Medway NHS Foundation Trust

Medway Maritime Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Medway Maritime Hospital

Requires Improvement 

A summary of CQC findings on urgent and emergency care services in Kent and Medway.
Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Kent and Medway below:

Kent and Medway

The health and care system in this area is made up of many health and social care providers and is supported by stakeholders, commissioners and the local authority. We found front line staff working across all services were doing their best in very challenging circumstances and had continued to do so throughout the COVID-19 pandemic.

Increased system wide collaboration, particularly between health and social care was needed to alleviate the pressure and risks to patient safety identified in some services we inspected. However, we did find some good collaborative working; for example, staff in acute and ambulance services had been working together to reduce handover delays, and primary and community services worked together to reduce attendances in Emergency Departments.

We found some access issues in primary care and some GP practices were not allowing patients to enter the building without staff permission; since our inspections, action has been taken to ensure patients can access their GP Practice freely. We did find examples of innovative practice including employing a variety of different healthcare professionals in GP Practices and across Primary Care Networks to better meet the needs of their patients ensuring people receive the right care at the right time. There was also funding available to provide interpreting and translation services to support people from diverse communities and to support people arriving in the UK from Ukraine.

Primary Care Networks were working well with community services to alleviate the pressure on ambulance and acute services where possible, particularly in out of hours services. In addition, technology was being utilised to improve services and provide timely access to patient information, especially for staff providing out of hours care.

Staffing issues and high levels of absence due to COVID-19 had impacted on services across Kent and Medway. GP Practices in this area had a larger number of patients per GP and demand had increased; however, in many cases this was well managed. The NHS111 service had experienced staffing issues as well as increased demand; this had resulted in significant delays in call answering times for people trying to seek advice.

Ambulance response times had also been poor across Kent and Medway. Whilst operational staff had done all they could to maintain response times to serious and life-threatening calls, response times to less serious calls were unacceptable, and performance had continued to be poor for a long time. This had widespread impact on people in Kent and Medway, and particularly on people living in care homes. Social care staff had to provide long periods of enhanced care to people waiting for an ambulance response whilst also caring for other residents.

There continued to be long ambulance handover delays at hospitals in Kent and Medway; however acute and ambulance services had worked well together to reduce these delays and improve handover processes.

Our findings

Emergency departments inspected in Kent and Medway continued to be under significant pressure. However, we found some improvements since previous inspections, including improvements in leadership and the culture within the departments. Staff worked hard to meet current demands and felt positive about the improvements they had seen. Some social care services had raised concerns in relation to the care provided to people with dementia and autism in emergency departments. Where specific concerns were raised, these were being investigated

There were delays in patients receiving care and treatment caused by poor patient flow across urgent and emergency care pathways. There were many urgent and emergency care pathways available within hospitals in Kent and Medway, however staff acknowledged these were not all working well or being fully utilised. Referral pathways between emergency department and urgent treatment centres aimed to meet people's needs and reduce pressure on acute services. However, we identified issues with inappropriate referrals, long waiting times and inconsistent risk assessments putting people at risk of harm. Patients also reported delays in their treatment due to inappropriate referrals. System partners were aware of issues with UEC pathways and had an action plan in place to address them.

We also found delays in patient discharge from hospitals and a shortage of social care capacity to enable people to leave hospital in a safe and timely way. In addition, social care services reported concerns about poor discharge processes. Examples included insufficient information about changes to medicines or people discharged into care homes who required a level of care for which staff were not trained to provide.

Staff working across Kent and Medway require additional support to manage the continued pressure on services. We also identified opportunities to upskill staff, for example, training additional social care staff in areas such as detecting early signs of deterioration in health. Increased collaboration between health and social care services and stakeholders is needed to address issues with patient flow across urgent and emergency care pathways. These pathways also require evaluation to ensure they are as efficient and effective as possible to meet the needs of people in Kent and Medway.

Urgent and emergency services

Good ↑↑

Medway NHS Foundation Trust provides acute hospital services from Medway Maritime Hospital. The trust employs approximately 4,400 members of staff.

The Emergency Department at Medway Hospital is open 24 hours a day, every day, for the treatment of serious and life-threatening illnesses and injuries for all adults and children. As well as being a trauma unit, the department and hospital has specialist services to care for patients with emergencies. The department receives over 125,000 attendances each year.

How we carried out the inspection

We carried out an unfocused inspection of Medway Maritime Hospital urgent and emergency care services (also known as accident and emergency- A&E) and some parts of medical care services between 15 and 16 February 2022.

This inspection was carried-out as part of a pilot approach of the urgent and emergency care pathway across Kent and Medway, to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures. It was also to review actions we asked the trust to take from our last inspection. The emergency department was previously rated as inadequate overall, with safe, responsive and well-led rate as inadequate.

Even though the service had an inadequate rating, we knew through ongoing monitoring and engagement that the trust and the service had made significant improvements. Therefore, while we commit to following-up inadequate ratings in a timely way, this was not an inspection carried-out in response to risk or concerns.

As this was a focused inspection, we only inspected three of our key questions which were safe, responsive and well-led. We included parts of medical care in responsive. We did not inspect effective and caring in emergency and urgent care at this visit but we would have reported any areas of concern.

We visited services and departments that patients may encounter or use during their stay. We also went to wards where patients from the emergency department were admitted for further care. This was to determine the flow of patients who started their care and treatment in the emergency department.

We spoke with eight patients, and over 20 members of staff. We reviewed 37 patient records.

