Cardiology scored well at 97% and rheumatology at 96.6% was only slightly below the England average at 97.2%.
- The trust acknowledged they were unable to achieve 92% compliance with the gastroenterology services due to capacity, workforce and the heavy reliance on locum staff. Gastroenterology is the branch of medicine, which deals with disorders of the stomach and intestines. .Although performance was improving, the referral to treatment times for gastroenterology services was 84%.
- The senior management team told us the trust looked at addressing some of the issues causing delays such as outsourcing electrocardiogram (ECG) reporting where there were six weeks delays. An electrocardiogram is a test that checks for problems with the electrical activity the heart.
- Other areas were delays in endoscopy, hysteroscopy and failure of the MRI scanner, which affected the urology prostate pathway. Staff used the electronic reporting system to report patients waiting over 100 days. These incidents were reviewed weekly. Managers shared the incident reports at the patient safety board and discussed the reports at the cancer board meetings.
- In February 2016, the trust conducted an investigation into the number of incidents where there was a failure to act or delay in treatment. The trust identified 42 incidents over a two-year period to February 2016. As part of the investigation, the trust was working to develop an alert system to flag those patients on a cancer pathway to ensure they received prompt investigations.

Medical care (including older people's care)

- Dedicated rapid access clinics were now in place to provide additional capacity. The clinics were consultant led supported by clinical nurse specialists. General managers reviewed the patient target lists weekly and at the monthly cancer board meetings.
- Each ward had an allocated pharmacist, however, the support available varied. On St Margaret's Ward, there was a good pharmacy service with the pharmacy communication book used daily. On the Cardiac Care Unit, there was limited pharmacy support. Staff told us "A technician visits weekly for any ordering and a pharmacist pops in if there are any problems."
- The rapid discharge team had an arrangement with a voluntary organisation to provide a service called 'Home and Settle', which was available from 10am to 10pm. The service provided minimal support such as help with shopping and ensuring the patient was comfortable and safe at home.
- The integrated discharge team consisted of therapists, discharge managers, social workers and administrative staff. The teams included staff from the local community trust, social services and the acute trust who worked together under an agreement. We spoke with the integrated discharge team at the hospital, who explained that although there were areas where the integration worked well there remained external barriers and challenges when making referrals. For example, lack of community placements for patients with complex needs who required a high level of care. The team worked 12 hours a day, seven days a week and supported staff with all discharges apart from paediatric.
- Staff told us that the daily board rounds had improved patient discharges as now all healthcare professionals were aware of each patients plan and what their responsibility was in making it happen. They told us that delayed discharges were now due to the lack of capacity in the community and the reduction in local rehabilitation beds.
- The hospital held three operational bed management meetings a day. Ward staff reported on the number of empty beds on their wards, expected admissions and discharges. The information then fed into the trust wide video conferences that were held three times a day to monitor bed capacity, discuss staffing, risks and escalation.
- Across the medical services, staff admitted patients to inappropriate beds because of the pressures on bed capacity. This meant on occasion, staff transferred outlier patients several times before they had a bed on the right ward. Outliers are patients who are admitted to wards outside of their speciality. On the day of our inspection there were thirteen outlier patients receiving care in areas outside of their speciality.
- We visited Birchington Ward, which was a 15-bedded ward for patients with gynaecological needs. On the day of our inspection, outlying medical patients occupied six of these beds. We spoke with staff who told us of the challenges of looking after medical patients on a predominantly surgical ward. This included the additional staffing resources needed for looking after frail, confused elderly patients. Staff told us of the difficulties in maintaining patient flow and gynaecological admissions when the medical patients had complex needs and could not be discharged. They told us because of this the gynaecology patients had their operations cancelled or had their surgery done in the day surgery or private hospital wing. Staff advised it was difficult to get consultant support for medical outliers and on weekends.
- Staff gave an example when nurses on the ward were called away to a gynaecology emergency and a medical patient with mental health needs had injured themselves. They told us how distressing this was for all the patients and staff involved. This demonstrated the challenges and difficulties in looking after outlier patients in environments that were not equipped or adapted for their specialist needs, with insufficient numbers of appropriately trained staff to care for them.
- The data on bed moves indicated that staff treated the majority of patients (77%) in the correct speciality bed for the entirety of their stay. This was a slight improvement on 2014/2015 when 76% of patients did not move wards. During the period June 2015 to May 2016, 13,791 patients out of 58776 patients experienced

one ward move or more. 9,555 (16) patients were moved once; 2735 (5%) patients were moved twice; 946 (2%) were moved three times and 555 (1%) were moved four or more times.

- We noted that staff recorded the anticipated discharge dates on the wards main communication whiteboard. This meant that all staff could work towards the planned discharge.
- The patients told us they had had their tests and investigations undertaken in a timely manner and had received the results.
- The QEQM Hospital's discharge lounge was open between 08.00 – 20.00hrs Monday to Friday. Staff had appropriately furnished the lounge with tables, chairs and a television. There was also a four bedded trolley bay. Food and drinks were available to patients waiting in the discharge lounge.

Meeting people's individual needs

- In order to meet patients' individual needs, each patient should be assessed on admission. Staff should then devise a plan of care to meet the assessed needs. However, we reviewed twelve sets of patient records across the medical services and found that that nursing assessment, repositioning charts, food charts and personal care round records were not always completed.
- The wards used a system of 'intentional rounding' to ensure that patients' basic needs were met. Nursing staff usually carried out the rounds at set times through the days.
- The trust employed specialist nurses to support the ward staff. This included dementia nurses and learning difficulty link nurses who provided support, training and had developed resource files for staff to reference. Wards also had 'champions' who acted as additional resources to promote best practice.
- The trust met the national target of screening over 90% of all patients aged over 75 years for dementia within 72 hours of admission.
- The trust provided additional support for patients with learning difficulties. The trusts website provided in depth guidance and information about the support available. This included pictorial aides and communication tools available for use with people with communication difficulties such as the healthcare passport, which was available to download.
- Staff modified the general environment to provide assistance for those with limited mobility. This included ramps, assisted bathrooms and lavatories, mobility aids and manual handling equipment. Staff told us that specialist equipment such as bariatric equipment or specialist pressure relieving mattresses were available on request. This meant that the hospital was able to care for patients with mobility difficulties.
- We spoke with patients about the catering service. Staff always served food hot and there was a good selection available. One patient told us "The food is smashing." Staff served hot drinks and snacks throughout the day and the nurses always served patients a hot drink before bedtime.
- Staff provided patients with red trays to identify those patients who needed assistance with feeding, without making it obvious to other patients and visitors. Staff noted eating and drinking requirements above patients' beds on a white board. We saw instructions such as "thickened fluids only", "nil by mouth" and "Red tray" to remind nursing and catering staff of the patients individual needs.
- Across the hospital, we saw that there were leaflets and useful information available to help patients and their relatives understand their conditions and the treatment options available. These were easily accessible and prominently displayed on most of the wards we inspected. However, printed information was only available in the English language. This meant there was little information readily available to support those whose first language was not English. According to the 2011 census Kent had a large population of over 63,000 people whose first language was not English. Staff told us that an interpreter service was available for those patients whose first language was not English.

Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas. Staff could also access the complaints policy on the trust's intranet.

Medical care (including older people's care)

- We saw information on raising complaints readily available on all the wards and departments we inspected with access to the Patient Advice and Liaison Service (PALS). Patients had access to PALS, who provided information about NHS services and supported patients to deal with concerns or complaints
- The senior nursing staff and managers told us that complaints were discussed at clinical governance meetings and information disseminated to staff through team meetings, briefings and the governance feedback bulletin 'Risky Business'. We reviewed a sample of governance meeting minutes and noted that staff monitored and discussed complaints.
- Staff were aware of the complaints process and knew how to direct patients to make a complaint. They told us that they usually received feedback from any complaint they had been involved in. Junior doctors told us they usually received feedback from any complaints.
- Patients told us they would raise any issues or concerns with the ward staff in the first instance, but they were aware of the formal complaints process.
- The management of complaints was included on the corporate risk register. The issues included an increase in the number of complaints, delays in response time, poor written responses and poor communication. The trust was investigating a web based complaints system to improve response times and communication between divisions and departments.
- Each speciality reviewed complaints in depth on a quarterly basis. The top three themes for complaints received were for delays, concerns about clinical management and problems with communication. The clinical governance minutes demonstrated that senior managers reported, investigated and learned from complaints at trust, division and speciality levels.
- Management produced a trust wide complaints newsletter for disseminating learning from complaints. The trust sent out the first issue in June 2015 and was attached to the trust newsletter. The newsletter contained the complaints and compliments data for the quarter for each division and included case studies identifying service improvements within the trust as a result of complaints.

Are medical care services well-led?

Good

We rated the hospital's medical services as good for well led because;

- The trust had a clear corporate vision and strategy, which engaged staff. Clinicians, staff and stakeholders were involved in the developing the strategy for medical services.
- There were clearly defined local and trust wide governance systems with well-established ward to board governance. The hospital had good cross directorate working, developing standard practices and promoting effective leadership.
- The managers acknowledged they were on an improvement journey and involved all staff in moving the action plan forward. Staff felt engaged with the direction of the trust and took pride in the progress they had made to date.
- Staff felt supported by their immediate managers. Front line staff noted and appreciated the visibility and engagement of the board and senior trust members.

However

- A number of issues identified at the previous inspection remained outstanding. Although the trust had action plans in place, issues such as medical staffing remained a concern.

At our last inspection, we rated the medical services as good for well led. On this inspection we have maintained a rating of good.

Vision and strategy for this service

- The hospital had well-documented and publicised vision and values. Their vision was to provide 'Great healthcare from great people', with the mission statement 'together we care: Improving health and lives'. These were readily available for staff, patients and the public on the trust's internet pages, posters around the hospitals and on the trust's internal intranet.
- Senior managers at the trust told us of the trust's "Improvement journey." All staff we spoke with from those on the wards to directors knew and understood the terminology "Improvement journey." They all

described an improving safety culture, better clinical leadership and governance. However, there remained challenges with bed capacity, patient flow and developing a sustainable clinical strategy.

- We inspected the trust in 2014 and 2015 and found that medical care services at the hospital required improvement. This was because we identified concerns with the environment, medical staffing and nursing staffing, support for patients with a deteriorating condition, the storage and management of medicines, record management and infection control procedures. Since the last inspection, the trust had a change of chief executive and support from outside agencies such as the NHS Improvement agency to implement a trust wide improvement plan.
- The improvement plan identified 30 actions. The hospital reported monthly on their progress against the action plan to all relevant stakeholders. Although there had been much reported progress, the trust acknowledged staffing remained a concern, which in turn affected the day-to-day activities and patient experience.
- We spoke with the Division of Medicine Directorate Management Team divisional leads. They told us of the new ideas and structural framework for the division. Staff had been involved in the design of the new structure, which was now 'bottom up rather than top down" as was the case previously. The strategic direction and strategy for the medical services across the trust was under review. The trust was working with the commissioning bodies, consultants and staff in order to develop a sustainable service for the future.
- The senior management team told us that the main challenges to the trust were working within the constraints of the environment and the impact of staff shortages. For example, staff shortages in the Audit Department affected the trust's ability to carry out clinical audit.
- The management team acknowledged the pressures of medical staff shortages. There were plans in place to address this through centralising some of the medical specialties. The trust was addressing the nurse staffing issues through an overseas recruitment drive and a recruitment and retention strategy overseen by the strategic workforce committee. Over the next year, the trust had offered positions to over 100 overseas nurses. There had been three nurse consultants recently been appointed in Acute Medicine.

Governance, risk management and quality measurement

- There were four divisions within the trusts governance mode. These included surgery, urgent and long-term conditions, clinical support services and specialist services. The majority of medical services were included in the urgent and long-term conditions division.
- Over the past year, the trust had introduced 'Triumvirate working'. This was a structure, which ensured that both clinicians and managers were involved in the management and planning of hospital activities at every level. The Triumvirate model usually consisted of a lead clinician, a senior nurse and a manager. Each of the triumvirate leadership teams had responsibility for designated wards and departments.
- The trust identified that the divisional structure had to work across all locations and specialities taking into consideration the unique factors of the individual hospitals but ensuring consistency across the trust. There were monthly trust wide clinical and quality assurance meetings together with a risk group to look at emerging issues.
- Ward and department governance meetings fed in to the divisions' safety and quality meetings. The divisional governance meetings reported to the executive safety and quality committee. We saw minutes of meetings where quality issues such as complaints, incidents, risks and audits were discussed.
- The Executive Team (ET) was the main committee for approval of trust policy and procedure, and for discussing and agreeing major strategic and policy decisions prior to approval by the Board of Directors. The trust board had commissioned a number of external reviews to assess the trusts progress and the effectiveness of the changes put in place. A report from July 2016 found that there was increased visibility of the senior managers and board; there was improved site management and safety, better staff engagement, stable divisional structures and strengthened leadership across the trust.

- The trust identified the five top risks, which were emergency care, staffing, clinical governance, planned care and finances. There were action plans in place to address the areas of concern and reduce the risks to patients and staff.
- We found there were corporate and divisional risk registers in place. Managers we spoke with were aware of the risk registers and knew the main risks and the actions needed to reduce the risks.
- A number of issues identified at the previous inspection remained outstanding. Although the trust had action plans in place, the issues such as medical staffing remained a concern.
- We reviewed the minutes of meetings, which demonstrated that regular team and management meetings took place. The minutes documented how information on incidents and complaints were investigated and any learning shared and good practice promoted.

Leadership of service

- Across the hospital, staff spoke of the visibility of the senior management team. They told us that the chief executive and chief nurse visited front line services on a daily basis. They told us they felt free to raise any issues with them direct or through their line manager. One band five nurse told us how impressed they were that the Chief Executive had recently visited their ward and had helped the staff. They told us in over seven years this was the first time that had happened. Another nurse on Fordwich Ward told us they had contacted the Chief Executive directly with some improvement ideas and he listened and took the suggestions forward. Staff told us this made them feel valued and that their opinions mattered.
- Across the medical services, local ward and department leadership was generally good. Staff told us they felt well supported, valued and that that their opinions counted. All the ward managers we spoke with knew what their wards were doing well and could clearly articulate the challenges and risks their ward faced in delivering good care.
- Staff told us everyone worked very closely together, from consultants to facilities management contractors. One member of staff told us "The whole culture has changed – it's a much better place to work now."
- Managers we spoke with were aware of the trust's improvement plan and their role in implementing it. There was a structure of daily site meetings, which occurred twice a day at the hospital. These fed into the trust wide video of conference call meetings, which occurred three times a day. Managers took issues that required escalating to the board through the various governance routes and the communicated the outcome back to teams.
- There were educational programmes designed to support and develop new leaders in the organisation. These included the nationally recognised Clinical Leadership Programme, the Aspiring Consultant Programme and the Medical Clinical Leadership Programme.
- Staff told us about the monthly open forums lead by the Chief Nurse where nursing issues could be discussed. The senior nurses we spoke with told us this was a useful initiative and they had adopted a similar approach on the wards. On Minster Ward, staff gave an example of improving the checks on CD registers by discussing at a ward meeting and finding a solution by agreement.

Culture within the service

- Following the last inspection the trust had initiated the "great place to work" initiate. The actions from this included the executive development programme, which was to start in October 2016, targeted interventions for the "respecting each other" campaign, the health and wellbeing group, embedding value based appraisals and medical engagement. The trust was auditing the engagement of clinicians during the inspection.
- We heard from all staff groups throughout the hospital that the trust was "On a journey." Staff were positive about working for the trust, and spoke with pride about how far the trust had come in such a short time. They told us they now felt valued and that their opinion mattered. Although they acknowledged there was still a lot of work to do they felt part of the plan to put things right. For example, staff remained under pressure to

deliver high quality care with an increasing workload and low staffing levels. The change in culture meant they now felt able to escalated the staffing issues and senior managers worked together to find solutions.

- The trust monitored workforce performance indicators in order to plan recruitment and monitor trends. The June 2016 staffing data indicated 11% vacancy rate, 10% turnover rate, 68% appraisal rate, sickness absence of 4% and mandatory training at 87%. This was similar to other NHS trusts. The staff survey action plan for the urgent care and long-term conditions division was working towards reducing sickness absence to 3.5%, improving the vacancy rate to 10%, the mandatory training and appraisal rates to 95%.
- Staff told us that the culture in the hospital was now inclusive and supportive. Management supported staff to undertake flexible working. We spoke with the integrated discharge team, which consisted of staff from external stakeholders. They told us that the trust was moving forward and felt "different now." They said it now felt "patient driven" and although there were challenges staff were talking and managers were listening.
- The hospital had raised the profile of appropriate behaviour through the implementation of a confidential report line and the introduction of the "Respecting each other" campaign. Staff told us since this campaign had started there were less incidents of bullying reported. Both nursing and medical staff told us the trust had addressed bullying and dignity in the workplace. They told us "Attitudes have definitely changed." Staff who felt bullied now could challenge that behaviour by making a complaint confident the trust would take action. Staff told us that bullying usually "Came from above – usually due to management pressures over bed availability."
- The June 2016 Family and Friends Test indicated that 80% of staff had never experienced bullying or harassment and the majority of staff felt confident in reporting such issues. Ninety six percent of staff were aware of the trust's anti bullying initiatives.

