East Kent Hospitals University NHS Foundation Trust

William Harvey Hospital

Quality Report

William Harvey Hospital,
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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	Inadequate
Accident and emergency	Inadequate
Medical care	Requires improvement
Surgery	Inadequate
Critical care	Good
Maternity and family planning	Requires improvement
Services for children and young people	Inadequate
End of life care	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

William Harvey Hospital (WHH) is one of five hospitals that form the East Kent Hospitals University NHS Foundation Trust, which is one of the largest hospital trusts in England. The trust provides services to the whole of East Kent, which has a population of around 759,000 people.

William Harvey Hospital had approximately 476 inpatient beds. It provided accident and emergency (A&E) services, outpatient services and a range of other specialties. We spoke to more than 75 patients, 18 relatives, and 120 staff while visiting the wards and departments in the hospital. We also held a listening event on 5 March 2014 where we spoke with around 25 people who came to share their views on this and the other hospitals managed by the trust. We undertook unannounced visits to WHH on 19 and 20 March 2014 when we inspected A&E, ward areas and spoke with the estates department.

Before and during our inspection we heard from patients, relatives, senior managers, and other staff about some key issues that were having an impact on the service provided at this hospital.

An issue which dominated many discussions was the trust's recent proposal to centralise surgical services to this site. The staff we spoke with did not feel consulted in this decision and did not support the decision made by the Board on 14 February 2014. Clinical staff raised detailed concerns with the Care Quality Commission (CQC) and with executives within the trust.

This inspection was undertaken because the East Kent trust had been identified as potentially high risk by the CQC's intelligent monitoring system.

Overall this hospital was rated as good for caring, requires improvement for effective, inadequate for being responsive to patients' needs and being well led, and inadequate for safety. We therefore rated this hospital as inadequate overall.

Our key findings were as follows:

- We saw that staff in all areas of the hospital were caring and responsive to patients' needs.
- We found that there were not always enough appropriately skilled staff, which placed patients at risk of receiving inappropriate care.
- The records of patients' waiting times in A&E were not an accurate reflection of the time patients waited.
- The trust's major incident policy was up to date however staff referred to the out of date policy and there had been mock major incident practice event.
- Children's needs were not always being appropriately met at this hospital.
- Most patients on medical wards received care according to national guidelines.
- Clostridium difficile (C Diff) and Meticillin-resistant staphylococcus aureas (MRSA) for the trust were within expected statistical limits.
- Some equipment was not maintained in accordance with manufacturers' guidance and therefore may not be fit for use.
- There was not enough staff to provide a safe service to women during their pregnancy. The midwife to birth ratio was up to beyond 1:33. This was above the national recommended ratio of midwives to births of 1:28.
- Risk management and clinical governance relating to the care of children was not managed effectively. Areas identified as serious concerns had not been addressed for long periods.
- Some clinics were routinely overbooked because the number of appointment slots did not always reflect patients' needs. Patients could therefore experience long waiting times, although they were kept informed about the expected length of delay. Patients who required follow-up appointments often had these appointments cancelled, moved to a later date and often there was a significant delay in patients receiving a follow-up appointments.

We saw an area of good practice:

Summary of findings

- The critical care unit monitored its performance and data from Intensive Care National Audit and Research Centre (ICNARC) and showed that patient outcomes were good.

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

Importantly, the trust must:

- Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.
- Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.
- Ensure all staff are up to date with mandatory training.
- Protect patients by means of an effective system for the reporting of all incidents and never events of inappropriate or unsafe care, in line with current best practice and demonstrate learning from this.
- Ensure that paper and electronic policies, procedures and guidance referred to by staff in the care and treatment they provide to patients are up to date and reflect current best practice.
- Ensure that the assessment and monitoring of patients' treatment, needs, and observations are routinely documented to ensure they receive consistent and safe delivery of care and treatment.
- Ensure that the environment in which patients are cared for is well maintained and fit for purpose.
- Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are completed appropriately to reduce the risk to patients.
- Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply and that in-depth cleaning audits are undertaken in all areas.
- Implement regular emergency drills for staff.
- Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.
- Review the provision of end of life care to ensure a coordinated approach.

In addition the trust should:

- Ensure that patients are informed of the reasons why their appointments are cancelled.
- Ensure that letters to patients' GPs are provided within the timescales established by the trust.
- Aim to reduce the number of transfers between wards experienced by patients.
- Review discharge arrangements for patients to reduce the risk of re-admissions.
- Ensure that strategies are developed and implemented, and that staff are fully aware of them in relation to escalation, emergencies, and dealing with patient capacity issues.
- Ensure that patients' privacy and dignity is maintained at all times.
- Manage patient documentation better to minimise risk of breaches to patient confidentiality.
- Introduce a policy to make clear the timescales for changing bed curtains.
- Ensure handwash and hand gel dispensers are kept topped up, as we found some that were empty or half full.
- Review the layout of the A&E majors area to provide improved visibility of patients from the nurses' station.
- Promote the Friends and Family Test (FFT) around the hospital to improve participation.

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?
Accident and emergency	Inadequate 	We found that there were not enough appropriately skilled staff in A&E, which placed patients at risk of receiving inappropriate care. Patients' privacy and dignity were compromised at times. For example, extra chairs and trolleys were used to meet demand but at times this resulted in conversations being overheard or care being delivered in inappropriate areas of the department. Children attending A&E did not always receive treatment from appropriately trained and experienced children's staff.We saw that staff were caring and responsive to patients' needs. Staff did not always maintain the documentation needed to show this was happening. We saw examples of good individual leadership in the department, but there was evidence that ongoing safety issues, for example the issue of insufficient substantive staffing had not been resolved by the senior management team.
Medical care	Requires improvement 	Patients told us they felt well cared for, and that staff always respected their privacy and dignity. However, we saw that there were not always enough nurses to staff the increase number of beds that were made available in response to winter pressures. Patients told us there were not always enough nurses to care for them at night. We also noted that patients were unhappy about the length of time they had to wait for their medication before they could be discharged. Some patients told us they had been moved up to four times between wards, which could lead to inconsistent care and treatment. Most patients received care according to national guidelines. There was evidence of effective practice across the medical division at WHH but it was inconsistent and not fully embedded. Staff at all levels told us that they were well supported by their immediate line managers but were unclear about the wider vision and values of the hospital and the trust as a whole. Not all junior doctors felt supported by their consultants.
Surgery	Inadequate 	We found significant staffing issues on some of the wards we inspected, including inappropriate staffing

Summary of findings

levels at night. Some wards were cluttered and cramped, resulting in a potential hazard for people whose mobility was unsteady following surgery. Some equipment was not maintained in accordance with manufacturers' guidance and therefore may not be fit for use.
The surgical risk register, which identified potential risks, was dated August 2013. When we reviewed this document we noted area that had not been updated since February 2013. We could not be assured that any potential current risks to the department had been identified and steps taken to mitigate the risk.
Patients told us that they felt their care and treatment at the hospital was good, and they were generally happy with the standard of facilities.

Critical care

Good

The unit was visibly clean, and there were systems in place to manage infection control. Infection control rates reported to be zero by the trust in the last two years. Staff said they felt well supported by their colleagues and that there was good team working.
There was a concern that a culture of bullying had not been addressed within the nasing staff.
There was a high number of vacancies within the nursing staff although a recruitment programme was underway. Junior doctors felt the current rota was not sustainable in the longer term and a business case to increase the number of doctors on the rota had been approved but not yet implemented.

Maternity and family planning

Requires improvement

Mothers received care that was delivered with compassion, dignity and empathy. However, There was not enough staff to provide a safe service to women during their pregnancy. The midwife to birth ratio was up to beyond 1:33. This was above the national recommended ratio of midwives to births of 1:28.
There had been frequent closures of the midwife-led Singleton unit in recent months. This had reduced choice for women and meant that some women were transferred to other units for non-clinical reasons.
We found that leadership vacancies and interim arrangements had continued for significant periods. Clinical guidance and policies used by staff were out of date. Some essential equipment was in short supply.

Summary of findings

Services for children and young people

Inadequate

The children's ward, special care baby unit, and neonatal intensive care unit provided a safe and suitable environment in which to care for and treat children. Other areas in the hospital where children were seen and treated had not been risk assessed to make sure that it was a safe and suitable place to treat children.

There were suitable numbers of appropriately trained nursing staff and the skill mix reflected current guidelines in the wards. Parents told us they were happy with the care and support that was provided on these units. Children did not receive care from appropriately trained and skilled staff in other areas of the hospital. In the day surgery unit, the staff caring for children did not have any specialist training or experience. In A&E children were not always seen by a specialist children's nurse and there was no specialist input into the care and treatment for children.

Risk management and clinical governance relating to the care of children was not managed effectively. Areas identified as serious concerns had not been addressed for long periods.

There was no leadership strategy in place for children's services and no clear accountability. Leaders were unaware of significant issues threatening the delivery of safe and effective care.

End of life care

Requires improvement

The specialist palliative care (SPC) team provides specialist advice and guidance for individual patients and family members. The staff are experts in pain management and deliver a holistic approach including emotional, spiritual, and psychological care, as well as providing up-to-date advice on symptom control.

Since the removal of the Liverpool Care Pathway, we saw little evidence of strategic trust-wide leadership and support for end of life care. The provision of end of life care was disjointed across the wards and departments. Although individual staff were committed to delivering good care, the result was an ad-hoc reactive response to people who needed care at the end of their lives.

Outpatients

Requires improvement

All the patients we spoke with told us they felt they had been treated with dignity, and that they had found staff in the outpatients department polite and caring. We found that some clinics were very busy

Summary of findings

and that staff routinely overbooked patients for clinics because the number of appointment slots did not always reflect patients' needs. Patients could therefore experience long waiting times, although they were kept informed about the expected length of delay.

Patients who required follow-up appointments told us that they often had these appointments cancelled, moved to a later date and often there was a significant delay in patients receiving a follow-up appointments. Staff told us that when appointments needed to be cancelled, they generally cancelled follow-up appointments as this did not affect how the trust met the two and 18-week referral to appointment time targets. We found that staff were collecting data on waiting times and overbooked clinics, however despite this felt unable to make improvements.

Inadequate

William Harvey Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Services for children and young people; End of life care; and Outpatients

Contents

Detailed findings

Background to William Harvey Hospital

The William Harvey Hospital, Ashford is an acute hospital with 476 beds providing a range of emergency and elective services as well as comprehensive maternity, trauma, orthopaedic and paediatric and neonatal Intensive care services.

The hospital has a specialist cardiology unit undertaking angiography, angioplasty, pathology analytical robotics laboratory that reports all East Kent's General Practitioner (GP) activity and a robotic pharmacy facility.

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this trust because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, East Kent Hospitals University NHS Foundation Trust was considered to be a high risk level service

Our inspection team

Our inspection team was led by:

Chair: Diane Wake, Chief Executive, Barnsley Hospital NHS Foundation Trust

Team Leader: Siobhan Jordan, Head of Hospital Inspections, Care Quality Commission

The team included CQC inspectors and analysts, doctors, nurses, midwives, patients and public representatives, Experts by Experience and senior NHS managers.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew about the trust.

We carried out announced visits of the three acute hospitals within the trust between 04 and 07 March 2014. We visited William Harvey Hospital on 05 and 07 March 2014. During these visits we held focus groups with a range of staff: nurses, doctors, consultants, allied health administrative and clerical staff. We talked with patients and staff from all areas of the hospitals, including the wards, theatre, outpatients departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

We held a listening event for William Harvey Hospital on 05 March 2014 where patients and members of the public shared their views and experiences of this hospital and the trust.

We also undertook unannounced visits to WHH on 19 and 20 March 2014.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Inadequate	Not rated	Requires improvement	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Services for children and young people	Inadequate	Requires improvement	Good	Good	Inadequate	Inadequate
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate

Notes

1. We do not give a rating for A&E/Effective and Outpatients/ Effective.

Accident and emergency

Safe	Inadequate
Effective	Not sufficient evidence to rate
Caring	Requires improvement
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

The accident and emergency (A&E) department provided a 24-hour service seven days a week and consisted of a triage area, majors and minors areas, a resuscitation room and a rapid assessment area. The adult emergency department saw approximately 230 patients a day (around 80,000 a year), of which 25% were children. There was no separate children's A&E staffed by skilled and experienced children's trained nurses. There was both a general waiting area and a small waiting room specifically for children and a relative's room.

On arrival at A&E, patients are assessed by a nurse and directed to the appropriate area. Patients arriving in an ambulance enter the department through a dedicated entrance and are assessed by a nurse and directed through to an appropriate area. The department has three specific areas, the 'majors' area, 12 bays and three side rooms, one for gynaecological patients. The resuscitation area had four bays, one of which was identified and equipped for children and another for those patients who have had a stroke and who were provided with care in line with the national stroke pathway. We were told the children's and stroke bays were used for other patients if required. There was also a psychiatric assessment room with two exits, which promoted the safety of both staff and patients. The 'minors' area staffed by a GP and a practice nurse had both trolleys and chairs.