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

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

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- The service managed medicines well.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Urgent and emergency services

- People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
- Staff were clear about their roles and accountabilities and all staff were committed to improving services continually.

However:

- The service did not always have enough nursing staff on duty however, the trust took mitigating actions to address the staffing shortfall.
- We saw patients queuing outside to be booked in in poor weather conditions. Patients had waited up to 40 minutes. Staff did not always go outside assess the state of the patients queueing.
- There continued to be poor flow of patients out of the department, with patients waiting for significant periods for speciality reviews and medical beds within the trust.

Is the service safe?

Good ↑↑

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

Nursing and medical staff received and kept up to date with their mandatory training. Training was provided either in person or via online training, depending on the topic. For example, life support training and manual handling were completed in person whilst equality and diversity were completed online.

The mandatory training was comprehensive and met the needs of patients and staff. Modules covered included, but were not limited to, basic and intermediate life support training, safeguarding, infection prevention and control and fire safety. Nursing and administrative staff were compliant with the trust target of 85%. Compliance with training was 97% for administrative staff, 90% for practitioners, 90% for adult nursing staff and 87% for paediatric nursing staff.

Compliance for medical staff was slightly below the trust target with a compliance rate of 84%. We saw an action plan led by the clinical lead to ensure all medical staff were up to date by March 2022.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said their managers would remind them when they needed to complete mandatory training and they also received an email reminder.

Safeguarding

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

Urgent and emergency services

Medical and nursing staff received training specific for their role on how to recognise and report abuse. Training compliance for safeguarding adults was 93% for administrative staff who were trained to level 1. All other staff had level 2 training and compliance was 100% for adult nursing staff, 96% for paediatric nurses, 90% for medical staff and 86% for practitioners which met the trust target of 85%.

All staff with patient facing roles were required to complete safeguarding and young people level 3 training. This was in line with the standards set out in the intercollegiate guidance document for healthcare staff providing care to children. Data showed that 96% of paediatric nurses had completed level 3 training, while 100% of practitioners met the target.

Adult nursing staff and medical staff did not meet the target with a compliance rate of 83% and 72% respectively for level 3 safeguarding children. Safeguarding training was provided by the local council and this had been stopped during the COVOID-19 pandemic. Training was to be resumed as of 11 March 2022 and the trust had identified the staff who were to be supported each calendar month to be compliant with the 85% target.

Staff said they reported concerns to the safeguarding team, using an electronic form and directly to the police when needed. They gave an example of recently needing to call the police when a patient reported they had been sexually assaulted. They were aware of the need to discuss consent with patients and when this was not needed, such as when others were at risk. They said the safeguarding lead for the department and the safeguarding team in the hospital had provided good support to them.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They gave multiple examples of when they had identified and helped patients. Staff told us of initiatives used to help patients such as giving patients a tube of lip gloss with a discreet helpline number for domestic abuse support.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. The service had a system to flag children with a child protection concern on their record. Staff told us this system helped them identify children that had been identified as at risk of abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Guidance was readily available and included contact numbers of the relevant persons and authorities, alongside an easy to follow flow chart of actions.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. Dedicated housekeeping staff were visible throughout the day maintaining the cleanliness of the department. The department was supported by a remote team, who were on standby to carry out any emergency deep cleaning alongside the regular daily cleaning that took place.

The service generally performed well for cleanliness. Cleanliness and hand hygiene audits took place monthly. Compliance with the hand hygiene audit varied between 85% and 100% across the various areas of the emergency department. Staff received feedback from audit via emails from managers about areas for improvement. The most recent feedback related to reminding doctors to remove gloves at the bedside to ensure hand hygiene compliance.

Environmental audits results from the last three months before our inspection were consistently above 93% for all areas.

Staff could access infection control policies via the hospital intranet. The trust had an infection prevention and control team who were available for advice and monitoring the department.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore face masks as required. All staff observed were seen to be bare below the elbows. We observed effective handwashing between patient contact.

COVID-19 infection control measures were robust. All patients were given a face mask before entering the department, temperature checks and COVID-19 screening questions were carried out. There were clearly designated red zones for patients who tested positive for COVID-19. Red zones had dedicated areas for donning (putting on) and doffing (removing) of personal protective equipment and we observed staff using these.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. All of the pieces of equipment we saw appeared clean, dust free and had "I am clean" stickers on them, that were dated so that staff knew the equipment was ready for use.

Hand washing facilities and sanitisers were readily available and in key points throughout the department. The department provided face masks to patients and the service had processes to ensure social distancing was maintained.

Side rooms were available for patients requiring isolation, for example if they posed an infection risk to other patients. Signage was used to advise staff and visitors not to enter without appropriate protective clothing.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. Since our last inspection in 2020 changes had been made to the emergency department to improve patient flow and the use of space. The main department was divided into the following areas: an eleven bedded cold resus area, a four bedded rapid assessment unit and a majors area with 15 cubicles. There was area 1, with two triage rooms and a streaming area, area 2 which had three consultations rooms and a triage room and area 3 with two cubicles and two consultation rooms. Patients with mental health needs were cared for in area formerly used as the clinical decision unit.

Staff said the layout of area 2 allowed extra capacity for triage and there was more space for patients. In majors, staff said they had everything they needed around the patient bed spaces allowing for them to provide better care and better patient experience.