Public engagement

- The trust's website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and the public a wide range of information about the safety and governance of the hospital.
- The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch, feedback from the Friends and Family Test, inpatient surveys, complaints and the 'How Are We Doing?' initiative.
- The stroke services organised ward based patient groups run in conjunction with charitable organisations. Staff provided patients and their families with details on how to access support groups and information resources to help them understand and adjust to stroke and traumatic brain injuries.
- The "hello my name is …" initiative was widely practiced by staff, which we witnessed during our inspection. The initiative is aimed at raising staff awareness to ensure they always introduce themselves to patients. We saw the named nurse highlighted at the entrance to each bay on St Margaret's Ward. Patients confirmed that staff always introduced themselves before any treatment or therapy.

Staff engagement

- The management team discussed good ideas put forward by staff at weekly ward meetings and monthly team meetings. Each ward or departments held staff meetings, and/or issued newsletters to staff to keep them informed. Useful suggestions and good ideas were then passed on to the clinical and quality boards. All the staff we spoke with felt informed and involved with the day-to-day running of the service, and its strategic direction.
- The hospital conducted staff satisfaction surveys in line with national policy. The latest published survey results demonstrated an improvement in communication (up 12%), decision making (up 11%) and managers acting on feedback (up 13%). The trust recorded the highest staff engagement score for five years.

- The hospital recorded a positive staff friends and family test result with 57% of staff recommending the trust as a good place to work (up 8%) and 78% recommending the trust as a good place to receive treatment (up 4%).
- All staff we spoke with assured us they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested that the trust had an 'open culture' in which staff could raise concerns without fear.

Innovation, improvement and sustainability

- Across the medical directorate senior managers, directorate leads and front line staff told us that the trust had another two years of hard work ahead to improve the quality of care. All staff were aware of the term 'Improvement journey' and told us that there was little risk of slipping back because of the changes at both senior management and ward level.
- The Queen Elizabeth the Queen Mother hospital's (QEQM) Improvement and Innovation Hubs were now an established forum to give staff the opportunity to learn about and to contribute to the trust's improvement journey. The hubs were run by staff and provided topics of interest suggested by staff that could be accessed at any time the hub was open. The QEQM Hub was open every Friday between 12 to 3pm. Staff told us the hospital hubs were a good open forum where new ideas could be presented and discussed by those present.
- We saw the programme of events developed by staff to educate and support each other on the improvement journey. These included dementia, sepsis, and staff wellbeing. Staff developed a fortnightly newsletter to spread information resulting from the hubs activities. The staff we spoke with spoke highly of the value of this means of communication and the only drawback was there were sometimes insufficient resources on the ward to release staff to attend.
- Staff told us they felt valued and listened to. If they had an idea, they could raise it with their manager or a link nurse. One nurse told us about the awards that staff were given and how innovation and doing a good job was acknowledged and encouraged.

Maternity and gynaecology

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

Information about the service

The Queen Elizabeth The Queen Mother Hospital in Margate delivers approximately 2,800 births a year. It offers specialist obstetric care (pregnancy, childbirth, and the postpartum period) for women with complications and anaesthetists. The maternity and gynaecology service is made up of four wards or units.

St Peter's midwife led unit, is close to the 'traditional' labour ward. Midwives ran the unit, which encouraged and supported normal birth in a less clinical environment. The midwife led unit has four multifunctional rooms, two with pools, which is used for labour, delivery and postnatal care.

The labour ward is consultant led and had a maternity specific theatre.

Birchington ward has 19 inpatient beds for gynaecology and general gynaecology, a nurse led pre-assessment clinic for all elective admissions and a nurse led early pregnancy assessment unit. Clinical nurse specialists for gynaecology and uro-gynaecology are based on this ward.

Kingsgate ward provides a high-risk consultant-led antenatal (before birth) clinic included fetal medicine, day care, labour and in-patient postnatal (after birth) services.

There is also an antenatal and postnatal service co-located with the delivery suite.

We spoke with mothers and their families, midwives, the head and deputy head of maternity services, midwifery health care assistants, ward clerks, sisters, consultants, matrons and ward managers. We held focus groups for staff and received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection. We also reviewed the trust's performance data.

On our previous inspection, we found there was not enough staff to provide a safe service to women and their babies. Some of the environment did not facilitate safe care and some essential equipment was not always available. Staff focused on providing a caring experience for women and their babies but due to staff shortages and interim arrangements, a number of clinical guidelines, policies and patient information leaflets were out of date, some in excess of two years. Staff had not measured the effectiveness of specialist services. Some decisions taken at a senior level did not appear to relate to the experience of staff at a ward level. We found there was a disconnect between the strategy and the organisation in general and the maternity services at an operational level.

Maternity and gynaecology

Summary of findings

We rated this service as requires improvement because;

- Lack of staffing affected many areas of service planning and the care and treatment of women. This included not meeting national safe staffing guidelines, meaning 1 in 5 women did not receive 1:1 care in labour.
- The physical environment was not conducive to the safe care and treatment of women. The department was intolerably hot, with patients visibly struggling with the heat. The trust rated unworkable temperatures as 'low severity' when reported by staff.
- Hospital management did not ensure robust governance, for example, hospital data of the number of surgical abortions was incorrect as figures included women who had miscarried and had a surgical evacuation.
- On our previous inspection, we found there was an ingrained bullying culture within women's services. This had since improved, however, the trust focused on overall culture rather than tackle individual cases.

However;

- Staff provided a caring, empathetic environment for women during their pregnancy and labour.
- Care and treatment was evidence based and patient outcomes were in line with other trusts in England.

On this inspection we have maintained the rating as requires improvement from the last inspection

Are maternity and gynaecology services safe?

Requires improvement

At our last inspection, we rated the service as requires improvement for safe. On this inspection we have maintained a rating of requires improvement but have seen improvements in;

- Equipment availability, for example CTG machines.
- Secure storage of medicines.

However

- There were substantial and frequent staff shortages, which increased risks to women who used services.
- The physical environment was not conducive to safe treatment and care of women or staff, for example, the temperature on the wards.
- There was inadequate maintenance of medical devises.
- Mandatory training completion rates were below the trust target, except safeguarding.

Incidents

- Staff recorded all incidents on an internal electronic reporting system. Staff from all bands had good knowledge of how to use the reporting system and their responsibilities regarding the reporting of incidents. Staff showed us how they accessed it through the trusts intranet.
- We saw minutes of mortality and morbidity meetings for April, May and June 2016. There was evidence of multi-professional input to ensure protocol and standard setting in reviewing incidents. Incidents were reviewed including learning points and action plans in accordance with Royal College of Obstetricians and Gynaecologists 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' and 'Improving Patient Safety: Risk Management for Maternity and Gynaecology'. However, staff did not include action completion dates or a date when the effectiveness of changes were going to be audited. Some actions were vague, for example, for maternal

pyrexia (a fever, which is greater than or equal to 38°C) in labour, the learning point stated "Consider vagina disimpaction" with no information regarding changes to policy and procedures or staff training.

- There was one never event reported to Strategic Executive Information System at the Queen Elizabeth the Queen Mother Hospital between July 2015 and June 2016. NHS England describes a never event as "Serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers." The incident involved a retained product following procedure. Staff completed the investigation of the never event in line with NHS England 'Never Events Policy and Framework'.
- There were 186 trust wide serious incidents in women's services between July 2015 and June 2016. The trust investigated serious incidents in accordance with the 'Serious Incident Framework 2015'. Postpartum haemorrhage (PPH) greater than 1000ml (the loss of blood from the genital tract within 24 hours of birth) should be reported as a serious incident. However, the trust incident summary showed postpartum haemorrhage was reported when greater than 1500ml, not1000ml. Therefore, the trust may be under reporting PPH serious incidents as it was only monitoring the number of incidents over 1500ml when it should include those of 1000ml and over.
- We saw the trust incident summary from July 2015 to June 2016. The document did not allow the user to categorise the information, for example by ward, in order to monitor trends and themes. Therefore, senior members of staff would not easily be aware of recurring issues.
- Staff reported non-clinical incidents such as staff shortages on the computerised incident system. However, management did not always follow up non-clinical incidents. Staff advised us they did not know what happened to incident forms after reporting, but staffing levels had not improved.
- Staff provided examples where policy and practices had changed because of incidents. For example, monitoring of twins had improved after an incident involving cardiotocography (CTG) errors. CTG is the recording of a fetal heartbeat and the uterine contractions during pregnancy. After the incident, changes to procedure ensured a registrar or consultant reviewed all results. Staff had good knowledge of these changes.
- Staff told us governance around incident reporting had improved over the past year. Management shared feedback from reported incidents and learning during team meetings, ward meetings, email communications and the clinical governance newsletter 'Risky Business'. The hospital held regular risk meetings to discuss incidents and learning, however staff advised us they found it difficult to attend these due to lack of staff on the ward.
- We saw copies of the 'Risky Business' newsletter on staff notice boards giving details of learning from recent incidents. Staff spoke positively about 'Risky Business' telling us this was a good way to promote learning and they felt able to contribute to its content. Staff discussed learning from incidents at midwifery development days.
- Staff triggered a duty of candour notice when they entered certain criteria into the incident reporting system. Staff had good knowledge of duty of candour and knew their roles and responsibilities. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Duty of Candour aims to help patients receive accurate, truthful information from health providers. However, at the time of inspection, staff were unable to give us examples of where duty of candour was discharged.

Safety thermometer

- The NHS Safety Thermometer website states a safety thermometer "Allows teams to measure harm and the proportion of patients that are 'harm free' during their working day. For example, at shift handover or during ward rounds." The safety thermometer looks at four areas of harm; pressure ulcers, falls (with harm), urine infection (catheters) and venous thromboembolism. We saw safety thermometers were visible throughout women's services and showed harm free care was better than the England average.

Cleanliness, infection control and hygiene

- There were no cases of Clostridium Difficile on the maternity or gynaecology wards for the period April 2015 to March 2016, which was better than the national average.
- Staff treated patients in areas that were visibly clean and tidy.
- There were infection prevention and control policies and procedures in place that were readily available to view on the trust's intranet. Staff knew how to access these.
- Hand washing sinks were readily available with sanitising hand gel throughout all the locations we inspected. Disinfection wipes were available for cleaning hard surfaces in between patients. Staff cleaned and labelled equipment it to indicate it was clean and ready to use.
- Clinical and domestic waste bins were available and clearly marked for appropriate disposal.
- An outside contractor undertook the cleaning of the hospital. Staff ensured linen cupboards were fully stocked and kept tidy, the cleaning equipment was colour-coded and used appropriately. We saw cleaning rotas and cleaning checklists completed appropriately by the contracted cleaners and checked by a manager.
- Trust wide figures for women's services showed on average 76% of staff were up to date with their infection prevention and control training, which did not meet the trust target of 85%.
- Staff were aware of the principles of the prevention and control of infection. We observed staff regularly use hand gel on entering clinical areas and between patients. The 'bare below the elbows' policy was adhered to and personal protective equipment such as disposable gloves and aprons were readily available in all areas.

Environment and equipment

- The trust did not have adequate maintenance arrangements in place for the medical devices used in maternity and gynaecology. Trust figures showed 74% compliance (which was worse than the improvement plan target of 95%) with 358 complete and 125 outstanding. A business case was approved in July 16 to ensure that there is sufficient staffing to ensure compliance across the trust. Equipment had been risk stratified to ensure that high and medium risk equipment was prioritised. The Royal College of Obstetricians and Gynaecologists 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' states equipment must be maintained in good working order.
- The temperature in some areas of the department was very hot. A patient on the day care unit was visibly struggling with the heat in the treatment area. Staff reported the issue on the electronic reporting system stating "Temperature in the midwifery led unit office and corridor ranged between 30-32.5 degrees centigrade from 20:15 to 07:30. Fan inadequate and does not reduce temperature. There are four windows that have been faulty since our opening. Headache and signs of dehydration regularly experienced between staff. We regularly feel fatigued." The trust rated the incident as 'low severity' on the annual incident summary; however, staff reported some incidents as an issue with facilities and estates whilst others were recorded as staff wellbeing. Therefore, senior staff may not get an accurate portrayal of issues with temperature in the department.
- Each ward separately audited the patients' environment on a monthly basis. We saw the audit for Kingsgate ward at Queen Elizabeth the Queen Mother Hospital. Staff rated the environment red, amber or green dependent on disrepair. On the May 2016 audit, 28 out of 30 areas were rated green, none were rated amber and two were rated red. For the areas rated red, there was an action required, timescale for improvement and responsible person.
- Adult resuscitation equipment was available in both the obstetrics and gynaecology wards. Trolleys were fully equipped in accordance with guidelines and were checked and signed off daily.

Medicines

- At the last inspection, we found staff did not always safely store and manage medicines as several medicine cupboards and clinical fridges were unlocked. At this inspection, we found all medicine cupboards and fridges were locked and audit results showed good compliance with the hospitals medicines policies and procedures as well as the Nursing and Midwifery Council 'Standards for Medicine Management'.
- Staff clearly documented women's allergies on medical administration records and in patients' notes.
- Controlled drugs were checked twice daily by two members of staff and this was documented. Staff safely

checked and disposed of controlled drugs appropriately when not required. We saw an audit of controlled drugs from April 2016 that showed good staff compliance. The document included actions and recommendations; however, some of the recommendations were vague. For example, "All registrants must be reminded of the importance of taking the CD register to the bedside and of the importance of documenting administration in the notes to facilitate a high standard of communication with colleagues." However, the audit did not state how registrants would be reminded or allocate responsibility for the task.

- We saw policies and procedures for the administration of antibiotics, which were compliant with the National Institute for Health and Care Excellence (NICE) standards.
- Staff checked medicine fridge temperatures daily; however, we did not see ambient room temperatures recorded in areas where drugs were stored. Some areas of the maternity wards were very hot, for example, Kingsgate ward. When medication is stored over 25°C it can deteriorate, therefore there was a risk of the efficacy of medications being compromised.

Records

- We checked seven patient records and found them to be contemporaneous, legible, dated and signed and contained full clinical details in line with the Royal College of Physicians 'Standards for the clinical structure and content of patient records 2013'.
- Women's hand held maternity notes provided a complete record of antenatal (pre-birth) test results in accordance with NICE guidelines.
- Staff completed risk assessments for patients, which detailed next steps as well as any further actions taken if needed. Where intervention was required, records clearly stated when follow up was required.
- Women's health records were stored securely away from areas where members of the public could easily access.

Safeguarding

- The trust had separate safeguarding vulnerable adults and children policies, which adhered to statutory guidance such as 'Working together to safeguard children 2015'. The guidelines were readily available on the hospital intranet and staff showed us how to access information.
- The midwifery department had a safeguarding lead who acted as a resource for staff and linked in with the trust's safeguarding team.
- All midwives were trained to level 3 in safeguarding children, which met standards set by the Intercollegiate Document 2014.
- The family nurse partnership supported families identified as vulnerable and made regular contact with families for two years after birth to support with issues and problems.
- There was a trust wide safeguarding children team, which was available Monday to Friday from 9am to 5pm. The team enabled staff to have direct access to information and support if they had a concern about a child or family. Staff we spoke with knew how to access this service.
- Midwives assessed social vulnerability when women were initially booked into clinic. Staff requested extra information from a woman's GP or social services if deemed necessary. Midwives gave women information about relevant support services, (for example about substance abuse, sexual abuse or a violent partner).
- Safeguarding training was included in the trust's mandatory training programme. Staff completion rates for safeguarding training were better than the trust target of 85% for level 1 training. However, the trust sent us their training action plan, which showed the number of clinical staff requiring level 2 training was 2,309, however only 54% of staff had completed their level 2 training. This was 31% worse than the trust target.
- Female genital mutilation (FGM) was included as part of mandatory safeguarding training. All staff we spoke with knew the correct procedures for escalating concerns as well as their responsibilities in accordance with 'FGM mandatory reporting in healthcare 2015'.

Mandatory training

- Mandatory training was a combination of e-learning and practical sessions. Trust figures for practical training were 57% for moving and handling and 82% for Hospital Life Support practical as of August 2016. Adult resuscitation figures were organised by site with the Queen Elizabeth the Queen Mother Hospital achieving 84%, all of which were below the trust target of 85%. We did not see plans to improve this figure.
- Staff received protected time to complete mandatory training. Staff were allocated 3 days a year to complete

practical mandatory training, which included safeguarding and obstetric emergencies. Management discussed mandatory training completion rates during appraisal.

- The Royal College of Midwives describes skills drills as "The accepted format by which healthcare professionals gain and maintain the skills to manage a range of obstetric emergencies." At the Queen Elizabeth the Queen Mother Hospital, the number of midwives up to date with their skill drills was 81%, this was lower than the trust target of 85%. The figure varied from ward to ward with St Peter's MLU achieving the highest percentage of staff with 90% as of 25 August 2016. However, doctor attendance of skills drills was low with 26%.

Assessing and responding to patient risk

- The trust did not meet the Venous Thromboembolism NICE risk assessment targets from June 2015 to May 2016. Therefore, patients were potentially at risk that deep vein thrombosis and blood clots would not be recognised and treated.
- Venous Thromboembolism data was not included on the maternity dashboard, which is a NICE requirement due to maternal deaths. Therefore, the trust was not meeting this standard.
- 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK 2015' states fetal growth must be regularly monitored by measuring the symphysis fundal height (a measure of the size of the uterus used to assess fetal growth and development during pregnancy). Records showed measurements were taken; we also saw the escalation pathway for abnormal findings.
- Staff on Kingsgate ward informed women of the importance of monitoring fetal movement as a method of fetal surveillance, in line with the Royal College of Obstetricians and Gynaecologists. We saw records that corroborated this.
- The hospitals surgical policies complied with the World Health Organisations Surgical Safety Checklist. It is a tool for relevant clinical teams to improve the safety of surgery by reducing deaths and complications. We saw an audit of the checklist, which showed full compliance.
- An early warning score (EWS) is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the six cardinal vital signs (Respiratory rate, Oxygen saturation, Temperature, Blood pressure, Heart rate and Responsiveness). Staff used the EWS system to continually assess women admitted acutely, which was audited to ensure compliance.
- Obstetricians were involved in multidisciplinary discussions regarding emergency caesarean sections in accordance with the Royal College of Obstetricians and Gynaecologists 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour'.
- We saw completed risk assessments for raised Body Mass Index (a person's weight in kilograms divided by his or her height in meters squared. The National Institutes of Health defines normal weight, overweight and obesity according to BMI rather than the traditional height/weight charts), gestational diabetes (diabetes during pregnancy), smoking and pre-eclampsia (a disorder of pregnancy characterized by high blood pressure and a large amount of protein in the urine) in accordance with National Institute for Health and Care Excellence guidelines.