We talked to eight patients, four relatives, and staff, including nurses, doctors, consultants, managers, support staff, and paramedics. We observed care and treatment and looked at care records.

Accident and emergency

Summary of findings

We found that there were not enough appropriately skilled staff in A&E, which put patients at risk of receiving inappropriate care. Patients' privacy and dignity were compromised at times. For example, extra chairs and trolleys were used to meet demand but at times this resulted in conversations being overheard or care being delivered in inappropriate areas of the department. Children attending A&E did not always receive treatment from appropriately trained and experienced children's staff.We saw that staff were caring and responsive to patients' needs, although they did not always maintain the documentation needed to show this was happening. We saw examples of good individual leadership in the department, but there was evidence that ongoing safety issues for example the issue of insufficient substantive staffing had not been resolved by the senior management team.

Are accident and emergency services safe?

Inadequate

Incidents

- The trust used an online system to report complaints, accidents and incidents.
- Some staff, both medical and nursing, told us that they had not always raised concerns because they had been too busy at the time of the incident and the online form took too long to complete.
- Staff received incident feedback via email.

Infection control

- The A&E department was visibly clean and uncluttered.
- We were told that there had recently been a big tidy-up in the department, which had improved the space available
- There were no cleaning schedules signed by staff to demonstrate that areas had been cleaned to the trust's guidelines.
- We observed that all staff had bare arms below the elbow and used appropriate protective equipment to reduce the risk of cross infection.
- The department had an infection control champion who took a lead in cascading new information to staff.
- There was a supply of hand-washing materials and hand-gel dispensers.
- All bays and cubicles had disposable curtains. There was no set policy as to when these should be changed and staff were unsure how often they were changed.
- Trolleys were stripped after each patient, but staff did not wipe down the trolley or equipment with a cleaning agent before the next patient.

Environment and equipment

- Each bay had a whiteboard on the wall that listed the oxygen, suction, and call bells that had to be ticked when checked by staff. However, there were no dates on the checklist to confirm when the checks had been undertaken.
- All equipment had a portable appliance testing label that was in date.

Accident and emergency

- All resuscitation trolleys had been checked and a checklist completed daily. There was central monitoring at the nurses' station that allowed all cardiac monitors to be observed. However, the layout of the major's area meant that not all patients could be directly observed.

Records

- On our unannounced inspection on 19 March 2014, we looked at the treatment records for five patients and saw that the documentation had been completed and showed the initial treatment given by the nurses.
- We saw that patients wore wrist bands and that their first observations were recorded.

Anticipation and planning

- The resuscitation room was designed and supplied with the equipment and medication required for expected trauma, cardiac and stroke patients.
- There was a dedicated bay that had all the medication and equipment needed to commence and follow the stroke pathway. The stroke unit would be informed by the nurse in A&E of the expected time of arrival so that the specialist nurse and medical doctor could be there to receive the patient.
- Staff planned patient transfers. Staff told us that patients transferred to other parts of the hospital, including wards, were accompanied by a nurse or healthcare assistant. We observed that patient safety was maintained during transfer in the hospital because patients were accompanied by a member of staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training and knew the action to take to safeguarding vulnerable adults and children.
- The safeguarding policies and procedures were up to date and had been reviewed regularly.
- Staff told us that they had not received training in the Mental Capacity Act (MCA) 2005 or in Deprivation of Liberty Safeguarding (DoLS).

Mandatory training

- The overall training matrix showed that the majority of staff had completed their mandatory training.

Safety and performance

- On arrival all patients are assessed by a nurse and directed to the most appropriate area in the department for treatment, based on guidelines for example, directing patients to minors or majors.
- A rapid assessment and intervention team (RAIT) took admissions from the main A&E; this was staffed by one consultant and two technicians. The team worked in two bays in an area separate to the main A&E; with its own equipment, and was open until 6pm. The consultant leading the RAIT spoke of the benefits of the service; these included relieving some of the pressures on A&E and to provide appropriate safe treatment to patients.
- We observed patients brought in by ambulance arrived in the assessment area and were usually assessed by A&E staff within the national guideline time of 15 minutes.

Nursing staffing

- The department did not use an acuity tool to assess the number of staff were required for each shift.
- There were specific staffing levels and skill mix for different times of the day to meet patient demand. For example between 7.30am to 8pm there were 16 registered nurses and three technicians. At 8pm the staffing level reduced 12 and then down to 10 staff for the night shift.
- The Royal College of Paediatrics and Child Health guidance, states that A&E's who see children should have a registered child nurse on duty. However, the trust did not have a registered child nurse on duty at all times and there were occasions cases where there were no nurses trained in emergency Paediatric Life Support (PLS).

Medical staffing

- The trust employed a significant number of locum staff to cover vacancies.
- There was a consultant on duty in the department between 8am to 7pm, Monday to Friday and for six hours at the weekend. Outside these hours a consultant on call could be contacted by telephone.
- There was only one consultant on call for both of the trust's A&E departments at night which were approximately 40 minutes apart by road.
- Currently the trust employed 7.5 whole time equivalent (WTE) consultants to cover two locations. Based on the College of Emergency medicine guidance, we were advised that an A&E seeing this number of patients should have 13 consultants. The trust had been actively recruiting to expand to this.

Accident and emergency

Major incident awareness and training

- Following the inspection we were provided with evidence that the major Incident policy and procedures had been reviewed and updated since 2011. However we found during our inspection staff referred to and showed us the out of date policy. They were not aware it had been updated in line with national guidance

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Use of national guidelines

- Staff were not able to access current national and good practice guidelines to deliver safe care.

Care plans and pathways

- Staff we spoke with explained the range of treatment pathways they followed in the department and were knowledgeable about the pathways for stroke, cardiac problems and fractured neck of femur.
- The trust had a management of pain in A&E policy which provided guidance to staff. For example all patients with pain should have analgesia within 20 minutes of arrival in the department.
- The assessment and management of adult patients' pain was not consistent. We looked at eight records and saw that a pain score was not recorded for any of these patients on arrival or within 20 minutes of arrival to the department.
- We observed several patients in pain, we saw one patient in considerable pain and distressed; they had been in A&E over two hours before receiving analgesia.

Outcomes for the unit/service

- We were told that clinical audits were carried out but we were not provided with the results of these audits. Therefore we were unable to confirm that they had taken place and that learning had been implemented.
- The national average rate for unplanned re-admission of previous attenders at A&E was 7%; the trust was at 9% to 9.25%

Are accident and emergency services caring?

Requires improvement

National surveys

- Data from the A&E Friends and Family test (FFT) for the period October 2013 to December 2013 was not disaggregated to location. The A&E did not display its own departmental score. Overall the trust performed lower than other A&E departments, with a score of 38 in December 2013 compared with the national average of 56.

Dignity and respect

- We spoke with 12 patients and six relatives in the department and the majority reported that staff were caring and kind. A relative commented, "very nice, but very busy."
- We observed that staff only communicated with patients' and their relatives when asked a direct question. Staff did not offer information until asked, one patient's relative told us, "I feel I am invisible but they are helping mum."
- We observed that care was not always provided in a timely manner. Staff did not always ensure patients had access to their call bell. Call bells were located on the wall behind patients' heads, out of their reach unless they were specifically given to them.
- We observed that one patient constantly called out for a bedpan. It took 15 minutes for a staff member to respond to their request.
- We saw that patients' privacy and dignity was not always maintained during treatment. For example when undertaking tests, checking details and taking blood. This was undertaken in the main area of the department.
- Patients were given a hospital gown if necessary and provided with a blanket to preserve their dignity. However, we saw patients left without pillow and in an uncomfortable position, which did not meet their individual needs. While another told us, "I have been on a trolley, on a chair and then on a trolley. I'm exhausted."

Accident and emergency

- The department was not seen to undertake regular comfort rounds and we observed that some patients had not had any comfort checks or fluids/food in over five hours.

Patient involvement in care

- Patients experienced varied, some told us they were satisfied with the care and treatment they had received and praised the staff and said they had been kept well informed and included in the decision-making process.
- One patient we spoke with told us they did not know the treatment plan or what was going to happen next. When staff became aware of this they quickly responded and rang the surgical team for an update.
- We observed that staff in the resuscitation area informed patients and their relatives about their plan of care and treatment. For example, we observed a nurse inform a patient and their relatives of time they would be transferred to a specific ward.
- Patient's specific needs were taken into account for those requiring follow-up appointments.
- There was a lack of information for patients and their families about the expected waiting times for patients to be seen by a nurse or doctor. There was no board or display with this information and the information was only offered if an individual asked the receptionist directly. One patient said, "I have to keep asking the receptionist how much longer I have to wait."

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

(for example, to feedback?)

Inadequate

Access

- Since April 2013 the performance against the A&E waiting target (which states 95% of patients attending A&E should be seen, treated and either admitted or discharged within 4 hours) varied from 84% to 100%. In November 2013, December 2013, and January 2014, the trust achieved 90%, 91%, and 92% respectively. This is trust level data and therefore we are unable to comment on individual site's performance.
- At this hospital recording of waiting times was unreliable as we noted staff removing patients from the A&E computer system before they left the department.

Maintaining flow through the department

- The trust had implemented a number of strategies to manage and reduce the pressure on the A&E department. An internal policy outlined the reporting mechanisms to senior managers, and bed management meetings were held two or three times a day to improve the management of patient flow and identify available beds in the hospital.
- The most senior A&E doctor led a review of the patient's assessments and treatment plan information on the patient board. A range of staff attended this review and advice was provided to other staff to help streamline and prioritise patient care in the whole department. On the day of our inspection, the department had breached the four-hour target for some patients. We were informed that their names had been deleted from the attenders' computer, indicating that they had been discharged, but we noted that they were still in the department. We saw this practice occurring, where a patient's details had been removed from the computer but the patient was still in the department for another hour.
- Due to the demand for A&E services the department was required to care for patients on additional trolleys and in chairs in the main treatment area.
- At times the trauma operating list impacted on the flow of patients in the A&E as the on call surgical team were unable to attend the department to review their patients.

Care of vulnerable patients, patients with dementia and those with learning disabilities

- We saw that there was a system to ensure that patients, both adults and children, could be referred to psychiatric services 24 hours a day. However, staff told us that once the referral had been made some patients waited for long periods, sometimes overnight before a member of the psychiatric services teams attended the department to assess them.
- Staff told us that some psychiatric patients were moved onto the clinical decisions unit (CDU) with no treatment plan in place. This placed the patient at risk of receiving inappropriate or no care to meet their specific needs however prevented them breaching the four hour target.
- Once the patient had been seen by the crisis team and a decision to admit to a psychiatric ward had been made, there was no further input from the crisis team. Therefore patients with mental health needs could be

waiting in the unit for a long time for a psychiatric bed to become available. Staff reported that this was a frequent occurrence and care was not provided by appropriately trained staff.
- The A&E department had two dedicated dementia link nurses. There was also a dementia board that included information and telephone numbers. However, we observed that staff did not use this information with dealing with two elderly patients living with dementia in A&E during our inspection.
- Staff had not received training or guidance in caring for patients who had learning difficulties. They told us they relied on patients' carers for guidance.

Equality and diversity for patients

- The trust provided a service to a diverse population. Staff told us they communicated with people whose first language was not English using a telephone interpreter service and that some staff were bilingual and could be used to interpret.
- A patient whose first language was not English, we spoke with stated that staff had communicated with them effectively.
- The hearing loops were not in use, although patients required them. Staff therefore had to speak loudly, which had an impact on patients' privacy and confidentiality.

Complaints handling

- While the matron was able to provide a summary of complaints received in the last six months of 2013, a senior nurse told us that there was no process in place to monitor and review these complaints.
- The complaint records for the last six months we reviewed, showed that there were some trends, for example, lack of fluids, lack of offers to use toilet facilities and discharge home at either an unreasonable time or without prior checking of patients' circumstances at home. These trends had not been identified by individual A&E/ ECC department.
- We found that some complaints had been investigated and outcomes recorded with action points as necessary.
- Complaints from patients who had dementia or who were considered to be mentally frail were closed and the reason stated as 'no consent'. Staff were unable to state why these complaints had not been investigated.

Are accident and emergency services well-led?

Inadequate

Governance, risk management and quality measurement

- There was a lack of governance systems and processes in some areas specifically major incident planning. Staff were not aware of the most recent policies.
- Staff did not acknowledge that by removing patients from the A&E system who had not yet left the department this did not only impact on the four hour target it placed patients at risk of not receiving appropriate care.
- The incident reporting system showed that a very limited number of staff reported incidents.
- Monthly governance meetings were held within the directorate and all staff were encouraged to attend including junior members of staff.
- There was limited evidence of learning from incidents, complaints, or concerns. We saw an example of a complaint at another hospital which had resulted in changes in practice, but this learning was not transferred across the trust.