Staff told us they were involved in the redesign of department. Staff who had been involved in the redesign of area 3 said this new design allowed for more nurses that were not practitioners to work in this area, and gain experience in minor injury and minor illness while under the supervision of a practitioner.

There was new a children's emergency department which was co-located to the main department. Staff said the layout helped to get children streamed and placed on the correct pathway quickly.

Urgent and emergency services

Although staff said the new department was more spacious, we found that as the department became busier, there was insufficient space in the waiting room which resulted in a queue forming outside the department for patients waiting to be booked in. At one point during the inspection, there were 13 patients queuing outside in the cold and rain.

The department was close to diagnostic imaging facilities which allowed for diagnostic procedures to be completed while waiting for a specialist review.

Staff carried out daily safety checks of specialist equipment. We checked four resuscitation trollies in the emergency and children's emergency departments. The trollies were secured with a tamper evident seal. The checklist attached to the trolley documented the seal number so staff were assured that a specific trolley had been checked. Checklists were completed daily and weekly and signed by a member of staff as per trust protocol. Electrical equipment such as the defibrillator was stored on the trolley and we saw it had been serviced in the last 12 months.

The service generally had enough suitable equipment to help them to safely care for patients. Equipment stocks were checked during the inspection. This included syringes, tracheal tubes, needles, PPE and anaesthetic masks. There was ample supply, and all pieces were in date.

Patients could reach call bells and staff responded quickly when called. Throughout the inspection we observed numerous examples of staff responding quickly to patients needing assistance.

Rapid testing for COVID-19 was completed for any patients suspected to have COVID-19. There was a dedicated testing laboratory within the department which processed an average of 120 tests a day. The lab had 17 analyser machines and staff told us that it took two and a half hours from swabbing a patient to receiving the result.

Ambulance staff told us it was often difficult to find a trolley to transfer patients from the ambulance trolley. They said at times they had walked around the hospital to find a trolley which caused significant delays in ambulance handovers. We noted during the inspection a patient waiting 40 minutes for a trolley to be found. This issue had been raised in the January 2022 emergency care governance group meeting and an action was agreed to buy more trollies for the department.

Staff disposed of clinical waste safely. Staff correctly segregated waste into clinical and non-clinical waste. There were clinical waste bins indicating what should be disposed of in them. They also had domestic waste bins for non-clinical waste which had signs on to remind people what could and could not be put into these bins

There were systems to ensure sharps were appropriately segregated and disposed of. During our inspection we observed sharps bins were correctly assembled and labelled in line with national guidelines.

The service had and maintained fire safety equipment to reduce the risk to patients from fire. The service had carried out yearly checks on fire extinguishers and these were secured to the wall where staff could access them quickly. All doors were closed and doors with "Fire door keep locked" signs were kept locked.

There was limited access to certain areas of both the children's and adult emergency departments with access only gained by authorised persons via a swipe card or intercom which created a secure environment.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Urgent and emergency services

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly including after any incident. Patients arrived in the department through the main entrance or the ambulance entrance. The main entrance had a streaming nurse responsible for assessing all patients for risk and for COVID-19 symptoms before streaming (directing) them to the relevant areas of the department depending on their needs; such as the urgent treatment centre, same day emergency care or majors. The ambulance entrance had an ambulance control nurse who took handover of patients from ambulance staff. We observed and spoke with the clinician undertaking streaming. Streamers were band 7 or above and had undertaken further training to perform this role.

Once patients were streamed, they were triaged by the triage nurse. Triage was used as a way to identify a patients' level of urgency and to treat them on their clinical priority rather than when they arrived in the department. We observed patients being triaged in both the main department and the children's department and found assessments to be thorough and complete. Some patients, depending on clinical need, would be sent for further tests before seeing a doctor. For example, electrocardiograms, blood tests and urinalysis. This meant medical staff would already have some results when they examined patients.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. As part of the triage process the national early warning score system (NEWS) was used. This is a tool for identifying deteriorating patients. A paediatric early warning score system (PEWS) was used for children. All records we reviewed had accurately calculated NEWS or PEWS scores. Where required, appropriate action was taken if the score was raised.

Staff knew about and dealt with any specific risk issues. Suspected sepsis would be flagged via a pre-alert. There were pathways which identified a specific bundle of care to be provided including the timely administration of antibiotics. The sepsis screening tool was automated within the electronic patient record. All patients were screened at the first time their observations were recorded using a screening tool. If this screening indicated the suspicion of sepsis, the sepsis six bundle was promptly started. The trust monitored sepsis screening rates and the timeliness of the first dose of antibiotics, which should be within an hour. Information provided by the trust for the last 12 months showed that the department's year performance stood at 98%, achieving a green status on the department's performance dashboard.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff used the safeguarding management and risk tool for any patients suspected to be experiencing a mental illness. Patients identified as high risk were provided with one to one care and regular monitoring from a registered mental health nurse. Our observations on the day confirmed that this took place.

Nurse staffing

The service did not always have enough nursing staff and support staff but ensured staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff. Managers told us they were often three or five qualified nursing staff short on each shift. On the day of our inspection the planned number of registered staff was 22 for the day shift and 19 for the night shift compared to the actual number of registered staff which was 18 for the day shift and 15 for the night shift.

The planned number of supporting staff was 10 for the day shift and seven for the night shift while the actual number was seven for the day shift and six for the night shift.