Midwifery staffing

- Lack of staffing was recorded as an incident. We saw a summary of all incidents at the trust between July 2015 and June 2016. The trust allocated incidents a severity rating; high, moderate, low or none. All incidents relating to staffing were given a severity rating of 'none'. The National Patient Safety Agency (2004) defines severity as: "No harm; Impact prevented (Near Miss) – Any incident that had the potential to cause harm but was prevented, resulting in no harm. Impact not prevented – Any incident that ran to completion but no harm occurred." However, lack of staffing occurred regularly, therefore, the trust may be underestimating the impact staffing issues had on the daily activity of the department. There was no easy way of categorising the information to find trends. However, we looked at the information and found Kingsgate ward had recorded staffing issues once, the Labour ward 4 times, Birchington ward 4 times, Antenatal 3 times and St Peter's once. However, some staffing issues had been categorised as 'staff wellbeing' others 'staffing level difficulties'. This made it difficult to analyse the information.
- The Royal College of Midwives Birthrate Plus is a midwife specific, national tool that provides insight to model midwifery numbers, skill mix and deployment. The Birthrate Plus Report showed women's services

were 22 Whole Time Equivalent (WTE) staff short. However, in addition to this, 13 staff were in post but had not started at the hospital, 11.5 were on maternity leave and there were 4.5 vacancies. Therefore, not including sickness the hospital was actually 29.5 WTE short at the time of inspection.

- The NICE required staffing ratio was 1:28. For the entire service, staffing establishment was a ratio of 1:30; however, the actual ratio was 1:32. Therefore, the trust was not meeting this target.
- The Royal College of Midwives 'Evidence Based Guidelines for Midwifery-Led Care in Labour Supporting Women in Labour' states all women should receive 1:1 care during labour. The trust was not meeting this ratio with 1 in 5 women not having access to 1:1 care during labour due to staffing levels.
- The trust conducted a Quality Standard of Intrapartum Care in December 2015, which showed maternity staffing in providing 1:1 care in labour was an area of non-compliance. In response to this, the trust were recruiting; there was increased sickness management and employment of agency staff and implementation of Birthrate Plus findings. However, staff in all areas of women's services said they were overworked and that activity had dramatically increased. Staff were unable to confirm whether the increased activity was being audited.

Medical staffing

- There was consultant anaesthetist cover for the obstetric unit from Monday to Friday, with weekends covered by an emergency on call rota, which was in accordance with Association of Anaesthetists of Great Britain & Ireland 'Guidelines for Obstetric Anaesthetic Services 2013'.
- The hospital provided 60 hours of consultant cover a week, which is in line with Royal College of Obstetricians and Gynaecologists 'The Future Workforce in Obstetrics and Gynaecology'. However, we found this included cover for maternity, obstetrics and gynaecology, which may not be sufficient during busy periods. It is best practice to cover one of these areas, rather than provide cover for all three at the same time.
- Medical staffing skill mix showed the trust had a slightly higher percentage of junior grade staff when compared to the England average. However, the percentage of consultants was lower than the England average.
- Staffing numbers were publicly displayed in all inpatient areas in line with NHS England's 'Hard Truths' guidelines.
- We saw consultants complete two daily ward rounds in accordance with Royal College of Obstetricians and Gynaecologists 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour'.

Major incident awareness and training

- The hospital was located in an area with several high profile locations where major incidents may occur such as the ports, international rail links, Channel Tunnel and airports.
- The trust had a major incident policy and plan, which had robust measures in place to deal with major incidents and maintain public safety. The policy was available on the trust intranet and staff knew how to access it.

Are maternity and gynaecology services effective?

Good

At our last inspection, we rated the service as requires improvement for effective. However following improvements in key areas we now rate the service as good because;

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Outcomes for women who use services met expectations. For example, readmission rates and third and fourth degree tears.
- There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking, peer review and service accreditation.
- Staff and patients had access to information they needed to assess, plan and deliver care in a timely way.

However;

- Appraisal completion rates were below the trust target.
- Understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards was poor.

Evidence-based care and treatment

- There was a robust audit programme for obstetrics and gynaecology which showed patient outcomes were in line with national standards. Audits were based on recognised national guidance including the National Institute for Health and Care Excellence (NICE), Royal College of Obstetricians and Gynaecologists 'Safer Childbirth: minimum standards for the organisation and delivery of care in labour'. Audits included; Management of women with anovulation, Maternal new-born and infant clinical outcome review programme and fetal abnormality.
- Staff completed assessments that identified risks. For example, staff tested glucose tolerance for women presenting with symptoms of gestational diabetes, for example increased thirst. This was in accordance with NICE and 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK' guidelines.
- The trust completed an audit of the British Association of Perinatal Medicine New-born Early Warning Trigger and Track Tool. The audit included an action plan for improvement. However, staff had not included a time scale changes would be implemented by, or a date for re-audit.
- An obstetrician audit for 2015 showed the trust was meeting 8 out of 9 standards. The one standard not being met was the 100% post-anaesthetic follow-up rate was standing at 84%. We did not see an action plan to improve this figure.
- Staff were able to access national guidelines through the trust's intranet, which was readily available to all staff. Staff demonstrated accessing the system and showed the system contained current guidelines.

Pain relief

- Staff advised us there were no issues in obtaining pain relief or other medication for women. All women we spoke with told us pain relief was effective and given when requested.
- Staff in Kingsgate ward provided women with information regarding the availability and provision of different types of analgesia and anaesthesia in accordance with Association of Anaesthetists of Great Britain & Ireland guidelines.
- St Peter's had a patient group directive (PGD) in place. This is a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor. The PGD enabled staff to be responsive to women's pain relief and provide women with, for example, gas and air when required, rather than wait for a doctor from the labour ward to administer.
- Women in labour on the midwife led unit had access to gas and air and pethidine as pain relief. Pethidine is a morphine-like opioid. Staff transferred women requiring an epidural to the labour ward. However, at the time of inspection, the trust did not monitor average wait times for epidural. The Association of Anaesthetists of Great Britain & Ireland states the time from the anaesthetists being informed that a woman has requested an epidural to the time the epidural is performed should not exceed 30 minutes and should only exceed 1 hour in exceptional circumstances. Therefore, the trust was not monitoring whether or not it was meeting this target.
- Policies and procedures were in line with the Faculty of Pain Medicine's Core Standards for Pain Management 2015 standards.

Nutrition and hydration

- The trust performed an audit of staff understanding of the nil by mouth policy prior to elective surgery in March and April 2016. It found that senior staff had a better understanding and knowledge of guidelines. Because of the audit, staff put up information posters on wards. Staff planned to re-audit to check for improved understanding. However, at the time of inspection we did not have the re-audit results.
- Throughout the department we saw information leaflets about breastfeeding including; expressing techniques, information sheets for issues such as 'My baby won't breastfeed' and details for local breastfeeding support groups.
- Two infant feeding specialists with backgrounds in lactation support provided assistance for women across the trust. They felt women required further support as when they started, there were seven infant feeding specialists across the trust.
- Staff supported women to breastfeed their child and provided women with information regarding community initiatives.
- Staff on the delivery suite provided women with snacks and lunch boxes, which supported women's energy levels during labour.

Patient outcomes

- Readmission rates at the trust were better than the national average for women's services for the year June 2015 to May 2016.
- The trust's total caesarean rates including both elective and emergency caesareans were similar to other trusts this size for January to December 2015. However, the numbers had recently increased. The trust was not able to provide us with information regarding the reasoning for this.
- The number of third and fourth degree tears and the still birth rate reported at the hospital was very low compared to other hospitals of this size.
- As of 27 July 2016 there were no maternity outliers reported. Therefore, women were being treated on appropriate wards.
- Unexpected admissions to the Neonatal Intensive Care Unit were better than the national average and had improved over the period August 2015 to July 2016. This was due to improved recording and a new maternity system.
- However, the Queen Elizabeth the Queen Mother Hospital did not meet 3 out of 5 indicators in the National Neonatal Audit Programme 2015. The two indicators they met were for temperature at birth and retinopathy of prematurity screening. A pathologic process that occurs only in immature retinal tissue and can progress to a tractional retinal detachment, which can result in functional or complete blindness.
- For the period July 2015 to June 2016, unplanned maternal admission to the ITU was slightly worse than the England National Quality Standards.
- Hospital Episode Statistics showed, for the period January to December 2015, the trust was 'similar to expected' for both elective and emergency caesareans.
- Other delivery methods such as breech (a delivery of a baby which is so positioned in the womb that the buttocks or feet are delivered first) and ventouse (suction cup used to assist delivery of babies head), were in line with England averages. Low forceps cephalic delivery was better than the England average and other forceps delivery was worse than the England average.

Competent staff

- Staff appraisal completion rates were 78% at the Queen Elizabeth the Queen Mother Hospital. This was worse than the trust target of 85%. Therefore, potentially management may not identify staff learning needs, or be able to support staff to maintain and further develop their professional skills and experience.
- The annual review of supervisors of midwives followed recognised guidance such as Local Supervising Authority Midwifery Officers Forum UK 'Policies for the statutory supervision of midwives'.
- Management supported staff during revalidation. We saw a revalidation folder, which provided guidance on writing a reflective account and practice related feedback.
- Specialist midwives were available to support patients and act as a resource for staff. These included specialists in screening, fetal medicine, teenage pregnancy, bereavement and the care of vulnerable women. There were lead midwives for health and safety, infection control and catheter care.
- On the day care unit, at the time of inspection, four nurses were training for third trimester scan competency. Staff identified this was an area they could take responsibility for and free consultants to complete other tasks.

Multidisciplinary working

- Community midwives met regularly with hospital midwives to provide continuity of care for patients. Women we spoke with said community midwives had up to date information regarding themselves and their babies. However, we saw details of an incident where a community midwife attended a patient who had miscarried 4 weeks prior to the appointment.
- We observed staff on the labour ward respond to an emergency buzzer. Staff responded to the call immediately with housekeepers clearing equipment out of the way. Staff were quick to respond and worked well as a team to send a call out to the theatre to advise them of the imminent arrival of the woman. Staff covered the entrance of the room with a screen so passers-by could not see into the room, which protected the woman's dignity.
- Staff advised us there was good communication between medical and midwifery staff. We saw evidence of this during handover and ward rounds where medical and midwifery staff supported and offered help to one another.
- The trust incident summary form for July 2015 to June 2016 showed 17 incidents at the Queen Elizabeth the

Queen Mother Hospital involved poor communication, usually between staff. Patients advised us there was poor communication between staff and information was not passed on effectively. For example, one full term patient who was having her baby at the hospital midwife led unit had not yet received a tour of the ward. She said this was because different wards did not communicate with each other and that had been a problem throughout her pregnancy.

- Staff within the maternity services worked flexibly between the midwife-led unit and the labour ward. Community midwives offered cover, although there was no formal rotation.

Seven-day services

- The labour ward, Birchington ward and St Peter's midwife led unit were open 24 hours a day, seven days a week.
- The day care unit was open from 8am to 8pm, seven days a week with a fetal medicine nurse available at the clinic from Monday to Friday.
- Inpatients had seven day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and pathology in accordance with 'NHS Services, seven days and week priority clinical standard 5'.
- Obstetricians provided cover on the delivery suite 7 days a week from 8am to 6pm.

Access to information

- Staff were able to access national guidelines through the trust's intranet, which was readily available to all staff. Midwifery staff demonstrated accessing the system to look for the current trust guidelines.
- At our previous inspection, we found guidelines were out of date, during this inspection, all guidelines we saw were in date and plans were in place to ensure they remained so. However, we found the trust system for dating guidelines was unclear, showing a review date rather than an expiry date. In addition, the date on the front of the document was not the review date; this was shown several pages in. Therefore, the trust system made it harder for staff to keep track of out of date guidelines.
- The trust had introduced the use of electronic tablets, which showed patient early warning scores. All staff we spoke with said it was a valuable initiative as it was accessible, ensured staff were working with the most up to date information, provided a prompt when observations were needed and supported effective handover as information was documented in one place rather than various folders and records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust consent policy was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details of the Mental Capacity Act 2005 and checklists.
- Consent, MCA and Deprivation of Liberty Safeguards (DOLS), were all part of mandatory training. MCA and DOLS came under the umbrella of safeguarding training.
- Staff on Birchington ward showed us the patient consent form. It showed details of the proposed procedure using non-jargon language, benefits and risks, any other procedures that may be required and space for an interpreter/patient to sign to confirm understanding.
- Staff told us the community midwife completed the consent paperwork for antenatal screening at the woman's first booking appointment. We saw copies of signed consent forms in seven records we looked at.
- Staff understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards varied depending on banding, with higher banding having greater insight. More than one staff member advised us that as community midwives completed consent paperwork, they did not have "Much to do" with consent and capacity. However, section 42 of the Mental Capacity Act states "It is the duty of a person to have regard to any relevant code if he is acting in relation to a person who lacks capacity and is doing so in a professional capacity." Therefore, not all staff had regard for the code, as they were unaware of their duties and responsibilities in their professional capacity.

Are maternity and gynaecology services caring?

Good

At our last inspection, we rated the service as good. On this inspection we have maintained a rating of good because;

- Overall, staff treated women with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.
- Staff kept women informed and made them partners in their health care decisions.
- Staff helped women and those close to them to cope emotionally with their care and treatment.

Compassionate care

- The 2015 survey of women's experiences of maternity services showed the trust was rated the same as other trusts for patients feeling they were treated with kindness and understanding by staff after the birth, with patients rating the trust 8.2/10.
- The hospital was in line with the England average for Friends and Family Test results for women recommending the hospitals antenatal care, post-natal care and as a place to give birth.
- Women received care that promoted respect and dignity at all times. Staff knocked on doors and waited for an answer before entering. However, a patient on the day care ward advised us they dreaded arriving for a clinic when they knew certain members of staff were on shift as they were abrupt.
- Women we spoke with reported positive experiences on Birchington ward. One patient said, “They could not have done any more for me. When I wanted to give up, the nurses came and sat with me and gave me all the time I needed.”
- Overall women, their partners and families stated they would recommend the service at the hospital.

Understanding and involvement of patients and those close to them

- Staff provided women with information that was clear and free from medical jargon. However, some women we spoke with reported feeling un-listened to by consultants and registrars. One woman reported she felt pressurised by a registrar to have a membrane sweep (a method of inducing labour) when she did not feel ready.
- Staff made partners feel very welcome and were involved in all aspects of care planning.

Emotional support

- Women had a named midwife and consultant responsible for their care. This enabled women to build a rapport with staff. Women said this empowered them to feel more able to ask questions and raise issues of concern. Of the women we spoke with, all of them knew the name of their consultant. We also saw a consultant greet their patients by first name.
- There was a chapel on the hospital grounds, which was available to patients, families and staff. There was also a 24-hour chaplaincy service that provided emotional support at any time of day or night. We saw the chaplaincy was well advertised and leaflets clearly stated the service was available for everyone, not just people who identified with a religion.
- Women and families experiencing bereavement had access to a free in-house counselling service, which passed on details of community support and initiatives.

Are maternity and gynaecology services responsive?

Requires improvement

At our last inspection we rated the service as Requires improvement. On this inspection we have maintained a rating of requires improvement because;

- Services did not always meet people’s needs, for example, women had to divert to another hospital on 22 dates between January 2015 and June 2016. Also, the trust did not monitor the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour.
- Staff did not deliver services in a way that focused on women’s holistic needs, for example, patients experiencing fertility issues were seated in the same area as women in late pregnancy.

However;

- The number of women being assisted and educated in the benefits of skin-to-skin contact and kangaroo care had improved. The trust had achieved level 1 in the BFI Baby Friendly Hospital Initiative and at the time of inspection were working towards level 2.

Service planning and delivery to meet the needs of local people

- The trust dashboard showed there had been no unit closures from August 2015 to July 2016. However, the trust also provided us with data showing the maternity

unit at the Queen Elizabeth the Queen Mother Hospital had closed 22 times between January 2015 and June 2016. Senior management stated there were no 'closures' of the service and the data mentioned refers to 'diverts' which have happened between the units at William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital. These were noted separately on the trust dashboard. Therefore, the trust could not provide assurance it was recording accurate data regarding service planning.

- There were early pregnancy units and day surgery for gynaecology patients at the Kent and Canterbury Hospital, the William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital. Therefore, there was good access to services across the trust for women in early pregnancy who presented with gynaecology issues.
- Discharge forms included a checklist to ensure personal child health records or 'red books' (a national standard health and development record given to parents/carers at a child's birth) were completed, neonatal checks had been completed or had been arranged and information leaflets explained, provided and documented. There was also a section which signposted staff to send copies of the discharge to health visitors and GPs, which staff signed and dated when completed.