Leadership of service

- During busy times we observed no visible leadership in the department; staff were not communicating effectively, which meant delays in providing treatment and pain relief.
- Staff did not always feel that the senior management listened to their concerns. One staff member said, "I don't think the top levels really understand how busy we get and how at times our department is unsafe due to lack of staff and space"
- We were told that staff morale was improving and all the staff we spoke with were positive about the fairly new management structure in A&E which consisted of a new matron and new senior nurses.
- We saw some evidence of team working during the inspection visit. Staff we spoke with told us they felt supported by their immediate line managers.

Accident and emergency

Culture within the service

- Staff had access to a counselling service if they needed further support. The senior nurse or matron would access the counselling through occupational health or the clergy team.
- Staff told us that at times there was a difficult relationship with some of the locum doctors because they did not always follow the trust's pathways, policies and procedures. One staff member said, "It's difficult at busy times when the doctor does not know the department and where things are kept."

Innovation, improvement and sustainability

- We saw that the senior charge nurse had been encouraged to develop and design the resuscitation rooms to improve efficiency and safety.
- This had improved staff confidence in working across two sites if the need arose, as the layout mirrored their normal working environment.

Medical care (including older people's care)

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

Information about the service

William Harvey Hospital (WH) has 12 medical inpatient wards. These included acute medical units, general medical wards, care of older people, and stroke and cardiac services. The hospital provides primary percutaneous coronary angioplasty (urgent treatment for heart attacks) and thrombolysis (urgent treatment for strokes).

We spoke with 29 patients, three relatives, and 33 staff including nurses, doctors, consultants, senior managers, therapists, and support staff. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust and WHH.

Summary of findings

Patients told us they felt well cared for, and that staff always respected their privacy and dignity. However, we saw that there were not always enough nurses to staff the increased number of beds that were made available in response to winter pressures. Patients told us there were not always enough nurses to care for them at night. We also noted that patients were unhappy about the length of time they had to wait for their medication before they could be discharged. Some patients told us they had been moved up to four times between wards, which could lead to inconsistent care and treatment.

Most patients received care according to national guidelines. There was evidence of effective practice across the medical division at WHH but it was inconsistent and not yet fully embedded. Staff at all levels told us that they were well supported by their immediate line managers but were unclear about the wider vision and values of the hospital and the trust as a whole. Not all junior doctors felt supported by their consultants.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Incidents

- Staff told us that they reported most incidents and were familiar with the electronic incident reporting system. They said that the inputting of data was time consuming and did not save the data if the nurse or doctor was called away on an urgent matter and discouraged incident reporting.

Safety thermometer

- The trust used the national Patient Safety Thermometer audit tool. This measures the incidents of new pressure ulcers, catheter and urinary tract infections, falls with harm to patients over 70 and Venous Thromboembolism (VTE).
- We noted that each ward and specialist department displayed the thermometer's indicators and the monitoring information.
- We saw evidence that pressure sores on the stroke unit had decreased, and the ward sister told us there had not been a new pressure sore for 100 days. In recognition of this, the stroke unit had received a certificate of good practice from the trust board.
- Pressure relieving equipment was available staff told us, "we ring the mattress care line, and we can usually get a mattress." However, a senior nurse on the ward told us there was "no consistency" in obtaining pressure-relieving equipment.
- Equipment had been put in place in the stroke unit to mitigate the high risk of falls to patients, these included a bedside risk assessment tool, and sensor mats.

Cleanliness, infection control and hygiene

- We observed that patients were protected from the risk of infection. The trust rates for Clostridium difficile (C. difficile) and methicillin-resistant staphylococcus aureus (MRSA) were within expected statistical limits.
- Medical wards and specialist medical units were visibly clean.
- Patients and visitors were given information on how to prevent infections, and we observed hand hygiene gel in all medical wards and department areas for patients, staff, and visitors to use.
- We noted staff wearing gloves, and washing their hands before attending to different patients.
- To prevent cross infection patients known to have transmittable infections were nursed in side rooms.
- There were higher than expected reporting of catheter and urinary tract infections. We were told that the hand-held clinical monitoring system did not check the date when a patient's catheter bag was due to be changed. We were also advised that there was no standard date of review for catheters.

Environment and equipment

- There had been delays of 'months' concerning the repair of the suction equipment on the resuscitation trolley and the checking of dates on the fire extinguishers in the stroke unit. Frequent requests had been made to the maintenance department but not resolved, this issue had been escalated to the matron.
- There were insufficient oxygen points and power points in some bays on the ward. This had been entered onto the risk register for the trust but no action had yet been taken to rectify the problem.
- The majority of equipment for example, resuscitation trolleys, hoists, slings, and the clinical monitoring system, had been tested and were maintained to the appropriate standard across the medical division.

Medicines

- Pharmacy staff told us that there were insufficient staff to cover the ward areas across the hospital.
- We noted on Cambridge M2 ward that medicine fridges were left unlocked and were above the recommended temperature for the storage of medicines.

Mandatory training

- Staff in the medical division attended mandatory training. The ward sister told us, "It is difficult to release staff to attend training sessions but we do the best we can." We noted that 25% of staff on the unit had received specialist training in cardiac care.
- The complexities of the electronic mandatory training system meant that it was not always easy for staff to navigate around the system. Staff were concerned about the reliability or their IT (Swipe) cards to access the system. This was a problem across the hospital and had yet to be resolved.

Medical care (including older people's care)

Management of deteriorating patients

- Observations were recorded electronically using a system known as Vital PAC. This allows early warning scores to be automatically calculated.
- However we were told that due to problems with the trust Wi-Fi this had resulted in there being problems for the past two years with Vital PAC uploading patient observations in a timely and consistent manner. The issue had been raised several times with the information technology (IT) department but had not been addressed. To mitigate the risk at local level, a paper-based system was in place for patients' observations.

Handover

- During the week, all teams in the medical division handed over to the junior doctor at 5pm. We were told there were no issues unless there were sick patients and this could lead to a delay in following up patients' results. A junior doctor told us about a recent incident when there had been a delay in identifying a patient's worsening respiratory failure.
- The junior doctor was unsure if a root cause analysis (RCA) had been completed following a recent incident. The incident had been regarded as a potential 'near miss', which required reporting on the trust's electronic reporting system. We were unable to clarify if this incident had been report while on inspection.

Nursing staffing

- Senior staff we spoke with told us that although a staffing review had been undertaken in 2013, the acuity tool did not accurately reflect the dependency needs of patients in the unit.
- The sister on the stroke unit told us there had been a review of the nursing staffing levels in 2013. The nursing establishment on the stroke unit had increased but there were difficulties recruiting nurses.
- Three ward sisters told us a patient dependency tool was also completed each month to enable the ward managers and matrons to anticipate the number of staff that would be required to staff the wards or acute medical departments safely. The ward sisters told us that agency staff made up 10% of the nursing rotas but it was unlikely that all shifts would be filled.
- One senior nurse told us, "We are never up to establishment, however hard we try to recruit the right nurses."
- The ward managers were not supervisory on the medical wards.
- On the day of our visit, we noted three nursing shifts had not been filled, due to staff being off sick and the agency had been unable to cover the vacant posts.
- One patient told us, "There never seem to be enough nurses particularly at night." Another said, "There have been times at night when I have called for help to use the commode. The nurses always come but I have to wait."

Medical staffing

- Across the trust 40% of the medical registrar posts were vacant. Locums were used to maintain rotas at night and at weekends. The junior doctors expressed concerns about the difficulties of being released to attend training and supervision sessions. This was evident in the results of the Doctors' Training Scheme Survey, which highlighted that doctors' workload as being 'worse than expected' in the medical division.
- Doctors told us their main concerns about the culture of WHH was the lack of clinical support from their consultants and the heavy workload, particularly at night.
- Consultants currently worked a five-day week, with on call doctors available at the weekend. However there was a lack of clarity about consultants taking over the care of patients who had been admitted out of hours.
- The trust risk register included a move to seven day working for consultants across the organisation. This had not been implemented at the time of our inspection.

Are medical care services effective?

Good

Evidence-based care and treatment

- We observed effective pathways of care across the medical division in the clinical decisions unit (CDU), the coronary care unit (CCU) and the cardiac catheter laboratory.
- Best practice guidelines were implemented in the stroke unit.

Medical care (including older people's care)

- Staff understood the National Institute for Health and Care Excellence (NICE) guidelines and stated that these were referred to in discussions with staff about patients' care and treatment.

Monitoring and improvement of outcomes

- The hospital contributed to the Myocardial Ischaemia National Audit Project (MINAP). The most recent results available to us (2012/2013) demonstrated that 90.6% underwent primary percutaneous coronary intervention within 90 minutes compared with national average of 91.7%. The national median 'door to balloon' time was 40 minutes compared with a site median of 43 minutes.
- 93.2% of patients had been prescribed all of the appropriate secondary prevention medication in comparison to the national average which was 90.1%.
- Three consultants told us, "we do comply with the national audit programme but we need to turn the national audit outcomes into local action. We have a new quality assurance board in place, which was attended by key professionals from the medical division at WHH and our other two sites, and this will help us to manage clinical audit in a more structured way across the whole medical division."
- The stroke unit also contributed to the Sentinel Stroke National Audit Project (SSNAP) which allows comparison of key indicators that contribute to better outcomes for patients. Overall performance is rated from A (highest, which no service achieved) to E. It is acknowledged by the audit that very stringent standards are set, however William Harvey only achieved grade D.
- In January 2014 the stroke service at WHH reduced their length of stay for stroke patients to 11.7 days; the expected (national target) was 16.6 days.

Staff Competency

- Staff had the appropriate skills and training, and their competency was regularly monitored through clinical supervision and the staff appraisal process.
- We observed that staff were professional and competent in their interactions with patients and colleagues.
- We saw evidence of formal staff appraisals that were documented and up to date in most areas.
- Staff told us they found the staff appraisal process helpful, but not many staff had used the new paperwork. A ward sister told us, "the new appraisal paperwork is very wordy and complicated and not at all user friendly."
- Staff attended a wide range of training which was recorded on the central electronic training record.

Are medical care services caring?

Good

Compassion, dignity and empathy

- Interactions between care staff and patients were kind and friendly. Patients told us that the nursing staff were respectful to them and ensured their privacy was protected when personal care was being given.
- We spoke to 29 patients and three relatives who all told us that the care at WHH was "very good". Comments included, "the staff are so kind and caring you cannot fault the nursing care", and "I am always happy to come back to WHH and are pleased it is my local hospital."
- Patients told us there were not always enough nurses on duty, particularly at night.
- One patient told us, "the care is good but I did have to wait for 45 minutes for my pain medicine as the nurses were so busy."
- Another patient told us, "I had to wait a long time for a commode (at night) which was a bit distressing but I knew the nurses were really busy."
- One relative told us that staff had cared for their relative with dementia in a kind and respectful manner throughout their hospital stay.
- We noted in the Family and Friends test for the medical division in December 2013 that Cambridge K and Cambridge M2 Wards, CDU, CCU and the stroke unit all scored between 80 and 93 (overall) for privacy and dignity, cleanliness, involvement, pain management, food and care. This demonstrated that the overall patient experience was to the required standard.

Involvement in care

- We reviewed three patients' care records in the stroke unit and noted that patients were involved in the planning of their care.

Medical care (including older people's care)

- One patient on the stroke unit told us that they had been involved in developing their care plan, and understood what was in place for the future management of their stroke.
- We spoke to a relative who told us they were the 'voice' of their patient relative and closely involved in every step of the care process, because their relative was unable to communicate verbally with the nursing staff. The person told us how the care staff involved them in the planning of their relative's transfer to another care setting, and how pleased they were that they knew everything that was happening to their relative.

Emotional support

- There were dedicated private areas where patients and their families could go to discuss issues with medical staff or amongst themselves relating to care and emotional support.

Are medical care services responsive?

Requires improvement

Meeting people's needs

- To improve access to medical staff the sister in CDU told us about the 'hot' and 'cold' clinical care teams that had been put in place to mitigate the shortage of doctors at weekends. The 'hot' team supported the A&E department and CDU. The 'cold' team supported the medical wards and any medical outliers at WHH.
- Each team had a doctor and senior nurse who were additional to the doctors' rotas. However, covering the teams did make the current shortages in doctors' rotas more difficult to manage.
- Staff were listening to patients and improving their experience at WHH. The ward sister on the stroke unit told us that, by reviewing patients' concerns raised in the Friends and Family test, she had identified that patients were unhappy that there was no relatives' room. A review of the rooms in the unit had resulted in the creation of a designated relatives' room that was well used by patients and relatives.

Access to services

- The cardiac service was unable to meet patients' needs in a timely and responsive way The National Institute for Health and Care Excellence (NICE) suggests angiogram should happen within 96 hours. This was not always being met; one patient had been waiting for six days, another for five days. In the previous week, there had been 14 patients waiting for the same procedure.
- We observed that medical services varied in their level of responsiveness to patients' needs across the wards and clinical specialist units in the medical division.
- We noted that there were admission processes and ward rounds in place in the CCU.
- CDU had well-managed care pathways, for example, for stroke, heart failure and dementia.
- Two patients told us they had experienced up to four bed moves during their hospital stay. One patient said, "I really didn't mind as I knew it had to be done to free up beds for other patients."
- We were advised by the sister in CDU that mixed sex breaches occurred most days. According to NHS England data, no mixed sex breaches were reported in the six months prior to our inspection.