However, the service had a process to mitigate risk. Managers used an online rostering system to determine the appropriate staffing levels based on the acuity of patients. They also used the operational pressures escalation level (OPEL) scale to escalate staffing concerns at the daily workforce calls which were held to identify concerns and to deploy staff to areas of high demand. Where there were shortages in registered nurse staffing the service generally allocated increased levels of nursing or support staff. Additionally, volunteers where deployed to the department to support staff and patients with general tasks.

Staff had the right qualifications and training to keep patients safe. The department had an in-house training programme they were proud of. There were 68 nurses who had completed the programme and gained an emergency department qualification.

All nursing staff in the children's emergency department were registered children's nurses. This was in line with guidance set out in the Royal College of Paediatrics and Child Care: Facing the Future: Standards for Children in Emergency Care Settings.

The service had high vacancy rates. The vacancy rate was 9.5%. Managers said an additional 10% of their nursing staff who were currently pregnant had been redeployed to other low risk areas in the hospital for their safety during the COVID-19 pandemic which further increased the vacancy rate.

The service had high turnover rates. The trust reported a turnover rate of 8%.

The service had low sickness rates. Data provided by the trust showed sickness rate for nursing staff at 4%, paediatric nurses and administrative staff was 2%.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. There were 10 consultants in total and a middle grade doctor covering a seven-day service. This had increased from seven consultants in line with the departments Get it right first time action plan. There was consultant presence onsite until 10pm daily including weekends.

The children's emergency department was fully staffed with middle grade doctors. We spoke with middle grade doctors and doctors in training who felt well supported by the consultant tier in the department, who they could escalate any concerns to. Nursing staff we spoke with told us they could contact medical staff when needed to attend and review patients.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

At the time of our inspection there were two registrar vacancies in the department and the service was actively recruiting to fill these posts.

Urgent and emergency services

Records

Nursing staff generally kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.However medical records were not always legible.

All staff could access patient records easily. Staff we spoke with told us patient care plans were accessible and kept with the patients' records. The department used both paper and electronic patient records (EPR). Paper records included individualised plans of care; for example, pressure area prevention and falls care plans, observations and treatment given. The EPR was used to register patients, monitor their movement through the department and request and review investigations.

Records were stored securely. Patients' records were all stored in areas that were secure and in locked trolleys. We did not see any patients notes left unattended.

We reviewed seven children and 23 adult patient records and found the majority were completed in black ink, had legible handwriting and documentation occurred at the time of review or administration of treatment.

Medical and clerking entries in patient records were not always legible. As part of our assessment of patient records, we reviewed seven sets of records completed a week before our inspection. The medical and clerking notes were at times difficult to read, not signed, timed or dated.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Medicines and equipment for use in emergencies were readily accessible to staff and were checked regularly. Information was available to department staff to highlight critical medicines and where they could be obtained if they were not in stock.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. A clinical pharmacist service ensured that patients' prescribed medicines were reviewed and checked by a pharmacist. Pharmacy could be contacted out of hours when needed.

Staff completed medicines records accurately and kept them up to date. There were appropriate arrangements for the recording of medicines administration and prescription charts showed medicines were being given as directed.

Staff stored and managed all medicines and prescribing documents safely. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely. We did see when Controlled drugs were delivered to the department the signature for receipt was not always signed. One medicine which had expired had been administered on two occasions, when made aware staff removed this medicine from the stock and raised an incident report. Fridge temperature records showed that medicines were being kept at appropriate temperatures.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy staff conducted medicines reconciliation and handled any medicines related concerns. (Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing it with the current list in use.)

Staff learned from safety alerts and incidents to improve practice.

Urgent and emergency services

Incidents

Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff raised concerns and reported incidents and near misses in line with trust policy. Incidents were reported on an electronic system. All the staff we spoke with were aware of how to report incidents and could give examples of the types of things they would report, this included 'near misses. There was an open culture around incident reporting. All staff had the ability to report incidents.

The service had reported no never events in the emergency department in the last 12 months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The electronic incident reporting system included a prompt on the duty of candour. Staff we spoke with demonstrated an awareness of the duty and the importance to be open and honest when delivering care.

Staff received feedback from investigations of incidents. Feedback was shared through staff meetings and emails. Staff also told us they had been provided with direct verbal feedback particularly if they filled in their email address at the end of the incident form. They reported that this feedback was limited but it was nice to know it had been looked at and resolved.

From reviewing clinical governance minutes and reports we saw evidence of incidents being monitored and discussed. We saw that the department had reported a backlog of incidents and had established an approach to manage the backlog. The corporate and divisional governance team was responsible for monitoring all incidents three days away from becoming overdue with the aim of ensuring the investigations of all no and low harm incidents were completed within the 20 days. All moderate harm or high-level incidents were investigated within 45 days and all severe harm, deaths and serious incident were investigated within 60 days. Data shared by the trust showed that there were 50 incidents awaiting a final review, while 15 were being reviewed at the time of the report. These incidents were within their investigation timescales. All high-level incident investigations were discussed and agreed weekly at the serious incident and incident review group. Data shared by the trust showed there were 123 incidents open in January 2022 which was an improvement from November 2020 where there were 479 incidents open.

Managers investigated incidents thoroughly. We reviewed five incidents reports and found action plans and lessons learnt were identified. Actions included providing staff with additional training, feedback to staff.

Is the service responsive?

Requires Improvement ↑

Our rating of responsive improved. We rated it as requires improvement.