Access and flow

- Since January 2015, eight clinical areas including gynaecology piloted the Draft Registered Practitioner Led Discharge (RPLD) Policy. The policy enabled trained and competent Registered Practitioner staff to identify patients ready for discharge and complete their Electronic Discharge Notification. Since the implementation of the policy, staff advised they could see the discharge process was more effective. However, figures were not available to show an improvement.
- The trust did not monitor the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour. The National Institute for Health and Care Excellence states analysing a delay of 30 minutes or more between presentation and triage is a method of monitoring a midwifery red flag event. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. As the trust did not monitor this, there was a greater risk management would be unaware of these issues.
- If there was an obstetric theatre conflict, staff requested assistance from main theatres for theatre space. Main theatres were able to supply a theatre team. There were plans for a second obstetric theatre to be available at William Harvey Hospital from January 2017. Once established, the Clinical Lead for Obstetrics and Gynaecology wanted to replicate the William Harvey model at the Queen Elizabeth the Queen Mother site. At the time of inspection this was in negotiation with the theatre team.
- The trust's bed occupancy levels were worse than the England average. In quarter 4 of 2015/2016, the trust had an occupancy rate of 73% compared to the England average of 60%.
- Staff on labour ward had identified a need for further training in NHS Newborn and Infant Physical Examination Programme (NIPE) to prevent prolonged discharge times. This is an examination of a child shortly after birth. The examination includes a general physical check as well as an examination of the baby's eyes, heart, hips and testes in boys.
- Staff provided women with contact details for a 24hr labour line that they could call when they went into labour but were not yet sure whether to present at the hospital.
- In 2015/16, the percentage of pregnant women accessing antenatal care seen within 10 weeks was 34% compared with the percentage seen within 20 weeks, which was 83%. The National Institute for Health and Care Excellence states in 'Quality Statement 22 Statement 1 services access to antenatal care' that service providers must ensure that systems are in place to support pregnant women to access antenatal care, ideally by 10 weeks 0 days. As 34% of women were seen within this timeframe, the trust was not ensuring these systems were in place.

Meeting people's individual needs

- Staff were able to support women whose first language was not English by using a 24-hour translation and interpreting service. Staff in the antenatal ward advised us they pre-booked interpreters when they knew a woman was presenting who did not speak English. Staff advised us the service was responsive and easy to organise.

- Staff provided women and their partners with information leaflets detailing; what to expect from your community midwife, concerns about your baby and how to recognise post-natal depression.
- The trust completed the Quality Standard of Intrapartum Care in December 2015, which showed women having skin-to-skin contact with their babies after birth was an area of non-compliance requiring action. In response to this, the trust introduced staff training in skin-to-skin contact; appointed an infant feeding coordinator and implemented kangaroo care. Staff we spoke with knew the benefits of skin-to-skin contact and patients advised us they had been supported and encouraged to provide kangaroo care. These initiatives supported the trust in achieving level 1 in the BFI Baby Friendly Hospital Initiative and are currently working towards level 2.
- The hospital provided specialist equipment, advice and treatment for bariatric patients. We saw the bariatric policy, which included information on; moving and handling, admission and discharge. Staff advised us equipment such as specialist beds and mattresses was readily available from the equipment library.
- Women with learning disabilities had their support needs assessed by the community midwives who worked with hospital staff, the woman and the woman's family to provide support during pregnancy, birth and after care.
- In antenatal and gynaecology clinics, patients experiencing fertility issues were seated in the same area as women in late pregnancy. Staff were not aware of any complaints associated with this arrangement but understood that this might be upsetting for some women.
- Women who had experienced miscarriage continued to receive scan letters and midwife booking letters congratulating them on their pregnancy. The trust was aware of this issue and was looking into ways to prevent the situation happening in the future.
- The delivery rooms did not have en-suite facilities, therefore women were required to cross public corridors to use facilities, which affected their dignity.
- The hospital provided two 'Afterthoughts' clinics a month. It is a confidential service that provides an opportunity to discuss and understand labour and birth. Women could self-refer or be referred by a health visitor or midwife.
- Visitor opening hours on Birchington ward were 2pm to 8pm or as negotiated with the nurse in charge. St Peter's, the antenatal unit and the labour ward had open visiting hours. This ensured partners and family could stay to support women outside traditional visiting hours.
- Patient opinion on the quality and variety of food was good. The hospital catered to different cultural and religious backgrounds by providing vegetarian and Halal options. However, one patient stated, "It tastes better than it looks."
- Women said the hospital website was a useful tool for understanding. It was easy to use and provided detailed information leaflets from recognised institutions. For example, 'The pelvic floor muscles-a guide for women' by the Pelvic Obstetric and Gynaecological Physiotherapy as well as direct web links to support groups such as the Miscarriage Association.
- At our previous inspection most of the guidance leaflets displayed on the wards associated with women's' health were out of date. In all areas we inspected, leaflets providing clinical information were up to date. However, we found a few non-clinical leaflets in the antenatal clinic were out of date. Information leaflets were available in other formats such as Braille, large print and audio and the trust provided documents in various languages on request.

Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas. We saw information on raising complaints was readily available on all wards and departments we inspected.
- Staff we spoke with were aware of the trust's complaint policy and how to support patients if they wished to raise a concern or make a formal complaint. Staff told us that they usually received feedback from a complaint they had been involved in. Staff told us they rarely received complaints and that feedback was usually positive.
- Patients knew how to raise complaints. Patients advised us they would discuss issues with staff in the first instance, but knew how to contact the Patient Advise Liaison Service if they wished to make a formal complaint.

Maternity and gynaecology

- We reviewed complaints made between June 2015 and June 2016. Women had made forty-three complaints about maternity services at the Queen Elizabeth the Queen Mother Hospital. We noted lack of communication was a discernible theme.
- Staff were able to provide examples of change in practice as the result of a complaint. For example, a patient diagnosed with pregnancy of an unknown location had missed their follow up appointment resulting in the patient attending A&E where staff diagnosed she had miscarried. Because of this, all staff in the early pregnancy unit made risk of ectopic pregnancy known to women with pregnancy of an unknown location and emphasised the importance of follow up appointments. Protocols were also put in place in A&E so all female patients attending with abdominal pain would receive a urine pregnancy test on examination.
- During our inspection, staff were unable to provide examples where policy or practice had changed because of a complaint.

Are maternity and gynaecology services well-led?

Requires improvement

At our last inspection, we rated the service as requires improvement for well led. On this inspection, we have maintained a rating of requires improvement because;

- Risk management and quality measurement were not always dealt with appropriately or in a timely way. Risks and issues described by staff did not correspond to those understood by leaders.
- Where changes were made, appropriate processes were not followed and the impact was not fully monitored.

However;

- Staff knew the vision and strategy for the service.
- The bullying culture seen at our previous inspection was improving, however there were still issues that needed to be addressed.

Vision and strategy for this service

- There were clear visions and a set of values for maternity services with quality and safety as the top priority.
- The strategy for the department was robust as well as realistic in regards to achieving good quality care. However, some areas of the strategy were not being achieved such as "We will provide 1:1 care for all women in established labour." This was due to staffing limitations.
- Staff we spoke with knew the vision and values of the department as well as their own ward values and knew their role in achieving the strategy outcomes.

Governance, risk management and quality measurement

- We found a number of areas where womens services was unable to show effective governance systems were in place, as reported figures did not reflect what we found on the wards. For example, the number of surgical abortions recorded by the hospital showed 173 surgical abortions were carried out at the hospital between April 2015 and March 2016. However, we found this was a data error as the figures included women who had miscarried and had a surgical evacuation. Therefore, management were not collecting accurate data on departmental activity.
- Governance meetings were held monthly and had good attendance from a variety of staff members including; risk leads, clinical leads, ward mangers, the community matron, midwives, obstetricians and gynaecologists.
- The trust risk register showed the maternity block at the Queen Elizabeth the Queen Mother Hospital was "Beyond their useful life and no longer fit for purpose." The trust planned updates as part of a rolling backlog liability of £30m of which significant and high-risk estate accounted for £18.2m. We did not see any planned dates for the work to commence.
- The head of midwifery had introduced 'Skip' meetings (a skip meeting is where a manager's manager meets with employees to discuss department concerns, obstacles and opportunities for improvement with a focus on maintaining and/or improving overall communication). Midwives on the labour ward advised us these had been a useful tool for multidisciplinary working and ensured good communication across banding levels.

- Management advised us the reason 1 in 5 women were not receiving 1:1 care in labour was due to staff sickness. However, we saw no action planning for how the trust was to improve this figure.
- We saw minutes for the Women's Health Clinical Governance Forum for April, May and June 2016. The meetings included regular items on the agenda including; incidents, risk register, clinical audit programmes and maternity and gynaecology guidelines. Staff were allocated responsibility for individual actions and the item chased up at the following meeting.

Leadership of service

- Women's services was led by; a clinical director who was supported by a consultant site lead at William Harvey and Queen Elizabeth the Queen Mother Hospitals; a service lead who worked with two site operations managers. The deputy head of midwifery was a new managerial role that supported the head of midwifery and gynaecology nursing.
- The trusts maternity department's improvement journey showed improvements regarding; environment and equipment, women and partner experience and capacity. However, areas that still required improvement included; cultural change, staffing and medical leadership.
- Staff reported there was an increase in experienced midwives leaving the trust due to staffing levels, increased activity and working on "goodwill." Management confirmed exit interviews were optional and they did not analyse trends regarding reasons staff left the trust. Therefore, management were less aware of and therefore unable to respond to issues, which resulted in staff leaving the trust.
- Individual members of staff demonstrated good leadership. We also saw that staff were very professional, loyal to the service and committed to providing a good experience for women and their babies.
- Staff advised us the current head of midwifery and deputy head of midwifery were approachable, which had not been the case historically.

Culture within the service

- The trust implemented a 'cultural change' leadership programme for divisional management teams. There was also the 'getting started' programme which focused on how managers could support cultural change. Band 8 and 7 managers had already attended this training and at the time of inspection, the programme was being rolled out to band 6 managers.
- Staff reported they felt the bullying culture at the hospital had been "Dealt with badly by management" as management were looking to improve culture generally, rather than investigate specific cases where individuals acted unprofessionally. Staff advised they felt the leadership programme would not change the behaviours of certain staff members. One member of staff who had experienced bullying said the investigation was not conducted anonymously; therefore, they wanted to move to another clinical area.
- We asked staff to describe the culture at the trust. Responses included "I've been here a long time, it has definitely improved recently, but still a long way to go" and "The team work so hard and are very supportive, although I would prefer it if management listened more, especially when we are busy."
- Good practice and achievement was shared and celebrated at team meetings. For example, Family and Friends Test responses often referred to specific members of staff. These were shared within the department.
- The team spirit amongst floor staff was impressive and staff told us that they were happy to work extra hours and shifts to help maintain the service. Staff working on the wards said they were "Very supportive of one another." However, staff advised us there was still a "Them and us" divide between staff and middle management.

Public engagement

- The trust had various means of engaging with patients and their families. These included various surveys, such as the Friends and Family Test, inpatient surveys and the 'How Are We Doing?' initiative.
- Management shared feedback and comments from patients on posters around the hospital and in monthly updates available on the trust's website.
- Management fed back results of surveys, feedback from complaints and the Patient Advice and Liaison Service to staff, the trust board and commissioners.
- Women shared their views and opinions on how local maternity services could be improved at the local maternity services liaison group.

Maternity and gynaecology

Staff engagement

- We saw staff monthly meeting minutes for Bands 2/3, Band 6 and Band 7. Staff felt meeting in smaller band groups was beneficial as they could be more open and honest than in a larger team meeting with people who managed them.
- Women's Health had created a staff charter, which looked at nine elements which staff believed contributed to making the trust 'A great place to work'. Elements of the charter included; 'I am well managed and led' and 'I have a voice and am listened to'.
- The trust re-launched its 'Respect' programme, which was aimed at supporting open communication between staff. Workshops took place in June, July and August 2016, which showed the trust commitment to 'I am part of and supported by my team' as detailed in the staff charter. However, staff felt the workshops did not do enough to address cultural issues within the department.
- The trust had introduced bullying champions, an impartial member of staff who was available for peers to discuss any bullying culture experienced within the trust. They were used as a reference to provide further support and mediation if required.

Innovation, improvement and sustainability

- The trust had opened Improvement and Innovation Hubs to give staff the opportunity to learn about and contribute to the trust's improvement journey as well specialist areas of care and treatment. However, when we asked staff whether they used or benefitted from the hub, responses were mixed as the hubs tended to focus on medicine rather than maternity and gynaecology. Management advised us the content of the hub agenda was driven through organisational and site need, identified through clinical and service development and staff feedback. As a result of this the content of the Hubs did not tend to be specific to a division, specialty or professional staff group. However, staff in women's services wanted hubs specific to their needs and requirements.
- We asked how the hospital got assurance that information provided at the hub was compliant and up to date. We were advised the specialist organising the training ensured information was correct. However, there we found no evidence this process was audited. At the time of inspection, the hospital did not capture staff feedback; therefore, there was no method of monitoring improvement in staff understanding.
- On the labour ward, the hospital had introduced computers into individual delivery rooms. This enable midwives to stay with mothers and support them at all times.

End of life care

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

Information about the service

Since the last inspection in August 2015, small changes had taken place across the trust in the staffing of the specialist palliative care (SPC) team. This included the appointment of an end of life facilitator and the reduction in the counselling team to one counsellor.

A nurse consultant in palliative care who worked across all three acute hospital sites led the Queen Elizabeth, the Queen Mother Hospital (QEQM) SPC team. In addition there were two clinical nurse specialists (CNS) who were based at the QEQM. An end of life facilitator, counsellor and social worker also worked across all three acute hospital sites, and visited this hospital site at points throughout the week.

A medical palliative care consultant from the Pilgrim's Hospice which was situated beside QEQM supported the SPC team.

The chaplaincy team provided multi-faith support.

End of life care was the responsibility of all staff. The SPC team provided support to patients with complex symptoms at the end of life and empowered generalist staff in non-complex symptom management .The end of life facilitator and CNS delivered the end of life training and education programme to all staff delivering end of life care across the trust.

The core SPC team were available Monday to Friday from 9am to 5pm. Outside these hours telephone support was provided by the local hospice.

Across the trust, there were 2,608 deaths from April 2015 to March 2016. During this period, there were of 1,625 referrals made to the specialist palliative care team.

During the inspection, we visited a variety of wards across the hospital including Cheerful Sparrows, Deal, Fordwich, Sandwich Bay, St Augustines, St Margarets, Viking and the Clinical Decision Unit. We also visited the relative support office, mortuary, chaplaincy and the porters' lodge.

We reviewed the medical records six patients who received end of life care. We spoke with 29 members of staff that included doctors, CNS, nursing staff of all grades, porters, administrative staff and managers of services to assess how end of life care was delivered.

We reviewed other performance information held about the trust.

We reviewed a variety of documents relating to end of life care provided by the trust and observed care on the wards. We spoke with one patient receiving end of life care and one family member. We received comments from people who contacted us individually to tell us about their experiences.

During the last inspection in August 2015, we rated the overall end of life care service as 'requiring improvements'.

The delivery of safe care was not always possible due to the lack of staff training when new equipment arrived. We found out of date medicine charts in use and where new policies had been introduced; frontline staff were unaware of the new policies and were not implementing them into

End of life care

clinical practice. Staff delivered good care, however, no extra staff were placed on wards when nursing end of life care patients which meant patients and their loved ones did not always get the support they required.

We found the effectiveness of the service to be 'inadequate'. Identification of patients who were approaching the end of their life's was poor which meant clinical interventions were not removed and comfort care put in place. We found no individualised care plans. Care delivered did not reflect patient's wishes and preferences and did not reflect national guidance. Attendances at end of life training sessions were poor for both medical and nursing staff with more buy in needed from consultant colleagues.

There was a lack of Trust Board direction and this was evident in a non-unified approach to end of life care. The SPC team had a high level of knowledge and expertise however, the team was small, and to support complex end of life patients, implement the end of life improvement plan and strategy when finalised was thought to be unsustainable.

Summary of findings

Overall, we rated the end of life care services at the trust as requires improvement because:

- The trust's SPC team demonstrated a high level of specialist knowledge. A strong senior management team who were visible and approachable led them. The SPC team provided individualised advice and support for patients with complex symptoms and supported staff on the wards across the hospital. However, the SPC team were small and there were concerns regarding the sustainability of the service. We noted the planned improvements and the implementation of the end of life strategy would be difficult to apply due to the current available resources.
- We found an array of service improvement initiates had been introduced across the trust since the last inspection. This included end of life care plan documentation, the appointment of an end of life facilitator and identification of end of life care link nurses, There was a stall at QII hub to spread the work and raise the profile of end of life care. All service improvements were based on national guidance. However, we found changes were recently implemented and more time was required to embed the changes into clinical practice, upskill staff and provide a robust training and education programme to ensure end of life care was delivered following national recommendations.
- Since the last inspection, we found the training of junior and speciality doctors had improved with the SPC team invited to divisional meetings to present and raise the profile of the importance of good end of life care conversations and symptom control. We saw clinical leads championed end of life care. However, further work was required to strengthen the collaboration of working with consultants.
- Staff told us that since the last inspection end of life care had a much higher profile across the trust. However, we found on the wards that ceiling of treatments were not generally documented, poor completion of nursing notes which made it difficult to access if patients were being reviewed regularly. There were no mental capacity assessments in place

End of life care

for vulnerable adults who lacked capacity. Where a patient was identified as dying it was often confusing for staff as in many cases interventions were still being delivered.