Vulnerable patients and capacity

- Staff told us they had undertaken online learning disabilities (LD) training to support the care of vulnerable adults in their care. A staff nurse raised issues about a vulnerable patient whose care had deteriorated while they were on the ward. The ward staff had been supported to care for the patient by the LD nurse.
- The dementia lead nurse said that they would contact the Mental Health Team for support to complete patient assessments (Best Interest Checklists) when they were required to do so.
- We also saw evidence of the dementia care pathway and displays about dementia on the wards and in the specialist medical departments. Although specific dementia care plans were not always implemented.
- We saw evidence of dementia champion roles and displays of dementia information across the medical division.
- Staff had attended dementia training but the care of patients living with dementia was not embedded in clinical practice. Not all patients with dementia had dementia care plans in their patient's notes.

Leaving hospital

- There was multidisciplinary working across the medical division concerning patent discharge planning and management of the discharge process.

Medical care (including older people's care)

- The number of patients' delays was reviewed at the daily bed planning meetings, and ward information was collected by ward clerks on the wards and in the medical specialist units.
- Staff told us that expected dates of discharge were not reliable because they were not managed consistently across the medical division and not all consultants were in agreement with using them.
- We noted in the Adult Inpatient Survey, CQC, 2012, that the trust had performed worse than other trusts for patients waiting to see a doctor and receive their discharge medication.
- The ward sister told us that pharmacy delays were an issue because of the reduce pharmacy service provided to the ward, resulting in some patients waiting four to five hours before being able to be discharged home.
- We had been advised by the pharmacy department that there were staff shortages there that had resulted in reduced cover and a reduced service for wards and departments across WHH.
- In response to this the Acute Medical Unit had discharge medication packs for 75% of medicines. This enabled patients to be discharged from the unit promptly, rather than having to wait for medication to be dispensed from the pharmacy department.
- However staff also told us there were discharge delays due to junior doctors not completing the electronic discharge ordering system because they were unable to keep up with the requirements of the ward as a result of their excessive work load.

Learning from complaints and concerns

- Patients told us they felt they were "listened to" and they believed that staff would act to improve shortfalls in patient services.
- We were told by the sister on the stroke unit that a patient had complained about being discharged home in their night clothes because they did not have anything else to wear. The complaint had been addressed and a new procedure was in place that asked families and carers to provide appropriate clothes for patients when they were first admitted to the hospital.
- We noted that the complaint and the outcome of the investigation were recorded in the monthly governance report for the stroke unit.

Are medical care services well-led?

Requires improvement

Leadership and culture of the service

- We noted that the trust scored worse than average in the NHS Staff Survey 2013 for a number of key findings, which included staff witnessing 'near misses' and violence between staff, as well as bullying and harassment, and work-related stress.
- A senior nurse in CDU who told us that "morale was at rock bottom" and staff had left because of stress due to the pressures of high workloads and the shortages of staff.
- Staff told us some staff had left because of stress and being unable to cope with the work pressures any more. The ward sister told us it had been very difficult to recruit to the vacant posts.
- We spoke to five ward sisters who all told us they had good relationships with their matrons and felt they could go to them with any problems or concerns they might have.
- There was a clinical leadership programmes but the ward sisters and matrons, we spoke with were unaware of the programme.

Vision, strategy and risks

- Some staff knew about the trust vision but felt like the hospital was business rather than patients focused. One nurse said 'I worry about being 'made' to move patients before they are ready to be discharged. I am sure this is why we have so many readmissions."
- The ward sisters told us about the nurse staffing review in 2013 and the subsequent investment in nursing of £2.9 million. We noted that ward managers would be supported to be 100% clinical supervisory but this had not been implemented at WHH. The ward sisters told us that only part of the ward manager's role (50%) had become supervisory ward sisters were able to take one to two management days a week and the junior sisters one day a week.
- The sister on the stroke unit told us that since the nursing review and investment all maternity leave was funded. However, there were problems at WHH in recruiting sufficient staff to enable the ward manager roles and maternity cover to be fully implemented across the hospital.

Medical care (including older people's care)

Governance, risk management and quality measurement

- Junior doctors told us they felt concerned about the gaps in the medical rotas. There had been some improvements in the medical rota after feedback, and a middle grade doctor had been incorporated into the rota at weekends.
- The junior doctors expressed concerns that the 'cold team', support team for wards at weekends, was being used to support sick patients in the acute care areas for example, CDU and A&E.
- Staff across the medical division were able to tell us about the clinical governance arrangements in their area and how they helped improve the care and support of patients.
- Junior doctors told us they were involved in quality improvement programmes.
- A stroke consultant told us, "the strength of our unit is clinical governance" and that the stroke unit was felt to be well led with effective governance and quality improvements in place.
- It was recognised by the stroke service that audit facilitation and data submissions had recently improved at this hospital.

Learning, improvement, innovation and sustainability

- Ward sisters told us that compliance with mandatory training was a challenge for all ward sisters in the medical division however the evidence we saw suggested that mandatory training was up to date on the wards that we visited.
- Nurses told us that there were opportunities for learning and development at WHH, particularly around enhanced clinical skills training in dementia and cardiac care.
- We saw evidence that senior nurses, ward sisters and doctors had been part of shared learning around complaints, incidents, and innovations in practice.
- Nurses told us there had been a lack of engagement with them around the implementation of the nursing strategy. All the nurses we spoke to could tell us who the Chief Nurse, Director of Quality and Operations was aware of the nursing staffing review in 2013.
- All staff we spoke to at WHH knew who the chief executive was, and most staff were aware of the trust's initiatives to involve staff in the wider organisation, for example, staff presentations for improvements for WHH and the Chief Executive Forums.
- Ward sisters and staff had little interest or understanding as to why they should need to be aware of the wider workings of the trust and the part they played in the overall care of patients at WHH.
- There was evidence of where innovations in practice were happening across the medical division, for example, developments in stroke services around the extension of emergency treatment for stroke patients.

Surgery

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

Information about the service

The William Harvey Hospital (WHH) had seven surgical wards, a fracture clinic, a central admission lounge, a day surgery and theatre unit, and a main theatre suite. The hospital currently provided emergency, general, trauma and elective surgery.

During our inspection, we spoke with 27 patients, 33 members of staff and three relatives. We looked at the records both in theatre and on the wards we visited and saw 18 sets of patient records. We also attended a listening event to gather the views of people who had used the hospital and lived in the local area.

Summary of findings

We found significant staffing issues on some of the wards we inspected, including inappropriate staffing levels at night. Some wards were cluttered and cramped, resulting in a potential hazard for people whose mobility was unsteady following surgery. Some equipment was not maintained in accordance with manufacturers' guidance and therefore may not be fit for use.

Patients told us that they felt their care and treatment at the hospital was good, and they were generally happy with the standard of facilities.

Surgery

Are surgery services safe?

Inadequate

Incidents

- Three of the four 'never events' that had been reported in the trust between December 2012 and November 2013, occurred in surgical services at WHH.
- Actions had been taken as a result of incidents that had occurred. For example, in the main theatre suite, changes to the way in which information were checked. Staff told us that this had led to an improvement in the care patients received.

Safety thermometer

- The trust used the national Patient Safety Thermometer audit tool; it was in use in all areas visited.
- This showed that rates of falls, pressure ulcers, and urinary tract infections (UTIs) were being managed. Staff were aware of the need to ensure that people were not at risk of developing pressure ulcers, and any risk of falls was now minimised.
- The use of the safety thermometer linked to the care planning documentation, which included risk assessments to minimise or mitigate the risk of falls and pressure ulcers, with the use of specialised equipment including pressure-relieving mattresses and bed rails, when needed.
- Risk assessments were in place to ensure that anyone at risk of malnutrition was assessed and measures put in place.

Cleanliness, infection control and hygiene

- Infection control procedures were in place on all wards visited. Hand gels were available at the entrance to each ward and instructions given for their use, reducing the risk of infection.
- Action was sometimes taken on the findings of infection control audits, for example an infection control audit in theatres carried out in January 2014, identified a number of issues. At the time of the inspection these were being addressed. However, these audits were not being undertaken in all areas within the surgical directorate.
- Some areas of WHH were very cramped and cluttered, making cleaning these areas difficult. For example trolleys in the day surgery unit were stored in the theatre corridor making the area difficult to clean and potentially blocking the exit.
- In theatres we noted that theatres nine and 10 had historical water damage to the ceiling that had not been repaired or repainted, presenting a potential infection control risk. A carpeted store room could not be properly cleaned or decontaminated, presenting a risk of cross infection. The theatre manager explained that this had been identified some months previously when the use of the room changed, but had not been addressed.
- There were no records of curtains being washed or replaced within the day surgery theatre or recovery cubicles.

Environment and equipment

- Servicing of equipment was not always done in accordance with manufacturer's guidelines. In the main theatre area, critical pieces of equipment were 15 months overdue for servicing. A departmental toolkit audit showed that servicing was only 72% complete and was highlighted as a high risk. In addition critical pieces of equipment in theatre such as diathermy had not been checked to ensure they are working and functioning correctly before use.
- A list of anaesthetic room equipment and emergency equipment checks showed these had been undertaken sporadically. They were partially completed in October, November and December 2013; checks between January and March 2014 were incomplete in places, and no checks had been recorded between June and September 2013.
- A number of daily theatre checks should be completed in theatre before surgery commencing including humidity, temperature, and cleaning, routine equipment. Checklists were in place but in theatre 11 records showed these were last completed in June 2013, no other evidence was provided to demonstrate these had been undertaken. Theatre 10 checklist showed several days in January, February, and March 2014 when the checklist had not been completed.

- Staff in the main theatres reported difficulties in obtaining equipment such as syringe drivers. In addition we were told of significant problems at weekends because they had no laundry facilities or access to stocks of dressings.
- Several wards were cramped, for example Kings A had various items of equipment stored along a narrow central corridor. Kings C1 was also cluttered and used as a thoroughfare to Kings C1 ward, compromising patients attempting to mobilise post-surgery, and represented a risk to their safety.
- There was limited access in the Ear Nose and Throat unit, the Rotary suite. A corridor and four side rooms were narrow and beds could not be moved from this area and instead had to be dismantled.
- During our inspection, we were told by a senior staff member that generator tests had not been carried out since September 2013, following the installation of a new generator. We saw evidence that an improvement plan was in place at all sites to replace or rationalise generators.
- Before our inspection, appropriate water testing was not always taking place. A request for additional funding to improve water quality and safety records had been applied for.

Medicines

- Medicines were mostly managed and stored appropriately. Controlled drugs were appropriately stored and checked and records maintained.
- On one ward we noted that the medication trolleys were locked, however the drug storage cupboards were not.

Records

- Patient records on the wards we visited were generally completed, although we noted some inconsistencies in the integrated care pathway documents used. These documents included all the medical and nursing notes and tracked the patient through their procedure.
- Theatre records were completed and the integrated care pathway documents recorded the medical and anaesthetist's input together with information on recovery. The pathway document also contained a detailed record of equipment used, and this provided an audit trail.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told that all staff received training in the requirements of the Mental Capacity Act (2005) as part of their mandatory training and, when we asked staff how they would manage a patient with limited capacity to make their own choices or decisions, they were clear of the process that they would follow. Support would be provided by medical staff and other health professionals in making a decision in that patient's best interests.

Management of deteriorating patients

- There were procedures for managing deteriorating patients, these included specialist services being available throughout the hospital to provide support, and the surgical department had close links to the intensive care service.
- There was access to a critical care outreach team who provided additional support to deteriorating patients when required.

Nursing staffing

- There were inappropriate staffing levels in some areas, particularly at night. For example a 20-bedded ward frequently only had one qualified member of staff and a healthcare assistant (HCA). Establishment figures on that ward at night were for two qualified nurses.
- The staffing rotas for the 10 days preceding the inspection showed that on six of the 10 nights before our inspection, with only one qualified staff member worked the night shift.
- Daytime staffing levels in the wards and theatres were usually appropriate to meet patients' needs as bank and agency staff were employed to cover staff shortages due to sickness, leave or recruitment issues.
- All staff were up to date with their annual mandatory training that included moving and handling, basic or advanced life support, infection control, safeguarding vulnerable adults from abuse, dementia care and discharge planning.
- Wards maintained their own staff training records that identified any gaps in staff training. Individuals were emailed if they had not attended training.

Medical staffing

- It was acknowledged by the trust there were not sufficient senior consultants in post in order to ensure that there was a safe on call rota at all three sites. Thus

discussions were underway to establish how surgical services would be delivered in the future. This had led to some consultants feeling that their views had not been taken into account.
- At the present time on the WHH site, one surgeon was not practising, one was on restricted practice, and one was shortly leaving. Senior divisional managers we spoke with were unable to provide detail or evidence to demonstrate how this risk was being mitigated.