Service delivery to meet the needs of local people

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

Urgent and emergency services

Managers planned and organised services, so they met the needs of the local population. The rapid early assessment care team provided nursing and therapy support to facilitate the discharge of the frail and older patients. The service helped to identify community provision and support to enable patient's early discharge.

The children's emergency department had a dedicated play therapist. They organised daily play and activities for children and supported the delivery of care for worried and anxious children.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health needs. There was an increase in patients presenting with mental health conditions. Improvements had been made since the last inspection to better support patients presenting with mental health conditions. There was a registered mental health nurse in the department 24-hours a day. This provision was provided through a service level agreement. We spoke with the mental health nurse on duty during the inspection. They told us that they completed four to five shifts a week in the department so were very familiar with the department and provided staff with support when caring for these patients.

The clinical decision unit was now used to look after mental health patients. This gave them some privacy and helped with security in the department. However, managers acknowledged the environment of the clinical decision unit was not suitable for the provision of therapeutic interventions for mental health patients. Managers were working together to find a permanent solution for these patients.

During our inspection we noted two mental health patients waiting for crisis beds. Police officers were present in the department having detained a patient under section 136 of the Mental Health Act 1983. We spoke to one officer who explained that this was a regular occurrence. Patients were brought into the department as it was a place of safety under the act. The officer said staff were responsive and provided detained patients with timely treatment. However, due to the lack of crisis beds in the region, mental health patients who were medically assessed and fit for discharge remained in the department for extended periods.

Facilities and premises were appropriate for the services being delivered however; their appropriateness was affected by the high volumes of attendances overcrowding the department. There was a separate entrance for patients arriving to the department in an ambulance. This gave direct access into the resus area of the department through a short corridor. However, as the department became busy, we noticed there were five patients in the corridor, five patients in wheelchairs and one on a trolley. The patient on the trolley was closer to the ambulance entrance and had asked for a blanket because they felt cold. Staff said corridor care was less common but occasionally happened when the department became busy.

Resus was appropriately sized and staffed however, during the inspection it was used as an extension of majors with only one out of the nine patients in there fulfilling resus criteria. This was an active decision to help prevent or reduce ambulance or corridor queueing.

The service relieved pressure on other departments and services however, this put a strain on the department. We spoke with a number of patients who told us they had attended the department having struggled to get an appointment with their GP or their dental practice. Staff said they had seen an increase in the inappropriate use of the emergency department since the COVID-19 pandemic. The leadership team stated they planned to communicate the correct services for the public to access or how to self-manage at home if they did not require the services of the emergency department.

Urgent and emergency services

The service worked with other organisations to plan services. Leaders regularly engaged with commissioning groups and local community services to plan the urgent and emergency care system in Kent and Medway. As a group, they had created an improvement plan focusing on four workstreams identified as priority areas for urgent and emergency care which were; admission avoidance, discharge, primary care access and performance.

Meeting people's individual needs

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

Staff made sure patients living with mental health conditions, learning disabilities and dementia, received the necessary care to meet their needs. The trust IT system had a flagging system that alerted staff to specific needs of patients who had attended before. Staff were able to add a flag for any patients who were new to the department or trust, for future attendances.

Staff supported patients living with dementia and learning disabilities by using patient passports. We spoke with staff about patients living with complex needs, dementia, or a learning disability. Staff told us they would treat patients as individuals, would involve family and carers in discussions about care needs to find out more about the patient. The department had a learning disability team which consisted of three disability champions, one safeguarding lead and one link nurse. Contact information for the team was displayed on noticeboards and staff told us the team were very responsive and could be called upon at any time to support staff in the department when needed.

Staff understood and applied the policy on meeting the information and communication needs of patients with disability or sensory loss. Staff told us they used 'Just a minute' cards which allowed patients with hidden disabilities or communication barriers to tell others that they needed extra time and understanding in a private and easy way.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Patients whose first language was not English, or those who used sign language had access to interpreting services. Staff we spoke with were aware of how to access these when required.

Access and flow

People could access the service when they needed it. However, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

The trust acknowledged that it continued to struggle with the management of flow through the hospital due to a significant rise in emergency attendances and subsequent admissions particularly in medical care.

Waiting times recorded and displayed in the waiting room did not consider the time patients had been waiting outside to be booked in. We spoke with patients who had been queuing outside the department for 30 to 40 minutes. The waiting time to be booked in was not captured as part of the 12-hour stay in the department therefore patients waited longer than what the department recorded.

We noted a number of patients queuing outside of the emergency department waiting to be booked in. At one point, there were 13 patients queuing outside in poor weather conditions including rain.

Urgent and emergency services

The department had a queue management document that described the streamer undertaking a visual of the queue every 30 minutes. However, we did not see the streamer going outside to check on the patients in the queue. We highlighted this to senior staff as a concern who explained this was due to there only being one receptionist available to register patients. A second receptionist was sought after to support the booking of patients into the building.

Emergency department staff carried out their assessments in a timely manner. National guidance states that following streaming, triage should be delivered within 15 minutes of the arrival in the department. We observed triage and there was a clear process for this. During this inspection we tracked the time of arrival (which was the time the patient was booked in) to time of initial assessment for eight patients and saw each of these were assessed within 15 minutes. In addition to this we looked at triage times on 18 sets of patient records and only three records showed patients waiting more than 15 minutes for an initial assessment.

Since the last inspection there had been significant improvements particularly with the quicker and safer processing of ambulances at the front door. The introduction of a streamer at the ambulance entrance, to ensure better senior decision making and enabling patients to be sent directly to urgent treatment centre and same day emergency care, had helped reduce handover issues.