- End of life training was not part of the mandatory training programme. We found some nursing staff on the wards had received training whilst others had not. Wards struggled with staffing levels and there were no extra staff in place to support end of life care.
- 100 link nurses had been identified as leads on end of life care at ward level.However, more time was required for the link nurses to settle into their new roles, to support their colleagues, and improve quality.
- No electronic palliative care record system was in place where providers shared information.
- A fast track discharge process was in place. However, staff told us the process was not fast with some patients taking weeks to be discharged to their preferred place of care (PPC). Whilst work had been undertaken to improve the process since the last inspection, further work was required to ensure patients could be discharged within hours to their PPC.

On this inspection we have maintained a rating of requires improvement.

Are end of life care services safe?

Requires improvement

At our last inspection, we rated safe as requires improvement. On this inspection we have maintained a rating of requires improvement because:

- Staff understood their responsibilities to raise and report concerns, incidents and near misses. They were clear about how to report incidents and we saw evidence that learning was shared across the teams. However, the IT system was still slow with some staff suggesting not all incidents were reported because of this. This has not improved since the last inspection.
- We found out-of- date syringe driver prescription charts were not in use across the wards we visited.
- A greater proportion of patients who were dying were recognised. However, we found the decision often left staff confused as active treatments were still being delivered. Experienced staff were able to question practice although more junior staff would not.
- End of life training of the generalist staff was patchy, and many had received no training around the use of end of life care documentation. There was a gap in the skills set of the generalist staff delivering end of life care. Staff still found accessing the training modules difficult.
- There were no seven day face-to-face access to the SPC team which meant that processes out of hours was often difficult, and time consuming which could delay treatment times for patients.

However since the last inspection there had been improvements which included:

- Portering training had improved since the last inspection. Porters received training around new trust policies and new equipment.
- We were able to view the training records on the wards of the syringe driver's competency programme. This programme had been introduced since the last inspection.
- The last offices policy had been embedded into clinical practice since the last inspection. Mortuary staff

participated in a 'task and finish group' which led to the redesign of the '10 steps form' used by the nursing staff on the wards along with a communication campaign at the Quality, improvement and innovation hub(QIIH).

Incidents

- There were no never events or serious incidents reported for end of life care services between July 2015 and June 2016.
- All staff we spoke with, including administration staff, doctors, nurses, mortuary staff and porters were encouraged to use the trust electronic incident reporting system. During the last inspection, staff told us the reporting system was slow. Staff confirmed during this inspection that there had been no change in the workings of the reporting system.
- The trusts incident reports for July 2015 to July 2016 consisted of 53 incidents relating to end of life care, with 19 incidents reported at QEQM. Incidents reported included delay in fast track process, patient approaching end of life still received active treatment and lack of medical and nursing staff and work-related stress. From the data submitted, we were unable to see what actions were taken to prevent similar incidents happening in the future.
- Lessons learnt from these events were regularly communicated through handovers and staff meetings. On Sandwich Bay ward, the ward manager described incidents, which had taken place on the ward; these included falls, incorrect and missed medications. Learning took place at ward meetings once every six to eight weeks. We reviewed the ward meeting minutes of June 2016 where top trust risks, incidents, safeguarding, general ward issues, and end of life care learning were discussed.
- The mortuary provided data about incidents across all three sites from July 2015 to June 2016. 48 incidents had been reported in the last year with 22 incidents related to QEQM mortuary. The majority of the incidents reported were around failures in identifying deceased patients correctly and needle stick injuries. From the data submitted, we were unable to see what actions were taken to prevent similar incidents happening in the future.
- We reviewed end of life board minutes and saw these incidents had been highlighted and extra training was to be introduced as part of the 'back to basics' nursing programme. However, reviewing the end of life board minutes we saw that ward incidents related to end of life care were not regularly discussed. A SPC CNS told us incidents had been recently introduced as a standard item and were now discussed at the end of life board, which had led to further training on a ward regarding the use of syringe drivers. We saw no evidence of this in the minutes we reviewed.
- During the last inspection, it was highlighted the last offices policy had not been embedded across the trust. This had resulted in mortuary staff participating in a 'task and finish group' for last offices procedure which led to the redesign of the '10 steps form' which was used by the nursing staff on the wards along with a communication campaign at the QII hub.
- Mortuary staff told us they had seen improvements since the last offices procedure was embedded with fewer incidents reported. If an incident takes place at ward level, mortuary staff would contact the manager and offer nursing staff to 'walk the path'. Mortuary staff attended the QII hub and drop-in sessions to educate staff.
- The lead mortuary technician at QEQM manages overall incidences and shared learning across the three sites. For each incident, feedback was provided to wards and portering managers.
- A portering manager at QEQM described one incident that involved a deceased patient at WHH. This was recorded on the reporting systems of the portering company and the trust. The porters involved in the incident had received further training around the placement of deceased patients into the mortuary fridges. Two porters at QEQM who were not directly involved in the incident were able to describe this, as the learning was shared across the three sites with all porters.
- Staff were able to describe the new duty of candour regulation. This regulation requires the trust to be open and transparent with a patient when things go wrong. Staff we spoke to were able to articulate the need to be open and honest.

Cleanliness, infection control and hygiene

- The wards we visited were clean, bright, and well maintained. In all clinical areas, the surfaces and floors were covered in easy-to-clean materials allowing hygiene to be maintained throughout the working day.
- On the wards we visited, we saw clear signs reminding staff and visitors to follow the infection control

guidance. We saw that staff observed appropriate precautions when attending to patients and between patient contacts. There were hand hygiene dispensers in place and written reminders for visitors to clean their hands.

- Ward and departmental staff wore clean uniforms and observed the trust's 'bare below the elbows' policy. Personal protective equipment (PPE) was available for use by staff in all clinical areas. Porters told us they used gloves and gowns when transferring a deceased person from the bed to the trolley in the wards. These were removed during the transfer and PPE was worn again on arrival at the mortuary.
- Guidance was available for staff to follow to reduce the risk of spreading an infection when providing care for people after death in the trust's 'Last offices policy'. The policy included the wearing of gloves, aprons and the use of body bags. We were told there were adequate supplies of body bags.
- We saw in the mortuary incidents that mortuary staff did not always become aware on time that a deceased patient had had an infection.

Environment and equipment

- Staff told us they had access to equipment needed for caring for patients at the end of their lives including syringe drivers, pressure relieving air mattresses and air cushions. These were readily available through the equipment library. Staff on the wards told us that there were no issues securing equipment in and out of hours to support patients.
- The trust used nationally recommended syringe drivers to deliver consistent infusions of medication to support patients with complex symptoms. Patients were discharged with the syringe driver in place. This did raise issues as the syringe drivers were not being returned to the hospital after use suggesting no security system was in place for the return of syringe drivers. However, by discharging a patient home with a syringe driver in place meant patient's symptoms were kept under control during the transfer to their PPC.
- We reviewed documentation for the syringe drivers and saw planned preventative maintenance (PPM) was 89% completed (108 of 122). A business case (to be approved) to improve medical devices maintenance for all of the medical devices in clinical use was currently achieving 75% across the trust, recommendations were made to increase this to 95%.
- Access to the QEQM mortuary was through a coded entry system that mortuary staff, consultant pathologist, porters and estates staff used, with a bell for other visitors to the area.
- We saw records in the mortuary confirming hydraulic trolleys and hoists were regularly serviced. There had been no issues replacing damaged equipment.
- Mortuary fridge temperatures were managed electronically. On-call mortuary staff were able to view the temperatures remotely. If the fridges were outside the range after a set time, the on-call technician would visit the site. The electronics and medical engineers were available in and out of hours to check for faults and an engineer from the fridge supplier was available.

Medicines

- Patients receiving end of life care were prescribed anticipatory medicines to enable prompt symptom relief at whatever time the patient develops distressing symptoms. The SPC team had introduced 'guidance for patients in the last hours or days of life', which set out the management of patients who had been recognised as dying. The guidelines gave easy to follow instructions on the drug management of symptoms in the dying patient. We saw that guidance was available in the ward resource folder and on the end of life care web page. On Sandwich Bay ward we saw anticipatory medications prescribed for an end of life patient.
- One doctor (SpR) told us end of life resources were good. Training and support were provided by the SPC team and the prescribing of anticipatory medications would be prescribed once symptom control management commences towards the end of life (days).
- Medical teams could contact the SPC team if patient symptoms persisted or the patient had a complex medical condition such as diabetes. We saw that guidance was in place to support patients with end stage renal failure and heart failure.
- Staff on the wards we visited told us medication for end of life care was available on the ward and was easily accessible. We observed locks were installed on all storerooms, cupboards, and fridges containing medicines and intravenous fluids. Nursing staff held medication cupboards keys.
- We saw controlled drugs were handled appropriately and stored securely demonstrating compliance with relevant legislation. Staff working on the wards we

visited regularly checked controlled drugs. We checked the contents of the controlled drugs cupboard against the controlled drug register on two wards and found they were correct.

- The previous inspection found that syringe driver prescribing and record of administration forms used were out-of-date. These referred to two types of syringe drivers no longer used in the trust. During this inspection, we found a sticker had been introduced referring to the correct syringe driver which is now in use in the majority of prescription charts we reviewed.

Records

- We reviewed six medical records of patients receiving end of life care. The records documented that the SPC team had supported and provided evidence-based advice, for example, on complex symptom control and support for the patients and families as they pass along the care pathway. This specialist input by the SPC team ensured that a high level of expertise was used to ensure the best possible care was delivered to end of life care patients.
- The 'record of the end of life conversation' (RELC) documentation was not in use at the time of the last inspection but was introduced across the trust in December 2015. This had been developed by the SPC team to support full discussions with patients and their families and had to be completed by the consultant or registrar caring for the patient. Medical records we reviewed on the Fordwich ward and Clinical Decision Unit showed the RELC form had been completed by the consultant and registrar.The SPC team told us that due to poor compliance of the completion of this documentation senior nurses could now complete the documentation.
- In the RELC documentation states that when completed a copy be faxed to the general practitioner (G.P) and the SPC team. We found no evidence in the patients' medical notes that copies had been faxed to the GP or the SPC team.
- The SPC team told us the record of end of life conversation (RELC) form, when completed, was the ceiling of care .However with poor compliance in completing the RELC form meant that many end of life patients had no ceiling of care documented.
- In one set of medical records we reviewed on Fordwich ward, the completion of nursing documentation was poor. We found that the skin integrity checklist was not completed daily. This meant that the patient did not receive the use of an air mattress promptly and resulted in a grade two pressure ulcer.
- The medical records we reviewed showed that patients were being regularly assessed by the physiotherapist to ensure all efforts were being made to ensure the patients were comfortable. We saw referrals made to the speech and language therapists to ensure end of life patients received adequate nutrition and hydration. Comprehensive assessments were documented in the patients' medical records by the therapists.
- In January 2016 the SPC team introduced the 'end of life care record' which covered the '5 priorities of care' and this was being implemented for patients in receipt of end of life care.On the Clinical Decision Unit, we found that staff used the end of life care record. The record was commenced when the decision was made to place the patient on end of life care.
- As part of a clinical audit following a patient review, the SPC CNS would place information onto an electronic palliative care episode summary sheet. Information documented included diagnosis, date of referral, investigations, spiritual and social needs. This would be completed and placed in the patient's medical records.
- In medical records for six patients, we found Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders fully completed, dated and signed by senior doctors, and were placed at the front of the medical records allowing quick access.
- Medical records were stored securely and patient confidentiality was protected. The SPC team audited a sample of patients' medical records for end of life documentation on a three-monthly basis and provided feedback to the wards.
- There were clear recording systems in the mortuary for the admission and storage of deceased patients and their discharge to the care of funeral services.

However:

- We saw loose filing of paperwork in the medical records we reviewed on the wards and whilst there was good documentation, they were not well organised which prevented quick access and were at risk of the loss of documentation.
- Staff had not embedded the use of documentation from the end of life pack since its introduction in January 2016.

End of life care

Safeguarding

- Staff undertook safeguarding training which was a mandatory subject. They were able to demonstrate a good knowledge and understanding of safeguarding vulnerable individuals, including signs and symptoms and the action to be taken.
- The relevant local authority and social services contact numbers were accessible to staff on the wards.
- On Sandwich Bay ward we saw records which confirmed adult and children safeguarding training was at 92% compliance which met the trust target.

Mandatory training

- All of the SPC team and mortuary staff were up-to-date with their mandatory training. The majority of the mandatory training was e-learning with some face-to-face training such as the practical part of moving and handling training.
- End of life training was not mandatory across the trust .However, the SPC senior management team were working with an outside provider to develop end of life care mandatory e-learning modules. The priority at present was to train all palliative care and end of life care link nurses who would support the training of generic staff on the wards. At the time of the inspection records confirmed that 54 end of life care, link nurses had attended the initial training day in July 2016.
- Mandatory training for the mortuary staff included last offices procedure, fire safety, moving and handling, information governance, infection control, equality and diversity and health and safety.
- Mortuary staff provided relevant training such as last offices procedure that formed part of the mandatory training programme for porters who worked in the mortuary.
- Porters we spoke with said they received annual updates on mandatory training, some of which was e-learning. Transfer of deceased patients and mortuary procedures were included in their mandatory training. For example, at the last inspection porters raised concerns as there was lack of clarity whether they should wear gloves when pushing the concealment trolley along the hospital corridors. Following training, porters understood and clearly described at this inspection that they wore gloves on the wards when transferring a deceased body from a bed to a concealment trolley. Porters reported that communications about changes were much improved since the last inspection.

Assessing and responding to patient risk

- Approach to end of life care was more structured at this inspection compared with the last, since the removal of Liverpool Care Pathway (LCP) in 2013. We saw an end of life care training programme for 2016 to 2017 which was available for junior doctors including drop-in sessions and at the quality improvement hubs across the three hospital sites for all staff.
- The end of life care pack was introduced and implemented in January 2016. This had been developed to support full discussions with patients and their families on their diagnosis, prognosis and options. There were guidelines and a nursing care pathway with complete documentation including the “End of Life Conversation” document.
- Wards we visited had the end of life care pack and staff could access the pack kept at the nurse’s stations. However, medical records we reviewed did not contain the documentation from the pack. The exception to this was the DNACPR forms. These were fully completed and filed at the front of the medical records to ensure visibility and quick access. We saw decisions and discussions recorded in the medical records.
- We also found that wards were using a symptom control flow chart for end of life care together with the end of life care pack.
- During our review of DNA CPR orders, we found inappropriate reasons for placing DNA CPR orders in place including fragility and dementia.
- The Last Offices Policy was available on all the wards we visited and was accessible from the trust intranet. Accessibility of the policy has improved compared with the last inspection when it was not available on some wards and the intranet.
- There was up-to-date guidance on symptoms and the ‘five priorities of end of life care’ was available on the trust intranet.

Nursing staffing

- The clinical nursing staff levels of the SPC team had not changed since the last inspection with a trust-wide

nurse consultant and one SPC CNS presently at the WHH site. No cover was available for annual leave or sickness for the nurse consultant role. The nurse consultant covered holiday periods for the CNS.

- The SPC team were unable to provide out of hours cover. Telephone advice out of hours was provided by the hospice.
- The SPC nurses provided advice and support to patients, relatives, and staff on all aspects of end of life care, including complex symptom control, patient involvement in decision-making and to deliver education and training to the staff across the hospital.
- End of life care 'link' nurses were available on individual wards. We were told that 100 link nurses had agreed to take on the role during the inspection.
- An end of life facilitator had been recently appointed to the team. This role would spend one day each week on each site and any extra time would be spent where support was needed. This role was not a clinical post but supported the training and education needs of all staff across the trust.
- Two McMillian funded nursing posts had been put on hold by the trust. Discussions were still taking place to decide the best role to support the SPC service across the 3 sites.
- Nursing staff told us that there were insufficient numbers of staff to ensure that needs of patients were meet. Staff told us that no extra staff were allocated when end of life patients were being nursed on the wards.
- A counsellor and social worker were part of the SPC team. They provided support across the three sites.
- The porters we spoke with felt that whilst they were busy there was generally sufficient numbers of staff during the day.
- There were two part-time Relative Support Officers working a total of 37.5 hours per week at QEQM. This was increased from the 25 hours per week at the last inspection. This was felt to have improved to cover the winter months with the increased admissions and deaths.

Medical staffing

- The palliative care consultant input from the hospice across the three hospital sites was increased from 0.6 to 0.8 whole time equivalent since the last inspection. The hospice is on the hospital site so there was easy access to the medical support. They undertook one ward round each week, attended the SPC multi-disciplinary team meeting.
- There was no medical palliative care consultant cover in the hospital out of hours but advice was available via the hospice. This had not changed since the last inspection.
- Junior doctors received weekly teaching and attended the Grand Rounds. We saw end of life care training scheduled for junior doctors in the trust 2016 to 2017 training programme for end of life care.
- During the last inspection, we were told that there had never been any service level agreement (SLA) regarding medical time between the trust and the hospice. Following the inspection discussions took place between the trust and the hospice. The first draft of the 'service level agreement 'was with the procurement team and the second draft had just arrived. The trust will use this SLA as a baseline and then work out the gaps in the service. The SLA will not address medical cover outside normal working hours.

Major incident awareness and training

- The trust had a business continuity management plan including a framework for disruption of services. This covered major incidents such as winter pressures,

severe loss of staff, loss of electricity or water. We saw that major incident training was now part of the mandatory training programme and staff were encouraged to view a video and sign onto the training day.

- Most staff we spoke with were aware of the hospital's major incident plan such as winter pressures and fire safety incidents, and they understood what actions to

take in the event of an incident such as a fire.