Are surgery services effective?

Requires improvement

Mortality
- In the past 12 months, mortality indicators data had identified an 'elevated risk' and an outlier by our Intelligent Monitoring for trauma and orthopaedic conditions and procedures, in particular head of femur replacement.
- Action plans had been produced and implemented to address issues with head of femur replacement care, and this had resulted in significant improvements across the trust.

Use of national guidelines
- The trust only participated in 39 of the 52 national audits they were eligible to take part in.
- The trust's contribution to the National Bowel Cancer (NBOCA) audit was 59% (262 of anticipated 447) of cases, and the data was inadequate with only 14 cases of major surgery recorded. Data completeness was 0%.

Care plans and pathways
- Integrated care pathways were in use, these provided multidisciplinary records of all interventions, including medical, anaesthetists, recovery and nursing care, in one document. Providing an audit trail to show the procedure undertaken and the patient's recovery from it.

Multidisciplinary team working, we need to work on how we access this
- There was evidence of multidisciplinary work throughout the department amongst the medical team, anaesthetists, physiotherapy, occupational therapy, speech and language, pharmacy and dieticians.
- There was evidence at both ward and theatre level that decisions about patient care were made in a multidisciplinary forum. This was recorded in individual integrated care pathway documents that combined both medical and nursing notes and tracked a patient's treatment from pre-admission, through the procedures undertaken, and on to recovery and post-operative care.

Seven -day services
- A move towards seven day services were planned by the hospital but had not yet been implemented. However, better use of theatre facilities was being made during weekdays with an earlier start time.

Are surgery services caring?

Good

National surveys
- Information gathered from the FFT, in which patients are asked whether they would recommend their friends and family to use the hospital, indicated that patients and relatives would recommend the trust. The patients and relatives we spoke with during our visit were very happy with the care and support they had received.

Compassionate care
- Patients who were receiving treatment were happy with the care and treatment provided. One person told us that, "it has been a good experience on the ward." Another said, "The staff here are wonderful and I have had lovely food." Another, who had just returned from surgery, described the experience as "brilliant".
- One person told us that they had found another patient talking loudly on their phone very annoying. They had spoken spoke to staff about the problem and it had been quickly resolved.

Involvement in decision making
- We saw how medical and nursing staff involved people in their care and treatment. We noted that doctors explained to all the patients what their treatment entailed and the plans for their future.
- Patients in the hospital were offered a wide choice of meals and we were told by those we spoke with that the food was very good.
- We noted that, when appropriate, families and relatives were involved in discussions, and we observed a

conversation with a family member in readiness for their elderly mother to return home. The discussion took place to ensure that the support and equipment the person needed was in place.

Dignity and respect

- Patients receiving treatment and support were treated with dignity and respect, particularly on the wards. Curtains were drawn around the bed before any conversations took place or treatment was given.
- On one ward we noted how appropriately staff managed a patient with a hearing and speech impairment, supporting them by having a pen and paper to communicate in writing with them.
- Patients awaiting surgery in the day surgery unit were not segregated between male and female patients therefore non-compliant with mixed sex accommodation criteria.

Emotional support

- Emotional support was available for patients recovering from surgery. We noted one person had been helped in coming to terms with an amputation and the support measures that were being discussed for them in the future. They were encouraged by therapy staff to become mobile as far as possible and to follow an exercise programme.
- Friends and family were encouraged to visit and, although there was a designated quiet period after lunch to allow people to rest, staff told us that when necessary they were able to be flexible with visiting hours to meet people's individual needs.

Are surgery services responsive?

Inadequate

Facts and figures

- Rates of surgical cancellations were within expected limits. Information about the hospital was provided by the trust. This showed that in the first two months of 2014 five elective procedures had been cancelled.
- Theatre utilisation data broken down at consultant level for the William Harvey Hospital, for the period April 2013 to January 2014, reported day surgery theatre utilisation ranged between 54% and 96%. The main theatres ranged between 66% and 96%.

Vulnerable patients and capacity

- Measures were in place at the hospital to ensure that vulnerable patients, or those who lacked capacity, received the highest standard of care. Specialist support nurses experienced in the care of people living with dementia and those with a learning disability were on site and available to provide support and guidance to ward staff.

Meeting the needs of patients

- During our inspection, concerns were raised by patients and staff that many discharges were delayed. This was particularly the case within the day surgery unit. Patients were remaining in the day surgery unit overnight, without proper beds and accommodated on trolleys. They did not have lockers to store their belongings or tables to eat their food off. This was unsuitable accommodation.
- The day surgery unit was being used routinely as an overflow service for the main hospital, with up to 10 overnight beds used to relieve bed pressures. This was impacting on patients in that male and female were not segregated, they did not have access to separate toileting facilities patients. Despite this, and that patients were often kept here overnight, the trust had reported no mixed sex breaches in the last six months.
- There was no disabled toilet in the ward and patients who required the disabled facility had to access the disabled toilet in the waiting area, while day surgery patients were waiting to be admitted.
- Arrangements were in place to meet people's cultural needs and access to interpreters and translation services was available.

Are surgery services well-led?

Inadequate

Vision and strategy for this service

- Most staff at ward level were unclear what the trust's vision and statement of values and did not understand how this impacted on the day-to-day work.
- We saw some evidence during the inspection that learning had taken place after incidents, and that procedures had changed to reflect that. For example, a

new safety checklist in theatre, 'five steps to safer surgery' had been introduced. This was a positive step but it was not being audited and therefore it was unclear if it was being used effectively.
- Information sharing between matrons both within the theatre suite and on the wards aimed for a consistent message to be delivered to staff. Information from the matrons' meetings, held bi-monthly, was shared with staff at team meetings. Evidence of this was seen in meeting minutes that we looked at during our inspection.

Governance, risk management and quality

- We asked for a copy of the surgical risk register which identified potential risks, but the latest copy made available to us was dated August 2013. When we reviewed this document we noted area that had not been updated since February 2013. We could not be assured that any potential current risks to the department had been identified and steps taken to mitigate the risk.

Service leadership and culture

- Some staff from the ward manager down, felt supported and encouraged to carry out their day-to-day duties. Concerns were expressed about the wider trust management, their approachability, and visibility on site.
- These varied as some areas felt the executive team was visible while others were not aware of any presence or visits. One person said, "there is a total disconnect between the executive team and the clinical areas." This was a view shared by other staff who felt that they lacked support from a higher level.
- Ward and theatre staff were satisfied with overall training offered by the trust.
- One senior nurse said to us, "this is the toughest time I have known in nursing." They went on to express their concerns that they were "unable to deliver a safe and effective service and that matrons who should be supportive do not have the necessary clinical skills.
- Audits were not undertaken to identify areas for improvement in practice.
- Clinical staff were not engaged in the seeking of solutions for issues identified, they saw this as a management responsibility.

Critical care

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

Information about the service

The critical care unit (CCU) at the William Harvey Hospital (WHH) had 11 mixed-level intensive care and high-dependency care beds. Capacity had been increased from November 2013 by the introduction of two new high-dependency beds in response to more patients needing a greater level of support or monitoring than was available on the general wards.

An outreach team provided staff with support to manage critically ill patients on wards and departments across the hospital 24 hours a day. The team used an electronic monitor recording system called Vital PAC, promoting early detection and intervention, to manage the deteriorating patient.

We spoke with one patient, five relatives, and 12 staff including nurses, doctors, consultants, senior managers, and support staff. During the inspection, we looked at care and treatment, and we reviewed care records. We received comments from our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

We found the unit to be visibly clean, and there were systems in place to manage infection control. Outcomes for patients in respect of mortality were within statistically acceptable levels although infection control rates of zero as reported by the trust in the last two years were unusually low. Staff said they felt well supported by their colleagues and that there was good team working. There was a high number of vacancies within the nursing staff although a recruitment programme was underway. Junior doctors felt the current rota was not sustainable in the longer term and a business case to increase the number of doctors on the rota had not been implemented, There was a concern that a culture of bullying had not been addressed within the nursing staff.

Critical care

Are critical care services safe?

Good

Incidents

- The critical care risk register for January 2014 identified specific incidents relating to ICU capacity. To resolve the issue two additional beds were made available and came into use in December 2013/January 2014.
- There was a lack of space around the two additional bed areas affecting the delivery of care and treatment to patients, and this was recorded on the ICU care unit risk register.
- There had been problems with a hemofiltration device; between September 2013 and February 2014, with 23 incidents reported relating to this issue. One incident had affected a patient and had been reported to the Medicines and Healthcare products Regulatory Agency (MHRA).

Safety thermometer

- NHS Safety Thermometer information was displayed. This included information about all new harms, falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections and new pressure ulcers.

Cleanliness, infection control and hygiene

- The unit was visibly clean and we saw staff regularly washing their hands and using hand gel between patients. The policy to have bare arms below the elbow was adhered to.
- There were infection control policies in place, including weekly spot-check audits.
- Nosocomial and blood stream infection rates and ventilation-acquired pneumonia (VAP) rates had been reported as zero for the past two years, this is unusually low.
- The process for recording care bundle, records used for recording the different elements in providing treatment and care, was not always adhered to and surveillance for VAP was weak.

Environment and equipment

- The sluice and equipment room was checked and found to be visibly clean and organised.
- Equipment was stored off the floor and had been standardised. It was visibly clean and well maintained.
- The resuscitation and emergency equipment was checked daily and these checks recorded.
- We were told there was a problem with the electricity supply to the ICU that did not meet current national standards. The electrical supply had been reviewed and the need for extensive electrical work identified. An interim solution was put in place in the latter part of 2013.

Medicines

- The pharmacist visited the ICU each day and reviewed the medicines and drug charts, but they did not join the multidisciplinary ward round.
- Medicines were stored correctly in locked cupboards or refrigerators as necessary. Fridge temperatures were checked.

Records

- Standardised intensive observation and nursing documentation were kept at patients' bedside.
- Observations were recorded; the timing of these was dependent on the acuity of the patient.

Mandatory training

- There was a competency-based structured training programme for all nurses and healthcare assistants.
- All students and new members of staff were allocated mentors to work with; this allowed their development and learning to be monitored and supported.
- The training matrix showed that a number of staff were not up to date with their mandatory training requirements as they had not completed online e-learning modules. We saw that the modules outstanding included safeguarding adults, health and safety, infection control and manual handling. A number of staff had not completed their resuscitation update training.
- Senior staff were amongst those who had not completed or updated their mandatory training.

Management of deteriorating patients

- An outreach team of eight nurses covered the hospital and provided a 24-hour service. There were two nurses on the day shift, one nurse at night and one nurse covering at the weekend.
- We were told that the outreach team followed the policy for the prevention and management of the deteriorating patient. The team used the electronic trigger system, Vital PAC, which provided a recording mechanism for patients' vital signs as well as essential screening tools.

Critical care

- The trust had implemented the national early warning score (NEWS) for patients; this system standardised the assessment of acute illness severity, and indicated when senior staff should be contacted. Referrals were made predominately to the team responsible for admissions, and rarely direct to the unit. One team member told us that there was usually minimal delay in escalation.

Nursing and medical handover within the unit

- Consultant-led rounds were undertaken twice a day with the medical handover at 2.30pm.
- Pre-printed daily sheets and care plans were used for medical and nursing records.
- Nursing staff were often not present on the consultant-led ward rounds due to other calls on their time, but bedside nurses, nurses providing 1-1 care for the whole shift, were always present.
- We were told that the microbiologist and dietician also attended the unit daily, but did not join the main ward rounds. There were few opportunities for group discussion between medical staff, nursing staff, and allied health professionals.

Nursing staffing

- Staffing numbers were being reviewed in order to meet the increased demand on nursing time to cover the two extra high-dependency beds, based outside the main unit. The skill mix for critical care was worked out in the basis of 5.3 whole time equivalent nurses per bed, and did not include healthcare assistants. Level 3 patients would have one-to-one nursing, and level 2 patients would have one nurse caring for two patients with healthcare assistant support. We were informed that the unit had four band 2 and two band 3 healthcare assistants.
- There was not a supernumerary clinical coordinator on the unit on all shifts in line with national guidance.
- The matron stated that the unit had 14 nursing vacancies; however five new band 5 nurses had been recruited and would follow the unit's ICU induction pathway.
- Agency nurses had been used to cover shifts especially at night, and this sometimes exceeded 20% of the total number of staff on duty. Planning for the use of agency nurses had been as block bookings to cover shifts. We were told that critical care unit staff could do extra hours and overtime to cover shifts.