We reviewed the total number of ambulance transports into the emergency department in December 2021. The trust had the highest percentage of ambulance conveyances in the region to a hospital site with 3255 ambulance arrivals. The average handover time was 22.30 minutes, a decrease compared to 28 minutes in November 2021. Data from December 2021 showed that 53% of ambulances were handed over within 15 minutes, and 7% of handovers were over 60 minutes resulting in 127 hours lost to handover delays. The longest handover was for three hours and 59 minutes due to lack of capacity. We saw that capacity had accounted for 82% of all ambulance handover delays.

The proportion of handover delays at the trust was often higher than the South East average. For eight of the days from 16 August to 12 December at least a quarter of all ambulances were delayed over 60 minutes, peaking at 31% on 31 October 2021.

Although the average number of ambulance arrivals per day had reduced from September to November 2021, the percentage of delays over 60 minutes had been between 8%-11%, which was higher than the integrated care system's average of 3%-4%.

The department was moving away from the previous targets of four hour and 12-hour breaches. They were embedding new metrics which included: time to initial assessment; the number of patients spending 12 hours in the emergency department; the number of patients spending more than an hour in the emergency department after being declared clinically ready to proceed.

NHS England defined the metric clinically ready to proceed (CRTP) as the first date and time that a healthcare professional (authorised to discharge the patient), makes a clinical decision that the patient no longer requires ongoing care in the emergency department and can be discharged to a ward, clinical service or to another healthcare provider. The time stamp from this should be less than 60 minutes.

Patients experienced exceptionally long waiting time in the department which did not meet the national target. Exit block was identified by staff as the biggest challenge to the access and flow of the department. The movement of patients out of the majors and resus areas was very slow. Managers were keen to stress acceptance of the CRTP measure, but this was not adequately coded or acted upon in terms of promoting the necessary onward movement or

discharge of patients. We saw limited evidence of the CRTP metric's effectiveness or visibility to staff. For example, at 2pm there were 20 patients waiting for reviews with speciality teams with the longest wait reported as 20 hours and 37 minutes. We noted other patients who had been waiting for beds an hour after they were declared clinically ready to proceed. We saw five patients had been waiting between 12 and 21 hours.

There were a variety of pathways to enable patient flow, including same day emergency care and the urgent treatment centre. Data provided by the trust showed that in December 2021, 30% of patients arriving by ambulance were redirected to the onsite urgent treatment centre which reduced the number of patients in the department. This pathway was currently under review to allow direct conveyancing of ambulances to the urgent treatment centre without the need to go through the emergency department first.

There was limited use of the same day emergency care pathway. Staff told us on average, 10 to 15 patients were referred to this pathway. Data from December 2020 to November 2021 had showed a gradual increase in activity from 165 to 375. The same day emergency care was open from 8am to 11pm however, they stopped taking patients from the emergency department after 6pm. This was a crucial time for the emergency department on the day of our inspection as there were more patients who could have been appropriately streamed to the same day emergency care, therefore relieving the emergency department of some of the pressure. Managers agreed there was work to be done to ensure all pathways within the department were fully utilised to support the timely movement of patients in and out of the emergency department.

Part of the inspection included a review of the medical care pathway to understand its impact on the emergency department. We visited Emerald ward (frailty unit), Lister ward (acute medical unit), Sapphire ward (COVID-19 ward) and the priority admission unit (an escalation ward).

Poor discharge of patients from the emergency department to the wards was attributed to acutely unwell patients on the medical wards and the configuration of medical care beds across the trust. Medway NHS Foundation Trust (18%) has seen larger increases in COVID-19 bed occupancy rates in the Integrated Care System, compared to the other trusts. COVID-19 occupancy of the high dependency unit and the intensive care unit were highest in the ICS at 12%.

We were told there had been several bed configurations and changes to the structures of acute admission units in response to COVID-19. This had caused disruption to the effective flow of patients from the emergency department.

On the day of our inspection the trust reported that there were 108 medically fit patients waiting for social care provision to be discharged. This had a negative impact on the availability of beds in the trust which in turn affected the flow of patients out of the emergency department into medical care wards.

The number of patients leaving the service before being seen for treatment was similar to the South East average. The trust had seen an increase from August 2021 to October 2021 and reported 4% of patients left the department without being seen for treatment.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Urgent and emergency services

The service clearly displayed information about how to raise a concern in patient areas. There were also leaflets displayed in prominent areas of the department on how to make a complaint which patients could take away and read at home.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with pointed to the posters displayed or said they would raise any concerns with staff.

Staff understood the policy on complaints and knew how to handle them. All staff we spoke with were clear about their responsibilities when patients complained. They told us they offered the patients advice on how to complain formally if they were unable to resolve the issue and made a senior member of staff aware of the complaint.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed six complaints and the associated responses. These had been investigated in line with trust policy and the responses were appropriate and compassionate. Each response included other options under the NHS complaints procedure if the complainant was not satisfied with the department's response.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

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

The service had a clear management structure which was led by an interim general manager, a head of nursing and a clinical director. The leadership team was relatively new to their posts, but we were told they were having a positive impact on the department.

There was a close working relationship between the emergency department leadership team and the executive team. Both the local and executive leadership teams told us their partnership was helping drive improvement from within the department with executive support to quickly address any challenges they faced.