- The mortuary technician lead was currently developing a trust wide policy specific to mortuary. This was due to be ratified by the end of life board in October 2016. This would link to the trust's overall major incident plan. Mortuary staff were aware of the major incident plan.
- Mortuary staff told us that if demand was high across the trust, 24 extra spaces were provided at WHH mortuary. If all fridge spaces were occupied, mortuary staff would work with funeral directors who would accommodate up to six patients per site within the hour throughout the week.

End of life care

Are end of life care services effective?

Requires improvement

At our last inspection, we rated the service as inadequate for effectiveness. However following improvements in key areas we now rate the service as 'requires improvements' because

- The SPC team had undertaken a range of service improvements since the last inspection to support the delivery of effective care for patients approaching the end of their lives. A variety of documentation had been introduced based on national recommendations to guide and record the care delivered to dying patients by the generalist staff. However, we found poor compliance in the use of the end of life documentation across the wards we visited which was reflected in the May 2016 documentation audit undertaken by the SPC team.
- The trust conducted a 'Do not attempt cardiopulmonary resuscitation' (DNA CPR) audit yearly with an action plan to address areas of concern.
- During the consent processes to place a DNA CPR order, we found patients who lacked capacity did not have mental capacity assessments in place. This meant national guidance and legislation was not being followed.
- The Critical care team had ceiling of treatments for all their patients in place, which meant all staff were aware of the personalised management plan for each individual patient. For patients on the wards, the record of end of life conversation form represented the patients ceiling of care. However, with poor compliance around completing the form across the wards we found very ill patients had no ceiling of care in place.
- We found no information booklets for patients and relatives receiving end of life medication as recommended by NICE (QS140).

However since the last inspection there had been improvements which included:

- 100 link nurses had been identified through the appraisal process to support good end of life care across the wards. Their role through training and education will be to cascade the latest end of life care information to all staff groups.Time will be required to embed these roles into clinical practice.
- Staff described how supportive and responsive the SPC team were which was reflected in the data we reviewed. The SPC team aimed to respond to requests to review patients with complex symptoms within 24 hours. In 2015/16 the SPC team received 1,471 referrals and reviewed 1,420 patients within 24 hours. This is a compliance rate of 96.5%.
- Since the last inspection, the trust took part in the National Care of the dying Audit Hospital (NCDAH) round 5: 2015. A NCDAH action plan was developed to address the key findings. We saw evidence during the inspection that improvements were in the process of being actioned.
- The SPC senior management team were able to tell us end of life training for medical staff was high on the training agenda. A training programme was in place for the new junior doctors. We saw the training programme included topics such as breaking bad news, case study reviews and symptom control

Evidence-based care and treatment

- East Kent hospitals University Foundation Trust (EKHUFT) had responded to the national recommendations of the Liverpool Care Pathway (LCP) review, 'More Care, Less Pathway' (2013) by removing the LCP from the trust in July 2013. During this inspection, ward staff confirmed the trust were no longer using the LCP and it had been removed some time ago. This showed that the trust had responded to concerns regarding the LCP and informed staff of its removal. However, during the last inspection we found no guidance had been given to staff after its removal apart from staff continuing to regularly assess the needs of all patients and clearly identifying patients who appeared to be dying.
- There had been 2,608 deaths across the trust during the period April 2015 to March 2016. We reviewed the SPC team data and saw that 1,625 patients referred to the SPC team during this period which was a 14% increase on the previous year where 1,393 patients were reviewed.
- The SPC team aimed to respond to requests to review patients with complex symptoms within 24 hours. In

End of life care

2015/16 the SPC team received 1,471 referrals and reviewed 1,420 patients within 24 hours. This is a compliance rate of 96.5%. Urgent advice was available from the SPC CNS via the telephone prior to reviewing the patient. Staff on the wards we visited told us the SPC team were very responsive and were always available to give telephone advice.

- The SPC team had introduced end of life care plan documentation in January 2016 which incorporated the '5 priorities of care' recommended by the Leadership Alliance. This meant that there was more guidance for generalist staff caring for end of life patients based on national recommendations. A 'multidisciplinary prompts for the care of patients at end of life' was introduced. The 'prompt' flowchart was a checklist which aimed to support staff as an aide memoire when caring for end of life patients. On reviewing six medical records we found the 'prompt 'in only one medical record.
- The RELC form was introduced in 2015 in response to national guidance. This identified that senior clinicians did not communicate or document well the end of life care conversations or decisions made with patients and their families, as end of life approaches.The RELC listed the core principles, which were felt to be crucial to good care in the last few days of life.
- On review of the June 2016 audit undertaken by the SPC care team, we found poor compliance of the use of this documentation with only two out of 30 sets of medical records having a completed RELC completed. This was a compliance rate of seven percent. During the inspection, we reviewed six medical records and found improved compliance with two out of six medical records that had the end of life conversation form completed. However, compliance rates suggest that further work was required to embed the 'prompt' and 'conversation' documentation into clinical practice.
- The trust took part in the National Care of the dying Audit Hospital (NCDAH) round 5: 2015. The audit highlighted the trust performed below the national average in all five clinical audit indicators. They performed poorly on audit indicator three which was 'patient was given an opportunity to have concerns listened to' and audit indicator four which was 'the needs of the dying patient and those important to the patient'. Of the eight organisational audit indicators, the trust achieved six of these. Of the two they did not achieve, one had been achieved with the appointment of an end of life facilitator in May 2016.This appointment will bring together the trusts education programme around end of life care. We saw an 'open training schedule' put in place for 2016/17 which covered training at all three hospital sites.
- In order to address the organisational audit indicators not achieved and to improve compliance in the clinical audit indicators, a NCDAH action plan was developed to address the key findings. We saw evidence during the inspection that improvements were in the process of being actioned.
- We saw National recommendations and guidelines had been used to develop the medication necessary to support the management of the five symptoms experienced by patients at end of life. Symptom control algorithms had been agreed and implemented to support the management of dying patients. These were available on the end of life care web page and in a symptom control booklet.
- The choice of medications at the end of life had been aligned to local community guidelines to support safe and consistent practice between care providers. Medical consultants from the SPC team worked across the trust and hospice which improved the continuity of care for patients.
- The nurse consultant was part of the end of life pathway/integrated group working alongside four Clinical Commissioning Groups. The aim of the group was to improve end of life care across the county. The work was based on national guidance. The group had recently introduced patient and carer information packs. However, on the wards we visited staff were not using the information packs as no training had been received by the generalist staff around the use of the information packs.
- By the trust having a SPC team, patients were able to benefit from the specialist knowledge of the SPC team, who worked alongside other specialist nurses in providing evidence based care and treatment. We reviewed the medical records of six patients receiving end of life care; these demonstrated the SPC team had supported and provided evidence-based advice for example, on complex symptom control and support for the patients and families. This specialist input ensured national recommendations were being implemented and patients benefitted from this.
- To maintain standards and ensure consistent care for patients approaching the end of their lives, staff were

asked to continue to regularly assess the needs of all patients. The decision to place patients on end of life care was a multi-professional one led by the medical consultant or a senior nurse after discussions with the patient and family. However on reviewing medical records and staff we spoke with, we found active treatment was still being delivered to patients who had been recognised as dying. This was seen in two medical records on Cheerful Sparrows ward.

- To record ongoing care, the' end of life care record' was introduced in January 2016.A new care record would be completed each day. However, in the notes we reviewed we found the completion of this on a daily basis was varied across the wards.
- Whilst reviewing medical patient records we found that patients receiving end of life care did not have personalised care plans as end of life documentation was not always being put in place by the generalist staff. We saw evidence that care was delivered and recorded around the needs of the individuals.

Pain relief

- Effective pain control was an integral part of the delivery of effective end of life care. Nursing staff from the wards we visited described that patient pain levels would be reviewed four hourly. If the ward team was unable to manage pain effectively, the SPC team would be called to review the medication prescribed. In the April 2016 end of life survey report, relatives were asked if they felt 'that pain was controlled in the last days of life'. Relatives responded that 40% of patients received excellent pain control, however 14% received fair to poor pain control. This suggested that more work was required to improve pain management in the last days of life.
- On Cheerful Sparrows ward staff told us that pain management was through observations which were documented in the patients' medical records. However, on review of two sets of medical records on this ward, we found pain assessments were undertaken regularly and documented in only one of the two medical records and both did not document the prescription of pain relief medication.
- The SPC CNS were nurse prescribers and were involved in advising and reviewing the medication of patients approaching the end of life. The SPC CNS were able to give advice on the medication required to manage pain effectively as well as advising the medical and nursing teams around the medication that the patient no longer required..
- We found no information booklets for patients on end of life medication. As part of NICE guidelines (QS140), patients and carers must receive adequate information when opioids are in use. We found syringe driver information for patients and carers that the SPC team had developed. However on the wards we visited staff had not seen the booklet and were not giving it out to patients and families.

Nutrition and hydration

- In the 'Multi-disciplinary prompts for the care of patients at end of life' multi-professional teams were encouraged to involve the patient's in all decisions regarding their care which covered nutritional and fluid requirements. The 'prompt' asked that patients and family wishes and preferences around nutrition and hydration were explored and addressed. It is recognised as good practice to discuss the role of nutrition and hydration with relatives of dying patients, as a perceived lack of adequate food and fluid intake can be a source of distress for relatives of a dying patient. We saw from the medical records we reviewed that staff involved patients and their families regarding nutrition and hydration in the patient records we looked at. The SPC team worked with families to ensure they were as involved as they wished to be. This meant that staff followed the multidisciplinary team prompts effectively to involve patients approaching end of life and their families.
- We saw examples where dietary needs had been catered for and patients' food and fluid intake monitored in the medical records we looked at.
- In the 2016 RELC audit undertaken by the SPC team, discussions around nutrition and hydration were discussed in 13 out of 15 cases(87%) of cases which was an increase from 8 out of 13(67%) in the previous year, showing that raising awareness of the importance in discussing nutrition and hydration has improved compliance.
- Nursing staff told us that on patients' admission, risk assessments which included a Malnutrition Universal Screening Tool (MUST) were undertaken; this identified patients at risk of poor nutrition, dehydration, and swallowing difficulties**.** We reviewed patients' medical records and saw that the MUST assessment was being

undertaken weekly. Staff told us the risk assessment would be conducted more often if the patient deteriorated. We saw that the electronic monitoring system highlighted to staff when a MUST re-assessment needed to take place.

- We saw on the wards we visited that patients were referred and reviewed by Speech and Language therapists if patients were identified as being at risk of poor nutrition, dehydration, and swallowing difficulties. Advice on the most appropriate types of food the patient could tolerate would be made. A variety of food was available to meet patients' needs including soft and pureed food.

Patient outcomes

- The trust had an end of life care audit programme in place for 2016/17. End of life care plan documentation was reviewed three-monthly, which looked at 90 sets of notes across the trust. The objectives were to identify if end of life care plan documentation (MDM prompt sheet, end of life care record, communication diary) was used to facilitate end of life care, to measure the completeness of the end of life care plan documentation and to monitor the quality of documentation. In the last audit (June 2016) results showed only 13% compliance rate around the use of the documentation suggesting that further work was required to embed into clinical practice.
- With the record of end of life conversation (RELC) form, a comparison of 2015 and 2016 audits showed a slight 4% increase in the use of the RELC form despite completing action plans and recommendations from the 2015 audit. We saw only one fully completed RELC forms in the six medical records we reviewed.
- Where the RELC form was used, completion has improved particularly around areas such as discussions of PPC, nutrition and fluids, DNACPR and documentation of patient and family concerns. To try to improve compliance the end of life board agreed to certain recommendations. These included senior nurses completing the RELC form and disseminating audit results via link nurses meeting and educational days.
- Other audits undertaken by the SPC team included the audit of Fast Track Supported Discharges April 2016, audit of Rapid Discharge Home for end of life care July 2016 and the NCDHA 2015.
- An audit was undertaken by a palliative care consultant at the Pilgrim's hospice in April 2016 to assess the quality of discharges home for end of life care from both East Kent Hospitals and Pilgrims Hospice sites. The aim of the audit was to identify areas of good and potentially substandard practice and offer an opportunity to make recommendations to improve future practice. Dying in the place of one's choice was considered one of the many facets of a good death. Of the patients discharged from a hospital setting, the SPC team were involved in the discharge process in 71% of cases.
- Mortuary staff were able to describe the last offices mortuary audit, which was performed daily and includes information such as patient's name, ward, date and time of death, mortuary arrival date and time, notification of death complete, identity bands present, incontinence pad present and one white linen sheet used over the patient. These were completed and sent to the quality manager who would report to the clinical governance group. Learning was cascaded back to staff through team meetings and specific individuals through appraisals.
- The portering service audited the time taken from a call received from the wards to the completion of the transfer of a deceased patient in the mortuary. We were unable to review the records during the inspection.
- The relative support officers told us they had started a database recording patients' details, including the date and time of death, division, hospital site, ward, consultant, referral to coroner and reason, date and time the doctor was bleeped, and date and time of medical certificate of the cause of death (MCCD) issued. By auditing this process, the trust was able to use the information collected to improve outcomes.

Competent staff

- Across the hospital, end of life care/palliative care (PC) link nurses were being identified on the wards we visited. 100 link nurses were identified through the appraisal process across the three acute hospitals. Their role through training and education was to cascade the latest information to all staff groups to support the delivery of good end of life care. The SPC team had developed a 'cancer/palliative care/end of life care link nurse programme for 2016/17'.This set out the expectations of the link nurse and their duties within this role.
- Training days had been introduced by the end of life facilitator to support the development of these roles. 68 link nurses have signed contracts showing commitment

to the role; with agreement from their line managers. 38 link nurses have completed their e-Learning module in relation to "Dying in the Acute Hospital.' The trust expected all link nurses to have completed their e-Learning by the end of September 2016 and by the next link nurse day in November 2016.

- On Sandwich Bay ward, we saw records that the ward manager has completed the link nurses training in August 2016 and had planned to ensure staff complete the end of end of life e-learning training. However, across other wards we found staff had not undertaken end of life training. We therefore found inconsistencies around who had and had not received training across the trust.
- The CNS from the SPC team were highly qualified in palliative care with several of the team having achieved their master's degrees in palliative care or associated subjects. One SPC CNS we spoke to told us as a medicine prescriber they attended two study days per year and attended a prescribing forum three times a year to keep their knowledge and competencies up to date. Other specialist training attended included an advanced planning and admission to hospital course.
- The SPC team were involved in education meetings where they would discuss case studies, medicine prescribing, and 'what went right' discussions. Twice a week the SPC CNS had peer review sessions with the palliative care medical consultant. This ensured the knowledge and skills of the SPC team were kept up to date and the most up to date care was delivered to those receiving end of life care.
- The SPC senior management team were able to tell us end of life training for medical staff was high on the training agenda. A training programme was in place for the new junior doctors. We saw the training programme included topics such as breaking bad news, case study reviews and symptom control .The training sessions were led by the SPC CNS's and were due to started in October 2016. A video around end of life care has been developed for the junior doctors and was available on the trust web page.
- Medical division training and mortality and morbidity meetings have end of life care as a standing item with the SPC nurses being invited.
- A recent care of the elderly training day included training from the SPC CNS where case studies were used to get doctors talking about death and dying.
- Orthopaedic surgeons attended an end of life training session and a rolling programme to cover identifying the dying patient and end of life conversations were being set up. However, it was recognised that more work was required to involve consultants in the education programme so a working group has been set up to address this.
- The Chaplaincy undertaken open meetings at each site around the role of the chaplaincy service in end of life care. They have conducted two meetings at each site with attendances running into the thirties at each meeting.
- The Chaplaincy volunteers went through an induction programme which included an interview, a 12 week course, DBS check, and a six month probationary period. Two training sessions take place annually for the team and site team meetings to create a sense of team.
- Training of mortuary porters has improved since the last inspection. Training was developed and provided by the trust mortuary and moving and handling teams, which was based on the last offices procedure/policy. A 'train the trainer' scheme took place where the portering company managers were trained to cascade training to porters. Mortuary training records provided by portering manager show 100% compliance. Training was provided at induction and annually.
- Areas of concern raised by the porters at the last inspection included Infection control training (IPC), the use of hoists and green sheets. Since the last inspection, we were told that IPC training was now provided in conjunction with the trust. Training was now consistent with the hospital staff training. Compliance on training in the use of hoists had improved with over 95% of staff having received training. The remaining are new staff and will receive their training at induction.
- We reviewed training records provided by the portering company for all sites. Porters said they felt confident in using the hoists. Staff reported the compliance on the use of green sheets had improved.
- The Relative Support Office provided an administrative service, staffed by three relative support officers (RSOs). The head of patient experience and deputy managed RSOs across the three sites. The RSOs received in-house training provided by the patient experience team. Recent training included communication skills training.
- Appraisals were completed for all RSOs. We saw evidence of completed appraisals, signed and dated within the last month.