Medical staffing

- We were told that an intensive therapy unit (ITU) consultant was available from 8am to 6pm, Monday to Friday; at the weekend they were available from 8am to 2pm. There was a consultant anaesthetist available out of hours but they were not always ITU trained.
- There were dedicated weekend ward rounds in place and took place each morning on Saturday and Sunday. There was a formal hand over on Monday morning led by consultants.
- Consultants were available to cover the unit 24 hours which in accordance with national guidelines.
- The consultant patient ratio was 1:11 which is in line with the Intensive Care Society standards.
- Junior doctors told us that the consultants were supportive and approachable even when not on call. They were easy to contact and would come in if asked. All potential admissions to the unit had to be discussed with the on-call consultant.
- The current trainee rota was 1:6, although the trainees felt well supported by senior staff and rated their protected teaching highly they reported that the rota very busy.
- Requests for additional trainees to make a more sustainable eight-person rota, submitted with the critical care unit expansion business case, had not been implemented.

Are critical care services effective?

Good

Use of national guidelines

- The intensive care unit (ICU) used a combination of guidelines from the National Institute for Health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine to determine the treatment it provided.
- We were told about audits that had either been completed or were still being carried out by clinicians in ICU. There were 12 audits: four had already been completed and at least one would be presented as an oral presentation in Brussels in March 2014.
- One of the audits we were shown looked at the hospital transfers from the ITU. This showed that in 2012/13 the WHH ITU carried out 29% of total transfers among hospitals in Kent and Medway of which 58% were

non-clinical transfers. We were told that the reason for this high number of transfers was due to the fact that WHH takes all emergency cardiology from East and West Kent.

Outcomes for the unit

- Results from the Intensive Care National Audit and Research Centre (ICNARC) showed that patient outcomes were within the normal range compared to similar units.
- Mortality meetings were held monthly, information on findings or outcomes of reviews was circulated. Minutes went to the trust safety board and an end-of-year report was written.
- The mean length of the stay for ICU from January to December 2013 was 3.6 days, which is in line with the national average.

Care plans and pathway

- Both medical and nursing staff in ICU used a daily ward round standardised handover sheet. Infection control issues were highlighted.
- We were told that the microbiologist and dietician also attended the unit daily, but did not join the main ward rounds. There are few opportunities for group discussion between medical staff, nursing staff, and allied health professionals.
- Nursing documentation was kept at the end of a patient's bed and completed appropriately.
- Care bundles were in place for specific situations, and daily monitoring of their components was documented on the daily observation chart, Vital PAC or specific bundle chart. However, there was no evidence of compliance monitoring.
- All potential admissions had to be discussed with a consultant and all new admissions were reviewed in person by them within 12 hours of arrival in the unit.

Multidisciplinary team working

- There were two ward rounds: one in the morning and a shorter afternoon round. Other members of the multidisciplinary team reviewed patients including the pharmacist, physiotherapist, and dietician, although this occurred separately from the main ward rounds.
- The unit was implementing the recommendations in the NICE clinical guideline 83 on critical care follow-up and rehabilitation.
- There was an action plan for critical care follow-up and rehabilitation in place and being co-ordinated by one of the ICU matrons.
- A critical care pharmacist was based on the ward, and all patients with a tracheostomy were assessed by a speech and language therapist. In addition, a dietician provided support to the unit five days a week.

Seven-day services

- A physiotherapist and pharmacist were available five days a week and would visit the ICU. Weekend cover was on an on-call basis.
- A consultant was available from 8am to 2pm on Saturdays and Sundays. Out-of-hours cover was provided by a consultant anaesthetist.

Are critical care services caring?

Good

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. All patients and relatives we talked to spoke highly of the service and said they were kept well informed and included in decisions.
- We saw that relatives were seated in the bed areas with the patients, and were able to observe the nurses who were caring for them.

Patient understanding and involvement

- Relatives told us that they felt very involved in the care that the patients were receiving. One said, "I could not fault the care, excellent communication." We were told that clear information was given at every stage; both the nursing and medical staff had been very approachable.
- One relative gave an example of how good communication was: the nurse caring for the patient had kept the family informed about when a scan was due to be performed by calling them at home.
- One family told us about how a communication difficulty had been overcome for their relative. The nurses were able to understand the patient and use alternative means of communicating.

Critical care

Emotional support

- ICU had facilities for relatives, and we saw that relatives and friends could wait if a patient was receiving care. We also saw that families could be spoken with privately if there was any change in a patient's condition.
- We spoke with two staff members who demonstrated that communication and keeping the patient, family and friends updated and informed was important. One staff member told us that "we put patient's first, patient-centred care."
- Another staff member told us that it was important to have in-depth knowledge about a patient; this included knowing the family and involving them in care decisions.

Are critical care services responsive?

Good

Maintaining flow through the department

- Due to capacity issues, patient flow in and out of the unit was not always at an optimum level due to a number of factors. These included an increase in the number of patients requiring an intensive care bed as specialist services including ear, nose and throat/ maxillofacial surgery had increased.
- In response to this the unit had recently opened two additional high-dependency beds,
- In 2013 there were 26 non-clinical transfers; the 2013 Core Standards for Intensive Care Units from the Faculty of Intensive Care Medicine rationalises that the risks of transfer prolong stays on CCU and may be associated with distress to patients and their families.
- During 2013 there were 734 admissions to ICU, which were predominately from surgery and medicine; 173 of these were elective surgical admissions.
- There were 17 cancellations of operations due to a lack of either critical care or high-dependency care beds being available.
- There were 39 delayed emergency patient admissions due to unit capacity issues and 28 patients not accepted onto ICU because they did not meet the admission criteria.
- During 2013 there were eight patients readmitted to the unit.
- We were told that there were two management meetings daily that looked at patient occupancy, bed availability and staffing.

Discharge and handover to other wards

- The patient admissions form booklet had an ICU nursing discharge/transfer form. When a patient was discharged from the ICU, an SBAR transfer form was used. 'SBAR' stands for 'situation, background, assessment and recommendation'.
- Relevant information regarding admission details, summary of assessments including cardiac, respiratory and neurology were included as well as completed risk assessments were recorded and signed by both the transferring and receiving nurses.
- ICU observation charts remained on the unit but the nursing and medical notes went with the patient. In addition there was a doctor's discharge summary.
- The outreach team followed up patients transferred out of the unit the purpose being to monitor their progress on discharge from the ICU. They used the Vital PAC system to monitor and record the patient's progress.

Complaints handling

- Complaints were handled in line with trust policy. The nurse in charge managed all informal complains.
- A Patient Advice and Liaison Service (PALS) assisted patients and their families if they wished to raise a more formal complaint.
- This complaints process was outlined in the leaflet 'Talk to us', which was available in the relatives' waiting area.
- We saw from the minutes of the senior staff meeting held on the 27 February 2014 that there would be a monthly report of compliments and complaints received. It was shown that the number of compliments received exceeded complaints.

Are critical care services well-led?

Good

Governance, risk management and quality measurement

- The ICU had frameworks for monitoring the quality of its service. It was part of the surgical division of surgery and monthly surgical governance meetings were held.

Critical care

- A critical care steering group met monthly across all three sites. A video-link option was available.
- We saw that there was a critical care risk register, and the recent problems with haemofiltration equipment had been recorded on this.
- We were told that a team leader completed the appraisal with each member of staff and that there was 85% compliance with the completion process. The training matrix with dates showed that most appraisals had been completed and were within date for starting in April 2014.
- Complaints, incidents and audits were discussed in senior staff meetings.

Leadership of service

- The ICU had a designated clinical lead consultant and evidence of unit leadership.
- The unit also had nursing leadership, with an identified matron and a nurse consultant who worked across all three ICUs in the trust and was a link and resource for all of them.

Culture within the service

- The relationship between the three ICUs across the trust was reported to be effective. There were forums for senior nurses to collaborate in working together.
- We were told by two staff members that team working was excellent and support from consultants very good in that they were approachable and easy to contact even when not on call. Other staff told us that there was good support from the nursing staff.
- Some staff we spoke with told us that nurses were leaving because of overwork and isolation. There was also concern expressed about bullying by senior nurses towards junior nurses, we were not provided with assurance that this issue had been investigated and addressed.

Innovation, improvement and sustainability

- There was a structured induction programme,
- ICU offered staff opportunities for applying to do a post-registration critical care course when nurses had completed both parts of their initial induction successfully.

Maternity and family planning

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

Information about the service

On average there were almost 4,000 births each year at the WHH, 735 of these were in the midwife led birthing unit. There was antenatal day care, a fetal medicine unit, a labour ward with adjacent theatres, and the antenatal and postnatal Folkestone Ward. Antenatal clinic services were situated in the outpatients' area and there were shared clinics with gynaecology. The WHH had a level 3 neonatal intensive care unit (NICU) for babies born before the 24 week of pregnancy,

There was also a modern midwife-led birthing unit, with two birthing pools, at this site. This, the Singleton unit, was for women with uncomplicated pregnancies who wanted to give birth naturally and in a less clinical hospital environment. There was also an early pregnancy service on this site for mothers in the first few weeks of pregnancy.

During our inspection, we visited the wards and units and spoke with more than 20 patients and their relatives. We observed care and treatment and spoke with about 30 staff who were working in a variety of roles offering medical and maternity services. We spoke with the site's maternity matron, midwives and their assistants, student midwives, a labour ward coordinator, facilities manager, ward clerks, volunteers. We received comments from our listening events and from members of the public who contacted us to tell us about their experiences. We also reviewed the trust's performance data.

Summary of findings

Women received care that was delivered with compassion, dignity and empathy. However, the midwife to birth ratio was below the national standard, the national recommended ratio of midwives to births is 1:28, the ratio at this hospital 1:33. Due to staffing levels there had been frequent closures of the midwife-led Singleton unit in recent months. This had reduced choice for women and meant that some women were transferred to other units for non-clinical reasons.

We found that leadership vacancies and interim arrangements had continued for significant periods. Clinical guidance and policies used by staff were out of date. Some essential equipment was in short supply.

Maternity and family planning

Are maternity and family planning services safe?

Requires improvement

Incidents

- Staff were aware of the trust's incident reporting system and used the online system to report incidents. However, staff told us that they did not always have time to submit an incident report.
- There was a policy for the management of incidents, including serious incidents for investigation and external notification. We saw evidence that the trust investigated incidents and identified learning including changes to practice when appropriate.
- Risk management and complaints were coordinated through the recently appointed divisional risk manager. The risk manager was making progress in ensuring maternity risks were reported to the divisional and trust board.
- Learning was shared. A newsletter entitled 'Risk Wise' was written and circulated to 'inform, educate, and enhance safety and quality, taken from best practice and lessons shared from adverse events locally'.

Performance data

- Performance data showed that a number of caesarean sections performed, both elective numbers and emergency, was similar to the national average.
- Maternity related infections, such as puerperal sepsis, were within the expected levels.

Cleanliness, infection control and hygiene

- There was an in date infection control precautions policy but there were out of date infection prevention and control leaflets on the wards, in one case more than three years.
- There was limited personal protective equipment available, such as disposable gloves, placing staff at risk of infection.
- In the single rooms equipment had been taken off the walls and the underlying plaster and old wallpaper was exposed.

Environment and equipment

- There was a lack of equipment in the delivery rooms. For example access to only one resuscitaire for seven delivery rooms, a second one had been condemned and not replaced. This resuscitaire was not located in the delivery room, resulting in the baby being brought from the delivery room and the commencement of resuscitation being delayed.
- A resuscitaire could be borrowed from theatres if more than one was required. It was reported that it was not unusual for babies to be resuscitated in the corridor.
- Ultrasound services were separate to routine screening services.
- The lack of equipment was an issue raised by several midwives who said they had to "beg, borrow and steal".
- There was one recovery unit/theatre complex on the labour ward with a separate large anaesthetics room. There was no second dedicated theatre.

Medicines

- Medicines were not always stored and managed safely. Several cupboards and clinical fridges were unlocked.
- Fridge temperatures were recorded daily.

Records

- Women carried their own maternity notes. There were processes to ensure notes were entered into the maternity information system as soon as possible after booking.

Midwifery staffing

- There were gaps in staffing due to vacancies, secondments, and maternity leave. Staff had been "acting up" to cover vacant posts for a significant period without having been formally recruited to.
- The trust had used Birthrate Plus to identify the number of midwives required to provide a safe service. We saw evidence that there were 16 vacancies in the maternity services across the trust. This had resulted in midwife to birth ratio being 1:33, which was below the national standard ratio of midwives to births of 1:28.
- Staff raised concerns about the staffing levels on the labour ward. These were reported to be a particular issue at night. The issues had been raised through the incident reporting system but no action had been taken.
- There was consultant presence on the unit Monday to Sunday 8am to 6pm a total of 70 hours a week. There were nine consultants, therefore a 1:9 on-call rota was in place.
- Dedicated anaesthetics cover was available on the labour ward.

Maternity and family planning

Are maternity and family planning services effective?