We spoke with a variety of staff including junior doctors, healthcare assistants, nursing staff and the flow coordinators. The staff were on the whole very complimentary about the emergency department's leadership team.

The leadership team understood and could describe the current and future challenges to quality and sustainability within the department. The leadership team identified workforce, flow and discharge as some of the challenges. They had pro-active on-going plans to address them. For example, workforce had been identified as a challenge particularly the recruiting of senior nursing staff, band 7 and above. The leadership team said they had over recruited nurses at other nursing grades to compensate for this. Additionally, they said they were "growing their own" staff in order to fill these senior roles in the future through an emergency nurse training programme provided in house.

Urgent and emergency services

Vision and Strategy

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

The department was part of the acute and emergency care group, which had its own vision. The vision was to "challenge ourselves to provide the best care possible for our patients, our staff and for each other".

There was a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care. The key objectives within the care group's strategy included:

- "Reducing the length of stay and accelerate specialist care and treatment and to reduce the risk of exit-block associated with mortality.
- Maintaining physical capacity within the department to manage growth expectations linked to demographic changes in the community. This includes diminishing access to primary care, increasing ambulance attendances and rising demand for an ageing population with chronic disease;
- Investing in internal and external relationships with a focus on common admitted pathways and demand regulation. Externally engage with their Integrated Care Partnership to collaborate on the care of mental health patients, ambulance demand and end-point community pathways such as palliative care and falls intervention;
- Improving the effectiveness and consistency of acute medicine through ongoing stabilisation of the medical workforce and 'restacking' of the acute assessment unit model above the department;
- Further development and profiling of the hospital at home service to improve out-of-hospital care and increase the number of hospital bed days saved from length of stay reduction. To move this service into the discharge and flow programme."

Staff knew and understood what the vision and strategy were and their role in achieving this. They felt included in the discussions about changes to the service and could list some of the key objectives.

Culture

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

The culture was centred on the needs and experience of people who used the services. All staff, managers and leaders we spoke with gave the sense that they put patient's needs ahead of everything else. Where staff gave examples of concerns they had raised with managers, these were concerns around patient safety and quality of care. Managers had listened to staff concerns and resolved these quickly. For example, the flow coordinators had raised concerns about reviewing clinical information despite their lack of clinical background. Clinical information was now passed directly to the nurse in charge and flow coordinators dealt with patient flow related information only.

Staff felt positive and proud to work in the organisation. We spoke with many staff from the department and ambulance staff and the majority said they would recommend it to their friends and family as a place to work and receive care. This was an endorsement of the improvements made within the department and trust. Clinical leads and consultants told us they were supported by the new executive team who were actively engaged, interested and visible in the emergency department.

Urgent and emergency services

During our inspection we found that the majority of staff felt supported, respected and valued. There was a sense of teamwork expressed by all of the staff we spoke with and staff spoke positively about their colleagues. However, while there was a sense of comradery among staff, they expressed feeling an immense pressure from their workload, particularly in the main department. They said although they could raise their concerns with their managers, there was at times very little the managers could do to limit the increasing demand on the service. They felt the managers were doing their best to support them.

There were development opportunities for staff across the service where staff wanted to take these opportunities. For example, staff could opt to become champions for a particular specialty or area of practice that was of interest to them. They could then attend study days and additional training to help them in this role.

Governance

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

All levels of governance and management functioned effectively and interacted with each other appropriately. The service held a range of governance meetings at regular intervals. Meetings included twice weekly ambulance liaison and emergency tactical meetings. There were weekly clinical governance, emergency care governance and acute strategy meetings. Monthly meetings held included the joint mortality and morbidity meeting with critical care and the care group governance meeting.

We reviewed various minutes including the care group governance meeting minutes. We reviewed the minutes of these meetings held in October 2021, November 2021 and January 2022. Governance items reviewed included operational performance, risks and incidents. Actions arising from the meeting were assigned to identified staff members and were reviewed and progressed at the next meeting. Meeting minutes were detailed and showed good attendance across the multidisciplinary team. Agendas were standardised and minutes were shared across teams to keep staff informed.

From our observations and discussions with staff there were systems and processes to share information and learning with staff. Information was displayed on notice boards and during handovers and huddles, we saw information being shared about incidents, risks or learning. This was also evidenced in team meeting minutes.

Staff of all levels were clear about their roles and understood what they were accountable for and to whom. We spoke with senior members of staff who said they were given protected time to participate in governance activities such as the preparation of reports and reviewing of audits before presenting them at governance meetings.

Management of risk, issues and performance

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

There were processes for managing current and future performance. In November 2021 the trust introduced escalation triggers across all care groups including the emergency department, to prevent the overcrowding of patients. Each area of the department calculated its own operational pressures escalation level (OPEL) and these were presented by the area lead at the daily board rounds twice a day. These in turn established the overall OPEL level for the department and what action staff should take.

Urgent and emergency services

The hospital had a full capacity protocol which was used when the number of patients occupying the department was beyond the capacity for which it was designed and resourced to manage. This protocol was used alongside the escalation triggers when there was a surge in activity and when there was insufficient staffing to manage normal activity. However, not all staff were aware of the full capacity protocol or how effective the escalation policies were given the stagnation of patients seen in majors throughout the day.

On the day of the inspection, the department's OPEL level was at 3 meaning there were pressures compromising the patient flow.

Future performance had already started to be considered. We were shown a timeline to prepare for the next winter. This involved a number of workshops planned to begin in April 2022. These included a debrief of the last winter including a review of the successes and lessons learnt.