End of life care

Multidisciplinary working

- A weekly SPC multi-disciplinary meeting between the three acute hospitals was held via video link. Consultants, SPC team, counsellor, and social worker attended from each hospital who brought cases of patients with complex needs for. Smaller local weekly MDT meetings took place between the palliative care consultant and SPC CNS where local patients were discussed and care planning took place.
- The SPC teams worked closely with the local hospices to discharge patients who wished to die in their own homes. They had established good working relationships with the hospices.
- The end of life board had a multi-disciplinary membership, which meant end of life care was everyone's responsibility. Information discussed at the board was cascaded from the board members to the teams across the hospital through a variety of directorate meetings. We saw ward team meeting notes that end of life care was presented to the staff.
- The SPC team had introduced end of life care plan documentation to support the care of patients approaching the end of their lives. However, we saw poor uptake of the documentation across the wards visited. This meant the care delivered to the patients could not be easily reviewed. It was unclear for these patients if the recommendations set out in national guidance were being delivered.
- We saw evidence across the wards of MDT meetings taking place throughout the week to review patient's management plans. On Sandwich Bay ward, we observed the ward manager, junior doctor and pharmacist discuss the needs of a patient and preparing to arrange a further MDT meeting. A multi-disciplinary team ensured the best care met the patient's individual needs.
- The SPC CNS told us that they had close working relationship with other CNSs across the hospital including cancer and non-cancer specialists. The SPC CNS told us joint reviews took place between the breast, colorectal and head and neck CNSs to provide joint care whereas the upper gastrointestinal CNS would manage patients until the end, as the CNS previously worked at the hospice. We spoke to a heart failure CNS who told us joint working took place when support was needed in the management of the patients with complex symptoms.
- Porters (employed by a contracted company), mortuary, relative support staff and ward staff all described good working relationships. The SPC senior management team told us the head of nursing for support services regularly feedback to support staff and gave guidance on new policies and procedures. Task and finish groups were set up when new guidance was being developed. All relevant staff groups were invited to contribute.
- There was no electronic palliative care system to share information across providers.

Seven-day services

- Since the last inspection there had been no changes in the hours worked by the SPC team, mortuary staff, relative support officers or the chaplaincy.
- The SPC team worked from 9am to 5pm, Monday to Friday. There were insufficient numbers of staff to provide a seven-day service. Outside these hours and at the weekend, the local hospice provided telephone advice and support.
- The mortuary was open 8am to 4pm Monday to Friday. Staff provided a 24 hour on call service seven days a week.
- Relatives were supported when attending a viewing by the RSO between 10am and 4pm, outside these hours this service was provided by the Site Coordinator.
- The chaplaincy service was available 9am to 5pm Monday to Friday with an on-call service from 6pm to 6am for emergencies only.

Access to information

- Staff had access to the information they required to provide good patient care.
- Each ward was provided with an end of life care resource folder that contained current information and trust documentation. Staff were able to show us the folders on the wards we visited. We reviewed the folders and saw that all the relevant information had been included in the folders including end of life conversation and care plan records, the multi-disciplinary prompt for the care of patients at end of life and medication guidance.
- Ward staff demonstrated to us how they accessed end of life documentation on the trust intranet end of life care page.
- During the last inspection, we saw that with patient consent the trust had access to GP records through the Medical Interoperability Gateway (MiG) system. This

meant that when a patient arrived in A&E the system automatically flagged up if they were at end of life. The palliative care team monitored the system and the local hospice was informed if they knew the patient. However, the SPC senior management team told us the MiG system was read only and therefore were not able to edit information, attach care plans, or add discharge summaries onto the system. We were told this was being resolved up by the divisional lead.

- We saw that the Trust had guidance on 'Religions, beliefs and practices - Guidance for the care of the dying/deceased patient'. This guidance gave information around beliefs, eating and drinking, key issues on death and dying, and covered a variety of religions including Buddhism, Hari Krishna, Hinduism, and Islam. Ward staff were aware of the guidance and described that even though they did not have many patients with different belief and cultures, they supported these when caring for dying patients. Mortuary staff gave an example that they supported the wishes of an Islam patient who had his body washed by family members.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During our visits to the wards, we saw and heard several occasions when staff sought the consent of patients before an intervention. On reviewing patient medical records, we observed that allied health professionals including physiotherapists and speech therapists clearly documented that consent had been gained before proceeding with an examination. We observed that staff of all disciplines communicated sensitively with patients at a level based on their communication need.
- Assessing capacity specifically for resuscitation decisions did not appear to be documented on a routine basis and was therefore not obtained in line with legislation and guidance. On reviewing the DNA CPR orders of six patients, we found that one patient was described as lacking capacity to make decisions and did not have the necessary Mental Capacity Act assessments undertaken.
- We found six DNA CPR orders we reviewed had documented patients and their relatives were involved in discussions and the orders were signed by a senior doctor.
- Nurses were aware of the Deprivation of Liberty Safeguards and showed us how they followed the process including the forms they used
- The mortuary staff were able to describe the trust processes they followed regarding the removal of human tissue which is the NHS Tissue Services recommendations and the trust used consent forms by the NHS Tissue Services.

Are end of life care services caring?

Good

During the last and this inspection we judged caring as good because:

- Staff at QEQM provided compassionate end of life care to patients. The SPC CNS performed patient reviews in a sensitive, caring, and professional manner, engaging well with the patient. The patient's complex symptom control needs were met and the supportive needs of both the patient and relative were addressed.
- In the April 2016 trust bereavement survey, 81% of the bereaved relatives reported that the overall quality of care delivered was good to excellent with 85% of relatives reporting family members were kept informed of their loved ones condition as well as receiving information that was easy to understand.
- Mortuary staff reported the nursing staff appropriately prepared deceased patients after death in line with hospital policy. Nursing and mortuary staff confirmed hospital porters transferred deceased patients to the mortuary in a discreet and respectful manner.
- We found ward staff were caring, compassionate, and respectful when they described how they cared for patients as they approached the end of their lives. Staff ensured that relatives were supported, involved, and treated with compassion as best they could. This was confirmed by a relative who sent a thank you note saying 'thank you for caring' and staff were invited to attend the patient's funeral.
- Spiritual and religious support was available through the chaplaincy. The chapel was open at all times of the day and night for patients and families to visit. Facilities for other religions and cultures were available including an area and mats for Muslim prayers.

Compassionate care

End of life care

- The SPC team developed a carer's bereavement survey to gather the views of bereaved family members with a report of the findings being published in April 2016. The response rate to the survey was low at 24% however it gave the SPC team valuable insight into the experience of dying patients and their families.
- The end of life care board have discussed the findings and actions sanctioned which include the end of life online training modules to be agreed to improve advance care planning, symptom control, communication and the management of the last days of life and SPC CNS to target ward hot spots and improve end of life care across the trust.
- The survey asked bereaved relatives a variety of questions to gain an understanding of the care delivered across the trust. The areas covered included the overall quality of care, communication, dignity and respect, emotional care, spiritual care and symptom control. From the survey, 81% of the bereaved relatives reported the overall quality of care delivered was good to excellent with only 5% reporting care was poor.
- With regard to communication, 85% of bereaved relatives reported family members were kept informed of their loved one's condition as well as receiving information that was easy to understand. This indicated that staff were mindful of the delicate situation family members found themselves in and ensured communication channels were open at all times.
- 57% of bereaved relatives reported emotional support was excellent to fair. However, 15% of bereaved relatives reported they were offered no support at the actual time of death. We asked staff on the wards we visited how they supported families after a death, staff were caring and compassionate which does not reflect the survey's findings.
- We observed that staff demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how the SPC teams work had positively influenced the overall service.
- Nursing staff on Sandwich Bay ward told us the porters were very respectful when transferring patients from the ward to the mortuary. Porters ensure curtains are drawn when transferring deceased patients on the wards. Dignity was maintained at all times with a single sheet to cover the deceased patient in addition to the shroud.
- Hospital porters transferred deceased patients to the mortuary in a discreet and respectful manner. The mortuary staff ensured from the documentation, that any particular religious or cultural wishes were respected. Mortuary staff said the porters treated the deceased patients with respect during the mortuary processes.
- The relatives support office was introducing a survey to bereaved relatives to monitor the service. This was in response to the recent bereavement survey where relatives spoke about delays in getting the medical certificates of cause of death (MCCD) and how relatives felt they were handled in a rushed manner.
- The same survey suggested relatives did not always feel conversations were conducted in a sensitive manner by the medical staff. Medical staff received extra training.

Understanding and involvement of patients and those close to them

- We reviewed six patient medical records and saw patients referred to the SPC team were kept actively involved in their own care and relatives were kept involved in the management of the patient with patient consent.
- Staff we visited on the wards told us they were not involved in preparing advanced care plans with patients and their families. As part of the interagency policy GPs and community nurse team leaders were expected to ensure anticipatory and advance care plan (ACP) were completed and agreed with the patient, carer or family. However, we did not see any ACPs in place during the inspection.
- Ward managers told us that families could stay on the ward as long as they wished after death to give them time with their deceased relative.
- We saw "You said – We did" boards on the wards we visited which provided feedback to patients and others who had raised concerns including actions taken which addressed those concerns.

Emotional support

- The SPC team members had completed the advanced communications skills course and several of the team were trained to psycho-oncology level two skills which supported several NICE Guidelines in Oncology. This highlighted the provider supported staff to gain the knowledge and skills required to meet the needs of patients requiring palliative and end of life care.
- The trust counsellor and social worker linked closely with the local hospices. This enabled them to signpost

patients towards community support after leaving the hospital. These included bereavement counselling and support groups as well as local site-specific tumour groups.

- The Chaplain was available to provide spiritual and religious support when asked by the patient/families and medical and nursing staff. There were trained volunteer chaplains who provided further support to patients and staff. We saw two examples when the Chaplain provided quick response (took 10 to 15 minutes from request to present on ward) to support patients and families on the wards we visited.
- The Chaplaincy supported bereaved families and staff and conducted funerals when requested. We saw that prayers had been collected from patients on the wards.
- The Chapel was available for all patients, visitors, and staff. The chapel was open at all times of the day and night. We saw facilities for Muslim prayers, including washing facilities.
- There were links with all the main faiths in the areas and a clear philosophy to support all people of any faith or no faith. There were information leaflets provided including bereavement, death of a child and support groups.

Are end of life care services responsive?

Requires improvement

At our last inspection, we rated the service as requires improvement. On this inspection we have maintained a rating of requires improvement because

- In the wards we visited, patients approaching the end of their lives would be cared for by staff in a side room if one was available, to ensure patients dignity and privacy was maintained at all times. However, during the inspection the majority of patients receiving end of life care were being nursed in bays as single rooms were not available. This meant there was little privacy from surrounding patients, relatives, and the workings of the bay for patients approaching the end of their lives.
- After a patient's death families would be asked to contact the RSO to arrange an appointment to collect their relative's belongings and the medical certificate of cause of death (MCCD) which enables the deceased's family to register the death .The trust set a target of 3 days to release a MCCD. The data we reviewed confirmed a small number of certificates were still taking between 3 to 7 days. However, we did see an increase in the number of certificates meeting the target through service improvement initiatives.
- During the last inspection, it was highlighted that there were delays in discharging patients to their PPC or preferred place of death (PPD) through the fast track process. Staff confirmed the process had not improved with the majority of patients taking weeks rather than hours to be discharged to their PPC or PPD. Since the last inspection, we found the timeliness of installing equipment at home had improved and care packages could be requested in four hours. However, if a patient's PPC was a nursing home or hospice, delays were presented whilst waiting for a bed to become available.
- The trust did not audit if patients had achieved their PPC or PPD.

However we saw improvements since the last inspection which included:

- SPC data from April 2015 and March 2016 we saw showed the SPC team reviewed 56% of patients with a cancer diagnosis and 44% of patients with a non-cancer diagnosis. The SPC team were supporting a high percentage of patients with a non-cancer diagnosis, which was well above the national average of 28%.
- The SPC nurse consultant sat on the group that developed the interagency policy. By being part of this policy group the trust could ensure their services were developed to meet the needs of the local community and help more people at the end of their lives to be cared for and die in the place of their choice.
- During the 2016 audit of the end of life record of conversation documentation it was found the PPC was discussed in nine out of the fifteen forms completed, this was a 60% compliance rate. This has increased from the 2015 audit where there was only 33% compliance. Discussions about PPC are vital if the wishes of patients and their families are to be fulfilled

Service planning and delivery to meet the needs of local people

- The four East Kent Clinical Commissioning Groups (CCGs) had an end of life work stream group. The SPC Consultant Nurse attended the East Kent CCG work

stream in order to feed back into the end of life care board at the Trust in order to deliver a service that meets the needs of the patients that are admitted to hospital.
- An interagency policy was in place across all the providers in East Kent. This policy ensured services was developed to meet the needs of the local community and help more people at the end of their life to be cared for and die in the place of their choice.
- There was no dedicated specialist palliative care ward. Patients reaching the end of their lives were nursed on the main wards in the hospital.
- When possible, patients approaching the end of their lives were given the opportunity to be nursed in a side room, if one was available. However, patients with infectious conditions took priority. On the wards we visited, the majority of end of life patients were being nursed in bays.
- If a patient was nursed in a bay, privacy was maintained by keeping the curtains drawn if requested by the patient or family.
- The trust had opened a suite on all three sites specifically for relatives of patients receiving end of life care. The suites consisted of sitting rooms, a shower, and a kitchen with access to a garden. They provided a place of quiet and peace for relatives to rest, freshen up, and make themselves drinks. Staff on the various wards we spoke to were able to tell us they signposted relatives to the suite.
- There were no camp beds available on the ward for relatives to stay by the bedside. Families would have to use the chairs available at the bedsides.
- We found little evidence of family rooms on the wards. Staff would use the day room or nursing/doctor's room to provide a quiet place for relatives. These rooms did not always provide the appropriate surrounding and privacy relatives required at such a time.
- Mortuary staff at QEQM provided the required information to the William Harvey Hospital mortuary team who undertook a daily track of the mortuary spaces available for the three hospitals and had processes in place to ensure adequate storage spaces were available at all times.
- The Human tissue Authority inspected the mortuaries across the trust which took place every four years. The last inspection was in November 2012 and all actions (minor) were completed. The next inspection is due October 2016.

Meeting people's individual needs

- There was no electronic system to alert the SPC team if a palliative care or end of life patient was admitted, the ward staff would make the necessary electronic referral to the SPC team if their support was required. In Accident and Emergency (A&E) if an end of life patient was due to be admitted ,the link nurse would contact the SPC team however most SPC reviews would take place when the patient arrived on the wards.
- All patients with complex symptoms within the trust who required end of life care had access to the SPC team. Referrals were accepted from any member of the health care team or by self-referral. Consultation with the patient's hospital consultant or a doctor in the team would be attempted on referral and after the assessment. Referrals to the SPC team could be made by telephone, bleep or electronically on the hospital management system.
- Once a patient was referred to the SPC team, treatment and care took account of the patient's individual needs. This could be working in conjunction with other specialist nurses to support patients with complex symptoms as well as those with complex needs being cared for by generalist teams. Ward managers described that the heart failure nurses were closely involved with the patients and liaised with the GPs and community teams if patients were due to be discharged to their PPC.
- The SPC team and other nursing staff we spoke with told us that all communication included the patient and those people who were important to them. During the inspection, we saw medical records where patients were reviewed by the SPC CNS who planned with the patient's consent to speak to the family on their next visit to the hospital.
- On Sandwich Bay ward, the ward manager described that any patients with dementia or a learning disability would have their care reviewed by the dementia care nurse. Staff had received training around caring for dementia patients and felt they had received the necessary training to care for these patients.
- Nursing staff on the wards we visited spoke of the need for opening visiting hours for families whose relatives were receiving end of life care. On Sandwich Bay and Fordwich wards, staff confirmed that visiting hours were

between three and eight pm. However, families for patients receiving end of life care were able to visit outside these hours. During the inspection, we observed family members visited throughout the day.
- After a death had occurred, relatives were given a bereavement leaflet called, 'Help the bereaved, A practical guide for families and friends' and the number of the

nurse in charge of the ward as they left the hospital. The families would be asked to contact the RSO who would confirm the details and arrange an appointment to collect their relative's belongings and the medical certificate of cause of death (MCCD).

- Staff told us relatives could stay on the ward after a patient died to help with the after care of the deceased patient. However, we were told that this rarely happened in practice.
- A porter told us that two porters would transfer a deceased person to the mortuary out of hours as per hospital policy. For access to mortuaries, the porters were provided with a key fob or pin codes.
- The relative support office was open from 10 am to 4 pm Monday to Friday. The RSO booked all appointments for families following a death, liaised with funeral directors and ensured that the medical records and all documentation was in place for the doctors to complete the MCCD which enabled the deceased's family to register the death. Information leaflets such as the "The funeral funding service" was available and given to relatives when required.
- The RSO described that the MCCD was made available for relatives ideally within the trust target of three days, or slightly longer if the death happened at the weekend. However, this did not always happen and there had been delays in releasing the MCCD. We reviewed the data and found at QEQM between June and August 2016, 136 certificates were issued of which 98 were issued within 24 hours, 29 were issued in less than 2 days and 9 were issued within 3 to 5 days. A RSO told us the time taken to issue a MCCD had improved since consultants had taken a more pro-active role in promoting this at junior doctor's induction. The trust has plans to extend this by introducing a routine slot in the junior doctor's induction. Consultants also chased up junior doctors on a daily basis to speed up the process however further work was required to further improve the MCCD issue times for relatives.
- The RSO explained they work with the chaplain to meet requests for next day funerals such as for patients with Muslim or Jewish faith. Relatives normally understood if an MCCD could not be issued within 24 hours however, the RSO tried their best to speed up the process to meet their needs.
- The RSO told us children who have lost a parent were dealt with by the staff in the wards/departments and the coroner's team. For patients who had no relatives the RSO investigated by using "Finders" to establish if the patient has a family or not. The RSO contacted the Chaplain was and a 'contract funeral' was organised .The funeral costs were covered by the trust.
- Families attending for appointments were escorted to a quiet room for discussion, advice, and information. Patient belongings were stored in the relative support office.
- The Chaplain was available on site from 9am to 5pm Monday to Friday. An on-call service was provided for out of hours.
- During the last inspection we visited the mortuary and observed the viewing suite where families came to spend time with their relatives after their death. The waiting area had neutral décor to take into account all faiths. Religious symbols were displayed when requested. There were comfortable seating, water, and tissues available. A call bell was available for the family. Information leaflet "funeral funding service" was available for relatives. A bible was available when requested. Staff received support and direction from the chaplaincy including any other religious and cultural requirements.
- Mortuary viewings took place between 11.30am to 3.30pm Monday to Friday. Outside these times, viewing could be arranged in exceptional circumstances, for example, a baby or child. No viewings take place in the evenings, weekends, or bank holidays. Staff advised relatives that viewing may be affected by noise from tools and unpleasant smells (post mortems) and would encourage viewings after midday because of this. Viewings are supported by mortuary staff and sometimes include the RSO.
- Mortuary staff told us they catered for other cultures and faiths. For example, they were able to allow Muslim families to undertake washing of the deceased and a Japanese family to use incense sticks.