Requires improvement

Use of national guidelines

- The majority of clinical guidance for maternity were out of date. Guidance on reducing the risk of streptococcal infection, and the birth centre/home birth criteria, had all expired in September 2011.
- The limited guidance that was in date included guidance on home births and an operational policy for the security of new born infants.
- Staff told us that they were aware that a significant numbers of policies and guidance were out of date. They stated that plans were in place to address this but due to staffing levels the work had not yet been completed.
- Many of the guidance leaflets displayed on the wards and units associated with women's health were out of date. The Monitoring your baby's heart beat in labour; leaflet included out-of-date guidance and facilities that were no longer in place.
- The on line leaflets, such as Neonatal death and Help for the bereaved, were up to date and links to national guidance.
- There was limited engagement with the obstetric team when guidelines were developed as this was seen as a midwife function.

Outcomes for the unit

- A new maternity dashboard was being developed but at the time of our inspection this had been finalised or implemented.
- There were 3,155 births in the consultant-led ward and 735 births in the midwife-led unit between February 2013 and January 2014.
- A range of audits had been completed; these included the feeding of new born infants, shoulder dystocia, intermittent auscultation and thromboprophylaxis. Audits and their findings were discussed by the midwifery management team and across the women's health service.
- All audit reports included recommendations for improving best practice with a target date for completion. The completion of these was monitored by the clinical audit committee.

Multidisciplinary team working

- Community midwives confirmed that they met regularly with the hospital midwives to provide continuity of care of mothers.
- The previous daily work was discussed by a multidisciplinary team and a daily audits of all caesarean sections took place on the labour ward
- There was also effective multidisciplinary practice between pathology, HIV and screening coordinators, and between the antenatal screening coordinator and gastroenterology.
- The staff on the midwife-led unit felt undervalued compared to their peers on the labour ward.
- Student midwives on the postnatal ward said that they felt "supported by the other staff and by their mentors".
- The majority of communication was through email as all staff had access to emails.

Are maternity and family planning services caring?

Good

Compassion, dignity and empathy

- There were privacy notices on doors and midwives and assistants knocked before entering.
- On the postnatal ward, mothers were asked if they would like the curtain pulled around the bed and their wishes were respected.
- All written comments from mothers on the postnatal ward were positive. Comments included, "all the ladies were excellent, couldn't have asked for anything more. The best care and support you could ask for."
- A new mother on the postnatal ward said, "they have all been so helpful and reassuring about the feeding, she (the baby) is now putting on a little bit of weight."
- Most mothers told us that they appreciated the care from staff and one said, "People are around when needed but left me to get to know my baby. Good advice given and helpful staff." Another comment was "very attentive and I was well cared for. Lovely nurses and doctors."

Maternity and family planning

- A minority of mothers told us that: “care was wrong, I felt unrespected and spoken to in a rude manner". “I was left for long time, when I asked for help.” “The window was broken and there was a draught and the staff left me there all night” also “I was treated like rubbish.”

Involvement in decision making

- The Maternity Patient Experience Survey showed that the trust was performing better than other trusts in the areas of questioning for care during labour and birth.
- One person who had been on the labour ward said, “the midwives and doctors did everything they could to keep me comfortable and accommodate my needs. I felt 100% supported and thought the care was second to none.”
- Another new mother said, “It was extremely professional, calm, and comforting. It was good to learn of the stages of pre C-section preparation. It was helpful that one of the theatre staff was telling [me] of the operation’s progress.”
- The trust scored better than other trusts in respect of mothers being provided with information at the start of their labour.
- One patient said that staff were “attentive, explained everything, extremely supportive and allowed me to follow up [my] birth plan”.
- Others said they were aware that there was a shortage of staff and one said, “I have been waiting for a scan now for over a day and I was hoping to go home.”
- Another said, “I know you are quite busy but it would have been nice to see more midwives.”

Dignity and respect

- The mothers we spoke with said that they received important information and advice on feeding and caring for their new babies, and they appreciated that the staff did not seek to impose their own views and opinions on breast or bottle feeding.
- Midwifes responded to patients, answering enquiries and buzzers.
- We observed that confidential enquiry over the phone were handled with discretion.

Emotional support

- Patients were appreciative of the continuity of care.
- At one of the listening events, a young mother told us how the midwife had stayed with her throughout the delivery and this was “exactly what I needed”.
- One mother had just had her fifth baby. She said she saw the same midwife at all her antenatal appointments, which she really liked.
- The antenatal and postnatal ward had a bereavement room where mothers could come and give birth when an intrauterine death had been diagnosed.
- There was a lead for developing new services for bereavement and staff had access to contact details for counselling services on the postnatal ward and early pregnancy unit.
- Four members of staff across the trust, three midwives, and an obstetrician had received specialist counselling training to assist women in need of additional emotional support.

Are maternity and family planning services responsive?

Inadequate 

Access and flow

- There were processes for midwives to refer women directly for consultant opinion at all stages of pregnancy and childbirth.
- Mothers had a choice of locations for antenatal appointments either in community clinics, GP surgeries, children’s centres, supermarkets, or at the four hospitals in Canterbury, Dover, Margate, and Ashford.
- Antenatal screening was in place which was managed by two screening coordinators.
- 85% of women booked before 12 weeks and six days and therefore received first trimester screening.
- There was a shortage of sonographers resulting in delays in ultrasound scanning. We were informed by several members of staff that 15 sonographers had left the trust recently, primarily because of a change to their pay and conditions in relation to on-call services in radiology. These posts were being covered by locum staff.

Meeting people’s individual needs

- The midwifery led unit had been closed 17 times in December 2013, 15 times in January 2014 and 18 times in February 2014, for a 12-hour period. This was due to insufficient staffing levels.
- Mothers who contacted the midwifery led unit when it was closed were diverted to the trust’s other

midwife-led unit in Margate 30 miles away or to the labour ward. Staff said, "It's terrible for the women when they have made their choice to deliver here and they get moved."
- From July 2013 there had been a "midwife vacancy freeze" in response to a fall in the birth rate, despite the unit already being frequently closed because of a shortage of staff.
- We saw the policy for the closure of a unit, which set out a standardised approach to closure and diverting patients to alternative services. However, this policy was overdue for review.

Delayed discharges/Leaving hospital

- The discharge form was out of date and overdue for review from July 2008.
- Written feedback from patients about the discharge process said, "very frustrating having to wait over 18 hours to go home after a quick delivery with a child under two at home." Another said, "I have been in hospital for 4 days due to a long labour and I am still waiting to be discharged." Another patient said "it takes all day to be discharged and means you and baby have to go out in freezing temperatures."

Vulnerable patients and capacity

- The perinatal mental health guidelines provided practical information for maternity staff working with patients with an existing mental health illness such as depression, eating disorders, and schizophrenia.
- With their consent, women with a history of, or currently experiencing, symptoms of serious psychiatric illness would be referred to the mother and infant mental health service.
- Interpreters were available and we saw that leaflets were available in a range of languages.

Environment

- Transfer of women between units was via public corridors impacting on their privacy and dignity.
- There was no reception on the antenatal day ward, mothers had to knock and wait at the ward office door The delivery rooms on the labour ward had no en-suite facilities. Mothers had to cross the main corridor to use the toilets and bathrooms.
- We received several direct comments about the facilities all of which were negative: "I felt that the facilities in the delivery suite could be better; the ward was very cramped." "Could do with an update – hole in the roof." "The ward is in serious need of repair, holes in the ceiling tiles, paint peeling off the walls, doors to rooms don't close properly."
- In addition, patients we spoke with commented on the lack of facilities available for partners including reclining chairs, visitor toilets on the ward and even a small bed.
- The midwife-led Singleton unit was modern, clean, tidy and uncluttered. There were birthing pools and birth balls, en-suite facilities and the lighting was gentle and could be dimmed. The feedback from women using these facilities included, "the environment was very friendly, comfortable and homely, which made it really easy to relax and feel secure."

Learning from complaints and concerns

- Complaints were handled by matrons and coordinated via the risk manager.
- Complaints had increased in relation to the regular closures of the midwife-led birthing unit.

Are maternity and family planning services well-led?

Requires improvement 

Vision and strategy for this service

- There was a disconnect between the strategy and the organisation in general and the maternity services at an operational level. There were signs that vision and strategy remained a 'top-down' and was not fully embedded
- The chief executive said that the maternity strategy consultation had been completed and the reconfiguration implemented successfully. This involved concentrating maternity services on fewer sites and the closure of some of the trusts birthing units such as the Canterbury unit.
- The clinical strategy was designed to make services safe and sustainable for the future but there were some difficulties with capacity, particularly at this hospital.

Leadership of service

- There was a lack of leadership of the service. We were told that some decisions taken at a senior level did not

take into account the impact of staff at a ward level. For example the decision to 'freeze' vacancies for an extended period, did not recognise that staff were finding it difficult to cope.
- Policies and procedures were out of date and there was poor governance to monitor them and ensure they were describing up to date evidence based care.
- The post of head of midwifery had been appointed but had not commenced in post. It was reported that the role and responsibilities of this post were considerable and the current acting head was unable to undertake all elements of the role. To address this a new deputy post to support the head of midwifery had been created but not appointed to
- Front line staff were professional and committed to providing patient-centred care.
- All staff were invited to a monthly open forum with the executive team. However, none of the staff we spoke with had attended.

Culture within the service

- The majority of the literature we saw set the vision for patient-centred care with the aim of making choices available for women. However, the reduced staffing levels in the maternity service had resulted in the frequent closure of the midwife-led unit, which undermined the strategy by therefore reducing the choices for women.
- The most recent risk register for maternity included an entry for a moderate 'risk of harm to women as a result of inadequate midwife-patient ratio'. This risk was identified following decisions taken at a divisional level not fully informed by the experience at ward level.
- Learning from incidents included changes about resuscitation after a maternal death. A training video had been developed and presented at a mandatory training day.

Public and staff engagement

- Consultation processes had taken place throughout the trust but members of the board and executive team were disappointed by the results from the NHS Staff Survey 2013, which found that communication between senior managers and staff remained poor.
- Board members said that the patient experience results were improving but the indicators for staff involvement and engagement remained disappointing.
- The FFT included negative comments about food, car parking charges, facilities on the older wards, noise at night and being left to wait.
- Some staff reported receiving direct feedback from patients and from the 'We care' programme at ward level.

Welfare, development and sustainability

- Supervision was described by staff in various ways ranging from supportive to passive. The current ratio of supervisors to midwives across the trust was 1:19 which is outside the recommended ratio of 1:15.
- There had been a high attrition rate of student midwives from the midwifery course.
- One patient said, "Staff should not have to struggle needlessly, if more staff and money are required and working conditions need to be bettered, then this should be so."
- Staff were appropriately qualified and competent. Delivery of training was shared across the service. A number of midwives were participating in additional training.
- The practice development midwife identified which staff should attend training and monitored and reported on staff completing training. Midwives were rostered to attend four training days per year and one e-learning day.
- 30% of appraisals were overdue and some managers confirmed that they lacked capacity to complete these.
- The results for the NHS Staff Survey 2013 reported that the trust was above the national average for the 'percentage of staff having well-structured appraisals in the last 12 months'.
- Some staff were not being given opportunities to share ideas and contribute to the work of the team.

Services for children and young people

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

Information about the service

WHH has 28 children's inpatient beds for children and young people between the ages of 0 and 16 years. The hospital had a special care baby unit, a neonatal intensive care unit**,** and children's outpatient clinics. Children were seen in the main A&E department (and this is reported in the A&E section of this report) and had their surgery in the hospital's separate day surgery unit.

Summary of findings

The children's ward, special care baby unit, and neonatal intensive care unit provided a safe and suitable environment in which to care for and treat children. Other areas in the hospital where children were seen and treated had not been risk-assessed to make sure that it was a safe and suitable place to treat children.

There were suitable numbers of appropriately trained nursing staff and the skill mix reflected current guidelines in the wards. Parents told us they were happy with the care and support that was provided on these units. Children did not receive care from appropriately trained and skilled staff in other areas of the hospital. In the day surgery unit, the staff caring for children did not have any specialist training or experience. In A&E, children were not always seen by a specialist children's nurse and there was no specialist input into the care and treatment for children.

Risk management and clinical governance relating to the care of children was not managed effectively. Areas identified as serious concerns had not been addressed for long periods.

There was no leadership strategy in place for children's services and no clear accountability.

Leaders were unaware of significant issues threatening the delivery of safe and effective care.

Services for children and young people

Are services for children and young people safe?

Inadequate

Incidents

- Staff we spoke with told us most incidents were reported and investigated. Feedback from the reports was presented at clinical governance meetings.
- The reports from all paediatric incidents within the child health division were seen by their governance team. However, other incidents involving children outside the paediatric division were not included.
- We were told that, while junior doctors reported incidents, senior clinicians did not always report issues.
- We found that, when incidents were reported, there was a system to investigate the cause and feedback the findings to the clinical governance team.
- The past three months of incident reports relating to child health, showed that staff were reporting incidents relating to children wherever the child was being treated for example A&E, the day surgery unit, main theatres and the outpatients department, as well as on the children's ward.
- There was limited evidence of learning from the incidents we reviewed. For example, in the day surgical unit a young person undergoing dental surgery became aggressive following the procedure. In the struggle a member of staff was hit. While the situation was resolved and reported appropriately, there had been no evidence of learning from the event. There had been no risk assessment undertaken or change in practice considered. Staff had not had any subsequent or updated training in managing children with challenging behaviour.