The service had robust arrangements for identifying, recording and managing risks and issues as well as mitigating actions. We reviewed the department's local and a care group risk registers. All risks had control measures, an owner, risk level and review date.

Generally, we saw that risks were not kept on the risk register for extended periods. Most risks had been raised in the last two years. However, the oldest risk on the risk register had been raised in May 2016 and related to staff security. Due to the environment and the patient group they saw, there was a threat of verbal and physical attacks on staff members in the emergency department. To mitigate risk, the service manager met with the security team weekly to review incidents and issue red and amber cards where needed. Furthermore, a panic alarm system had been installed and included individual alarms for staff working in vulnerable areas without access to panic button. The risk score had remained the same since the risk was raised and this was monitored regularly at the care group board meeting.

Information about the services performance and development was displayed in the communal areas. We saw a selection of noticeboards which demonstrated completed projects or action taken to improve the service.

Leaders understood performance issues, including patients waiting long to be admitted within a recommended timescale and the extended total time patients spent within the department. Staff told us they were concerned about patient safety due to crowding and poor flow. During our inspection we saw examples of this when most areas of the department were at full capacity with patients awaiting inpatient beds for 12 or more hours.

Information Management

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

Staff received training on information governance as part of their mandatory training. Information provided by the trust showed that 100% of practitioners, 97% of administrative staff, 96% of paediatric nurses, 93% of nursing staff, and 86% of medical staff had completed information governance training. Compliance for all staff groups met or exceed the trust target of 85%.

There were effective arrangements to ensure information was used to monitor, manage and report on quality and performance. Monthly board reports were produced and discussed at the relevant governance meetings. We saw that action plans were created to monitor progress and were revisited at every meeting to ensure improvement in performance was maintained and embedded into practice.

Urgent and emergency services

The service collated and submitted data to a range of national audits and benchmarked with other trusts in the region. This allowed the comparison of data against national averages and standards to help facilitate continuous improvement. For example, data relating to ambulance performance was regularly submitted externally and anaylsed internally by the care group.

We noted that the IT system used in the department was not always compatible with other systems used in the trust. This had resulted in a data breach incident due to the patient's information not being updated on other trust wide systems. We saw a business case for a new system which would be used across the trust and also with system partners.

Engagement

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

The service gathered people's views and experiences and acted on them to shape and improve the service and culture. We saw feedback was gathered regularly in different ways. For example, the department had carried out a survey seeking the views of patients to improve the patient experience. An action plan had been created to respond and make changes in relation to the common concerns raised by patients in the survey. Actions were included to address issues with patient information, waiting times, the environment and facilities. All actions had been completed in September 2021 and we evidence of some of these completed actions during our inspection.

Patient feedback was also sought through the use of a feedback box. Comments and actions were shared through the "You say we did" board which were available to patients and visitors. We saw that patients had raised concerns about being left for hours without food. The department responded by ensuring refreshments and food were offered throughout the shift. Tea rounds were carried out and there were water stations available which we saw during our inspection.

Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. The leadership team said that any good ideas put forward by staff were discussed at huddles and monthly team meetings. 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. We saw from team meetings when changes had been made, managers were keen to understand if the changes had been effective from the staffs' point of view ensuring staff had an input at all stages of the change process.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The service was engaging with local commissioning groups, the integrated care partnership and other local healthcare providers to specifically address local challenges. We saw and were told of various streams of work under development including plans to educate patients about self-management and redirecting patients to the correct services within the community.

Learning, continuous improvement and innovation

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

Urgent and emergency services

The service had systems to support improvement and innovation work. We saw a number of initiatives aimed at improving performance and patient experience. The trust had a flow and discharge transformation programme aimed at shaping the delivery of high-quality care by enabling flow and expediting discharges through best practice. They wanted to transform working practices, processes and pathways to optimise the services they deliver and support the current demands of their health and social care system.

The trust was using the Patient First document published by the Care Quality Commission to support improvements in emergency department performance, relating to winter planning and pressure resilience. Patient First is a tool designed to support flow through emergency departments and reduce the risks of overcrowding and nosocomial (hospital acquired) infections.

We saw the trust's plan to redesign the model of care at the entrance of the emergency department. This was called the hospital ambulance reception improvement system (HARIS) project. Plans included the introduction of virtual and physical solutions to ease the capacity in the department by building virtual beds, hot clinics and enhancing streaming straight from the ambulance to other pathways.

Good efforts were made to maintain teaching, supervision and quality improvement projects with good evidence on display boards around the department of progress in these areas.

A key focus of the department was to support competency through training and development. The service had a positive focus on developing its own staff. Managers explained this was a deliberate strategy to help recruit and retain medical and nursing staff. They were proud of their emergency nurse training program and they offered this training to other emergency departments in the region.

The service had carried out a research project in 2020 looking into the use of a form of pain relief instead of anaesthetic such as nerve blocks administered by an anaesthetist for fracture manipulation. The medicine was now in general use. Staff said they could administer this which meant patients did not have to wait for an anaesthetist for adequate pain relief.

Areas for improvement

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

Action the trust SHOULD take to improve:

Urgent and emergency care

- The trust should follow its own queue management document, so staff are aware of patients waiting outside the department to be booked in and patients are not left waiting for extended periods.
- The trust should continue to improve the flow of patients out of the department and into hospital beds.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC inspector and three specialist advisors with urgent and emergency care experience. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.