Access and flow

End of life care

- At the last inspection, we noted delays in discharging patients to their PPC or PPD through the fast track process. The purpose of the Fast Track Pathway Tool for NHS Continuing Healthcare November 2012 (revised) was implemented to ensure that individuals with a rapidly deteriorating condition, entering a terminal phase, were supported in their PPC as quickly as possible. This has not improved during this inspection. Ward staff told us the discharge process was anything but fast with many patients not achieving their PPC due to the length of time the process took to facilitate the discharge. On the wards we visited the majority of staff told us the process took weeks rather than hours or days to complete.
- There was a multi-professional approach to discharge processes. This included doctors, nurses, physiotherapists, and occupational therapists working together to ensure that patients had all the necessary clinical support and medical equipment in place for the patients discharge. The SPC senior team told us that since the last inspection, installing equipment at home had improved and that care packages could be requested in four hours. However, if a patient's PPC was a nursing home or hospice, delays were presented whilst waiting for a bed to become available. This led to a long and cumbersome process which could result in the patient not receiving their PPC.
- As part of the interagency work, it was the responsibility of the GPs to identify the patients' PPC and PPD. However, this was not always in place. When patients were admitted to hospital, the information regarding the patient's preference was expected to be collected at the time of the end of life conversation. The 2016 audit of the end of life record of conversation documentation found the PPC was discussed in only nine out of the fifteen forms completed. This was a 60% compliance rate. This had increased from the 2015 audit where there was only 33% compliance. Discussions about PPC were vital if the wishes of patients and their families were to be fulfilled.
- The trust did not audit the percentage of patients that achieve their PPC or PPD. Patients were discharged to their home, hospice, or nursing home. The SPC team records showed in 2015/16, 49% of patients were discharged home with between 9 and 12% being discharged to the hospices.
- Of the patients reviewed by the SPC team between April 2015 and March 2016, 56% of patients had a cancer diagnosis and 44% of patients had a non-cancer diagnosis. The SPC team supported a high percentage of patients with a non-cancer diagnosis which was well above the national average of 28%. This highlighted the SPC team's commitment to supporting all patients with complex symptoms approaching the end of their life regardless of the diagnosis.
- At the last inspection, the SPC team told us only patients with the most complex needs were referred to the SPC team. This remained unchanged in the last year, as there was no increase in the SPC staffing. The SPC team acknowledged they did not have sufficient resources to support generalist staff to have the skills and confidence to care for patients at the end of life. However, with the appointment of the end of life facilitator and link nurses, the skills and confidence of generalist staff was expected to improve.
- The SPCT CNS reviewed patients depending on their needs, offering them support and reviewing their care needs. Patient contacts ranged from 15 to 60 minutes depending on the need of the patient and their families, with many end of life patients requiring more than one contact in a day. Palliative care medicine consultants reviewed complex cases during the twice-weekly ward rounds and spoke to medical teams and carers in-between the ward rounds if required.
- The portering service recorded the time of each patient when removed from the ward to the time the transfer was completed at the mortuary. This was recorded as taking from 30 minutes to an hour for all three sites.

Learning from complaints and concerns

- The end of life care and palliative care service did not receive a high number of complaints. We were provided with the complaints log for the period June 2015 and June 2016 and there were no complaints received related to QEQM. No complaints had been made against the SPC team in the last year.
- The end of life board reviewed end of life complaints. The complaint process demonstrated that systems were in place to respond to complaints in a timely manner. We noted a good governance structure and a service that learned from its complaints.
- The RSO told us if relatives raised concerns regarding the care their relative had received, they listened to the

issue and contacted the relevant medical team to meet or speak with the relative. The RSO provided PALs contact details and explained the trust complaint process.

Are end of life care services well-led?

Requires improvement

At our last inspection, we rated the service as requires improvement. On this inspection we have maintained a rating of requires improvement because:

- The end of life strategy for East Kent was a working document. However, the majority of the agenda was to be implemented by the SPC team. The sustainability and success of its implementation is questionable due to the current size of the SPC team and their continuous clinical commitment to support patients with complex symptoms. The trust had been in negotiations with a cancer charity and had secured funding for two further nursing posts.
- Since the last inspection, a clear governance structure was in place to support end of life care. The end of life care board was well represented by a multi-disciplinary membership, which covered a variety of specialities across the trust as well as with outside stakeholders.
- The terms of reference for the end of life care board had recently been changed and it was now a decision making board. However, we did not see that end of life care incidents from across the trust were discussed at this meeting. One SPC CNS told us incidents were now being discussed but we were unable to confirm this. This meant the board did not have a comprehensive overview of the service and an awareness of the wards that were providing the best or worse care.
- No separate risk register was available for palliative /end of life care. A separate risk register would allow the risks to this patient group be discussed regularly at the end of life board, and allow plans to be made to alleviate any identified risks.
- The service level agreement between EKHUFT and the hospice was still not finalised. The signing of the contact will allow the trust to establish the gaps in their service provision.

However we saw improvements since the last inspection which included:

- The leadership of the SPC team to be strong and forward thinking. Staff told us they were approachable and visible. Staff in the SPC team new their reporting responsibilities and took ownership in their areas of influence.The SPC team were on the right trajectory and had done a lot of good work.
- The SPC team had undertaken a bereaved relatives and staff survey since the last inspection to gather views and use the outcomes to initiate change.
- The introduction of the QII hubs was very positive and had raised the profile of end of life care.

Vision and strategy for this service

- End of life care sits in the Specialist Service Division and there was a Trust-wide End of Life Care Board met bi-monthly. The head of nursing and consultant nurse for palliative care attended this board. The four East Kent Clinical Commissioning Groups (CCGs) had an end of life work stream group and was setting the end of life strategy for East Kent in which the Consultant Nurse for Palliative Care attended so feedback was given to the end of life Board at the Trust. An improvement plan was in place to implement the strategy.
- During the last inspection, we saw the strategy was only available in draft from. The East Kent End of life strategy has now been ratified and was a working document and available to review on the EKHUFT web site. The strategy stated a commitment to improving the end of life experience for patients and their relatives and involved all parties working closely together. It considered an expected increase in demand for both cancer and non-cancer end of life care in the region. This was reflected in the referrals to the SPC team, which have increased, by 16% in the last year.

Governance, risk management and quality measurement

- There had been considerable work done to improve communication between the board and the wards by having a wide range of health care professionals from various specialities attending the end of life board. We saw representation from critical care, surgery, renal, oncology, urgent care and the chaplaincy. Stakeholders from outside the trust including members of Healthwatch and the CCG also attended.

End of life care

- The end of life Board minutes fed into the Patient Safety Board and into the Specialist Palliative Care meetings for decision-making and implementation. The terms of reference for the end of life care board had recently been changed and it was now a decision making board.
- The Head of Nursing for the Specialist Service Division was able to tell us that there was no specific risk register for end of life care. No high risks had been identified for the service at the last governance board.
- We reviewed the minutes from three end of life boards. However, we did not see end of life care incidents from across the trust were discussed. This meant the board did not have a comprehensive overview of the service and an awareness of the wards that were providing the best or worse care.
- Since the withdrawal of the LCP from the trust in July 2013 and the introduction of the end of life care plan documentation in January 2016, the SPC team had introduced a three monthly audit programme to monitor the implementation of the documentation across the wards. Results from the audits were discussed at the end of life care board where members would feedback results via there divisional clinical governance meetings. Results were placed in the QII hubs for staff to review during visits.
- Staff told us the introduction of the QII hubs was very positive and had raised the profile of end of life care. The hub was opened every Thursday from 10am until 2pm.The mortuary team had worked with the nurses in the hub to train staff in the last offices procedures, which included care after death.
- The last two audits of end of life documentation showed that there was still limited take up of the documentation with variable understanding and knowledge on the wards. Improved compliance was expected with the appointment of the end of life facilitator who was engaging with the wards and the end of life link nurses to raise the profile of end of life care across the trust
- The SPC teams oversaw the whole end of life care agenda trust-wide however, with no increase in the medical and nursing establishment this was a tall order for all the staff concerned. The trust had been in negotiations with a cancer charity and had secured funding for two further nursing posts. However, the trust, at the time of the inspection, had put this on hold to evaluate the best way to support end of life services across the trust.
- During the last inspection, we found no contract or service level agreement in place between the trust and the local hospice. The SPC senior team told us that a second draft had been received by the trust and they expected to sign the contract in the coming months. The signing of the contact will allow the trust to establish the gaps in their service provision.
- There was a trust wide Specialist Palliative Care Team Annual Report for 2015-2016 described the staffing, role and training provided by the team. With the recent appointment of the end of life facilitator, this role will bring together the education and training of all the staff groups and support the role of the link nurses to embed quality end of life care across all the hospital sites.

Leadership of service

- The Medical Director was the nominated lead for end of life care and was a member of the end of life care board. All actions from the Improvement Plan relating to Specialist Services Division were circulated to the trust board.
- Staff we spoke to across the trust were passionate and committed to delivering quality care to patients and their families at this difficult time. However, we found this was still frequently managed in an ad hoc and reactive manner as need was recognised. To address this at ward level, end of life care was to be led by the end of life care link nurses with support from the end of life facilitator and SPC CNSs. Link nurses through signing a contract showed a commitment to support staff to deliver good end of life care and give regular updates on new guidance. At the time of the inspection, 100 link nurses had been identified and training was underway to skill up the staff across the trust through an education programme.
- We saw strong leadership of the SPC team with the appointment of a new head of nursing for the specialist service division. One matron described how supported they felt by the head of nursing for the specialist division. We observed that the SPC team were visible, responsive and were active in policy and audit. Team working within the SPC team was of a high standard and all the staff we spoke with who told us the SPC team was 'responsive and very supportive'.

End of life care

- The hospital chaplains led the chaplaincy service. We observed that the chaplaincy team were visible, responsive and were involved in policy and auditing. The lead chaplain was an integral member of the end of life board.
- Through the end of life board, formal links were in place with stakeholders from the community, hospice and CCGs. This meant that stakeholders opinions were included in the decision making process.
- The Critical Care team had an end of life group chaired by the ward manager who was also a member of the end of life board. This was a trust wide group ensuring clinical practice and documentation was consistent across the trust's critical care units.
- Across the trust 'Schwartz Rounds' had been established for staff to regularly come together to discuss the non-clinical aspect of caring for patients, including psychological, emotional and social challenges associated with their work and help staff deliver compassionate care. We saw that end of life care was on the agenda of the next Schwartz round.
- Porters told us that communication had improved since the last inspection. For example, there was a trust general manager on each site and information about the trust was being cascaded to portering staff via the portering manager and supervisors. Porters told us they do not get to hear about all new policies, only the policies that were applicable to the portering staff and then training was provided accordingly.
- The RSO we spoke to felt very well supported by their line managers. They also said the new senior management team including the Director of nursing, CEO, medical director were more visible. All staff we spoke to felt they were working very hard to help the trust get out of special measures.
- Staff on the wards we visited felt generally supported by their clinical leaders.

Culture within the service

- Across the trust, it was being communicated that end of life care was everyone's responsibility. We saw that through a variety of methods including the end of life care board, with its multi-disciplinary membership, the QII hubs, the appointment of end of life facilitator and link nurses and a structured education programme, end of life care was not being delivered in isolation. The SPC team told us they were changing the focus and trying to change the culture and release the burden from the SPC CNSs by empowering the ward teams. We saw that this shift in culture was work in progress.
- We saw that the SPC team integrated well with nursing and medical staff, there was obvious respect between specialties and disciplines. SPC team members we spoke with were passionate about supporting patients, families, and staff in end of life care. This was confirmed when we spoke to staff on Sandwich Bay ward who told us the SPC nurse was dedicated and even though there was a huge workload at the moment , the SPC nurse would always be supportive and offer telephone advise to doctors, support families and sort beds out at the hospice.
- All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work influenced the overall service. The SPC CNS told us staff were much more involved and aware of what was expected of them in the delivery of end of life care. Since the last inspection, staff told us there was a heightened focus on end of life care with the introduction of syringe driver competencies and end of life care plan documentation. However, several nurses told us they were not using the documentation as they were unsure when to introduce it.
- The mortuary and RSO told us they were all working very hard to take the trust out of special measures. Staff felt supported and moral had improved.
- All staff we spoke with described an improving culture since the new Chief Executive Officer (CEO) and other changes in the senior management team had taken place. Staff also told us the CEO and Head of Nursing were seen on the wards. Staff could talk honestly and felt the senior team were generally interested on what was going on in the wards. The CEO had an on line blog. Staff felt it was becoming a more open organisation and was changing for the better.

Public engagement

- The end of life care service had conducted an end of life carers' survey in January 2016 which sought the experience of bereaved relatives and carers. The trust end of life board and CQC improvement board have actions to monitor the survey and produce an action plan against the key findings. Following this year's

survey, actions included the SPC CNSs targeting wards to improve end of life care across the trust and robust education programme around the use of the end of life care plans.
- The trust had completed the End of Life Care Audit – Dying in Hospital: National report 2015. No previous involvement in the audit was available for comparison. However, we did review the trusts audit programme and found the trust planned to participate in the next audit.

Staff engagement

- The end of life care service had undertaken a staff survey in order to obtain the opinions of staff across the trust. The SPC team will use the findings to develop their education programme.
- Staff spoke highly of the QII hubs. This was an area where staff could come with suggestions for improvement. There was an end of life care information stand. It was manned once a week from 10am to 2pm.Staff told us they had attended the stand and thought it was a great way to spread the word and receive updates on end of life care.

Innovation, improvement and sustainability

- The SPC team submitted data to the National Minimum Data Set, which allowed the team to benchmark their service nationally and use the findings to improve their service to ensure they fit the needs of the local community. The team also input data into a specialist cancer database.
- The SPC team had introduced the end of life care plan documentation which was based on the '5 priorities of care' to support the delivery of good care by the generic staff on the wards. All the new documents were set out in an easy-to-follow manner following national recommendations. We saw limited up take on the wards of the documentation. However, this was work in progress.
- The SPC team were actively involved in audits to monitor the quality of end of life care across the trust and used the outcomes to initiate change across the service.
- Both a bereaved relatives and staff survey were undertaken since the last inspection, to gather the views of the end of life care delivered across the wards as well as the views of the staff. This meant the SPC team were using the views of service users and staff to initiate change.
- The SPC team were working with the community teams to develop a provider-wide prescription chart.
- Staff from the therapies speciality including Occupational, Speech and Language therapists, and Physiotherapists shadowed the SPC CNSs to support them in their role, as no formal training has been available.
- The trust took part in the National Care of the Dying audit: Hospitals 2015 to gather further views of the care delivered. An action plan was in place to address the issues raised.
- The SPC team was implementing the end of life care agenda. With a team that had not increased in size since the last inspection and a large number of deaths that took place across the trust, it was questionable as to how the small specialist team could deliver the agenda and support the delivery of high quality care to patients with complex symptoms.
- The service level agreement with the hospice was not in place at the time of the inspection.

Outstanding practice and areas for improvement

Outstanding practice

The trust's Improvement and Innovation Hubs an established forum to give staff the opportunity to learn about and to contribute to the trust's improvement journey. Staff ran the hubs and provided topics of interest suggested by staff that could be accessed at any time the hub was open.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times. This includes medical, nursing and therapy staff.
- The trust must ensure there are systems established to ensure there are accurate, complete and contemporaneous records are kept and held securely in respect of each patient.
- The trust must ensure that all staff have attended mandatory training.
- The trust must ensure that there are adequate maintenance arrangements in place for all of the medical devices in clinical use.
- The trust must take steps to ensure the 62-day referral to treatment times for cancer patients is addressed so patients are treated in a timely manner and their outcomes are improved.
- The trust must ensure there is sufficient staff available to complete its agreed audit programme. Where audits identify deficiencies; the trust must develop clear action plans that are subsequently managed within the trust governance framework.
- The hospital must review staffing numbers in maternity and gynaecology services.

Action the hospital SHOULD take to improve

- The trust should continue to reduce the number of bed moves patients experienced during their stay.
- The hospital should monitor ambient room temperatures where medication is stored.
- The hospital should review the maintenance of medical devises.
- The hospital should review the appropriateness of the maternity and gynaecology environment.
- The hospital should include venous thromboembolism data on the department dashboard.
- The hospital should review the effectiveness of current plans to improve culture.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Ensure that there are sufficient numbers of suitably qualified, skilled, and experienced staff available to deliver safe patient care in a timely manner.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The trust must ensure that all equipment used by the service provider must be properly maintained

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust must ensure there are sufficient staff available to completed its agreed audit programme. Ensure that where audits identify deficiencies, clear action plans are developed that are subsequently managed within the trust governance framework.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

17-(1) Systems or process must be established and operated effectively to ensure compliance with requirements of this Part.

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...