Cleanliness, infection control and hygiene

- The ward was visibly lean and tidy with cleaning schedules in place. We saw that checklists were retained to verify that the designated cleaning tasks had been completed.
- There were suitable arrangements in place to support staff with infection control issues. An infection control link nurse provided support for the nurses on the ward.
- During our inspection, we saw staff wore personal protective equipment and there were effective arrangements in place for the classification, segregation, storage, handling, and disposal of clinical waste.
- One parent told us that the facilities in the parents' room were not always kept clean. They told us that when they had last used the room the sink had been dirty.

Environment and equipment

- The children's ward, neonatal intensive care unit and special care baby unit provided care in safe and suitable environments.
- In other areas where children received care and treatment, the environment was not safe and had not been risk assessed to identify and address concerns.
- The general environment in the OPD was not child friendly. Parents told us that the facilities were hot and cramped with no separate area for children.
- We found that the provision of specialist paediatric equipment varied across the hospital and that different equipment was used for the same procedure.
- The neonatal ventilators had recently been replaced and staff told us there were no issues with obtaining equipment.
- Staff reported that they often worked between the different hospital sites and worked with equipment they were not familiar with. They told us this was a potential risk to children's safety; however, this risk was not on the trust's risk register.
- The equipment used to look after children on the day surgical ward was not safe. For example, when children received fluids through an intravenous drip, there were no pumps available to ensure the correct amount of fluid was given at the correct rate. This put children at risk of receiving too much or too little fluid, thereby endangering their health and recovery.
- We noted there was no piped oxygen or suction available in some areas where children were treated. Therefore children were not always cared for in a safe environment with safe equipment fit for purpose and readily to hand.
- In the day surgical unit, we saw the emergency equipment was unsuitable and inadequate to meet the needs of children For example, there was no paediatric resuscitation equipment.

Services for children and young people

Medicines

- Although some intravenous drugs were stored in boxes on the floor; all the fluids were kept in boxes and were within their expiry dates.
- Access to medicines and drugs was not secure in the children's ward. For example individual cupboards where the drugs were kept were locked, the room was open.
- The paediatric risk register stated that the pharmacy room in the neonatal intensive care unit became very hot during the summer, which caused potential problems with drug stability. This issue had been on the trust's risk register since 2009 without being rectified. The target date for completion was October 2014. This was five years after the issue was identified and put on the trust's risk register as a serious concern.

Records

- The medical and nursing records were dated, timed, and appropriately completed.
- Records documented that safeguarding procedures were followed and that children were referred to other services such as mental health teams and social services. We saw that the paediatric team was involved in child protection strategy discussions and case conferences. Parents had been copied into letters, which demonstrated parents were involved in discussions and decisions about their child's care.
- The care pathway records used for children's surgery documented the child's care and treatment from pre-assessment, the surgery, recovery and through to discharge.
- The documentation used included nationally recognised surgical safety checklists and prompts for staff to ensure multidisciplinary working between nursing and medical staff, and information sharing with children's parents.
- We saw that the documentation used in the day surgery unit was the same as that used on the children's ward and throughout the trust.
- The paediatric procedure pathway included a pain tool that was child friendly.
- On the neonatal ward, specific neonatal care plans were used to ensure that the care babies received was consistent with neonatal best practice.

Consent

- We saw that the paediatric procedure pathway included a consent form and guidance for parents and children on completing the form. The guidance referenced best practice and legal considerations when obtaining consent from children and young people under the age of 18.
- The trust had policies and procedures in place regarding obtaining consent from parents and, if appropriate, to decide if a child had capacity to consent and to involve them in the decision making, which staff could access if required.
- There was no evidence that the trust conducted audits to monitor that consent forms were always appropriately completed according to its policies.

Safeguarding

- There were child protection policies and procedures available on the trust's intranet, and these referred to best practice and local safeguarding protocols. However, vulnerable children attending A&E were not flagged.
- There was no guidance on how looked after children should be managed to make sure these vulnerable children were kept safe. For example, there was no safeguarding checklists or protocols on the action to take when vulnerable children missed outpatient appointments.
- The safeguarding lead monitored child protection training across the trust. They were unable to provide assurance that all staff caring for children across the hospital had completed the appropriate level of child protection training. In theatre, staff told us they had undertaken level 2 training, while the day surgery staff told us they had undertaken level 3 training.
- The safeguarding children's leads worked closely with the local safeguarding boards and ensured that any learning from serious case reviews and safeguarding investigations was disseminated.
- Minutes from the children's and multidisciplinary safeguarding meeting, demonstrated that local and national child protection issues were discussed within the child health team.
- The safeguarding team assisted with investigations into any serious child safety concern that they were made aware of, and that they fed back any learning from these to staff. However, we noted that there was a lack of medical input in these meetings; although clinicians were invited, they often did not attend.
- The safeguarding team told us they worked with the local authorities to manage child protection in the local

area. They told us they attended the local authority safeguarding committees and worked closely with community teams to ensure the safety of vulnerable children and their families.

Management of deteriorating patients

- The trust used a paediatric early warning score system (PEWS). This system enabled staff to monitor a number of indicators to identify if a child's clinical condition was deteriorating and therefore a higher level of care might be required.
- The PEWS system was used across the trust in all wards and departments where children were cared for. On the neonatal ward, specific neonatal PEWS charts were used.
- Senior nursing staff had raised concerns that the PEWS system was not being implemented correctly across the trust which was confirmed by an audit undertaken in February 2013.
- At the time of our inspection in March 2014 staff we spoke to on the day surgery unit had not had training in the use of PEWS.
- Clinicians raised concerns that the paediatric medical high dependency unit beds on Padua Ward were not available for children with complications post-surgery. Therefore seriously ill children post-surgery were not cared for by an experienced specialist children's team in the hospital.
- Following our inspection we were informed that children who deteriorate post operatively are transferred to specialist children's unit.
- The resuscitation officer confirmed that staff on the children's wards were prioritised for paediatric life support training and not all staff that looked after children in other areas of the hospital had such training.
- Staff on the children's ward told us that there was effective communication between frontline staff gave us examples of concerns about a child's health being escalated to the medical staff and told us this was well managed.

Nursing staffing

- In the day surgery unit, we found there were no specialist children's nurses or staff trained in children's care available and no cover available from the children's ward.
- Day surgery staff expressed concerns about caring for children when they had no training or experience. They had not undertaken any relevant study or training in caring for children.
- The children's ward, neonatal intensive care, and special care baby units had specialist children's nurses to support children and their parents/carers throughout their stay in hospital.
- The ward team included play specialists who provided cover during the day, Monday to Saturday. The play specialists told us they were an integral part of the team and had a regular session on the junior doctors' induction.
- The skill mix on children's ward, neonatal intensive care, and special care baby units reflected current professional guidance. For example, on the neonatal ward all staff were appropriately trained to neonatal unit standards.
- The past three months' duty rotas showed that the numbers and skill mix were maintained.
- In theatre, senior staff told us that there were no children's nurses available to care for children before and after surgery and this had been the position for some time. They told us that staff had experience and awareness of child health issues, but no formal qualification or training.
- We saw that children were pre-assessed for surgery by nurses who do not have training or experience in the care of children.
- The children who were admitted for dental surgery had no pre-admission check done to make sure that they were fit and suitable for the surgery.
- The training records for staff were held centrally and included the date when update training was required. However, it was reported that managers found it difficult to access the training records for individual staff members in order to monitor training across their ward, department, or division.
- In the neonatal intensive care unit, staff had 'competency log books' in which their competency on key pieces of equipment was assessed and recorded.
- Senior managers told us that sickness was managed with support from the human resources (HT) team. They said that bank and agency staff were used on the children's ward to cover sickness.
- Staff on the neonatal unit told us that they never used agency staff and covered any vacant shifts between

themselves. They said that the length of time it took to recruit staff was an issue, and that the lengthy recruitment process was a barrier to ensuring the wards were always appropriately staffed.

Medical staffing

- There was only one paediatric registrar available in the hospital for out-of-hours supervision of the paediatric, maternity and the neonatal unit. The British Association of Perinatal Medicine standards states that there should be separate cover for neonatal intensive care units.
- We could not verify that all clinicians had up-to-date life support and safeguarding training.
- In the day surgical unit, staff told us that, if a child remained on the unit after 5pm, there were only the medical crash team available to support them.
- Staff outside the children's ward told us that they were anxious about the level of responsibility this placed on them without their having any specialist training.

Are services for children and young people effective?

Requires improvement

Outcomes for the unit

- The child health division participated in most of the clinical audits they were eligible for. However, on the children's ward, there was limited evidence that the results of these audits had been fed back to staff and were being used to improve outcomes for children.
- Three audits had been undertaken in 2013 but there was no audit plan. For example, there had been no auditing of key performance indicators or monitoring of compliance against national standards such as the British Association of Paediatric Surgeons Standards for Children's Surgery.
- There was no systematic process for implementing and monitoring best practice guidelines and standards, or monitoring the quality of care and treatment of children.

Use of national guidelines

- Staff were able to show us where the trust stored its online policies, procedures, and protocols. This was guidance for staff to enable them to provide safe, evidenced-based care and treatment to children.
- There were very few key documents available on the intranet and no reference to the National Institute for Health and Care Excellence (NICE) quality standards and other best practice guidelines for staff outside the neonatal unit.
- The wards and departments had developed local protocols to assist them in providing care for children. However, the majority of this information was out of date.
- On the neonatal and special care baby units, staff had access to national guidelines. Staff ensured their practice reflected up to date guidance through regular meetings, audits, and taking part in the network of neonatal professionals that disseminated good practise guidance.

Care plans and pathways

- Theatre staff told us they operated on approximately 20 children a week in mixed operating lists.
- We found that a wide range of procedures was carried out on children including facial surgery, ear, nose and throat, dental, some general surgery and minor trauma cases.
- Clinicians voiced their concerns about the pre-admission process as some children were assessed in the day surgery unit by nurses who were not trained in looking after children.
- No anaesthetist was involved until the day of the surgery, which staff told us was a risk to children and might mean that the surgery had to be cancelled on the day of the operation.
- Staff told us that a child's journey through the hospital was not always straightforward because the operating surgeon made the decision about where they wished the child to be looked after and operated on.
- Children were not always admitted to the children's ward, some recovered from their surgery in the day surgical ward and were then be transferred back to the children's ward.

Services for children and young people

Are services for children and young people caring?

Good

Compassionate care

- We observed that staff on the children's ward responded appropriately to the immediate needs of the children and provided reassurance to their parents.
- The children and families on the ward and in the day surgery unit told us that they were happy with the care given. They said that the staff were caring and passionate about the service they offered. Medical staff were praised for their commitment and we were told that the children's services provided good care.
- On the children's ward, we saw that staff were helpful and caring. For example, a parent asked if the discharge of their child could be hurried up because they hadn't slept. The staff nurse spoke with the consultant who agreed to see the child. The parents also told us how helpful staff had been in providing food and drink out of hours because the parents had not eaten for some time.
- Children and parents receiving care across the hospital told us that they were very pleased with the care and support they had received.

Patient understanding and involvement

- On the children's ward, parents told us how they felt informed and how all the staff were friendly.
- One group of parents told us how they had waited for 2.5 hours, but the staff had told them the reason for this and kept them informed.
- Other parents told us how the staff had gone out of their way to reassure them. They told us they really appreciated being able to stay with their child until they were asleep under anaesthetic and then being able to go with the nurse to collect them from outside the recovery room.
- Children and their families were helped to make choices with leaflets that were readily available and gave information about the hospital and various conditions.
- Parents in the neonatal intensive care unit told us that the care both they and their baby had received was "amazing". They told us that the medical team took the time to explain what was going on.

Dignity and respect

- Staff answered the telephone promptly and were courteous in all their dealings with parents.
- Staff were considerate when communicating with parents and their children and were mindful of respecting their confidentiality.
- In the neonatal unit, parents told us they were always treated with dignity and respect. They told us that, although the food wasn't great, both they and their babies had received "really good care".

Emotional support

- Children and their parents across the hospital told us that the care they received was usually very good. They told us that the nurses were excellent, supportive and very caring.
- One group of parents on the neonatal intensive care unit told us the care and emotional support they had received from staff over the past month was "better than good, really, really good care!"
- We saw that on the children's ward parents were encouraged and supported to visit their child. There were no fixed visiting hours although parents were expected to leave at a reasonable time in the evenings unless there was a problem.
- Parents told us they always felt engaged with the staff who kept them well informed.
- In the neonatal intensive care unit, parents were encouraged to visit at any time of day or night unless there were social concerns. This included four designated visitors, which could include parents, grandparents or siblings.

Are services for children and young people responsive?

Good

Multidisciplinary working

- The child's health division demonstrated good joint working arrangements with other specialist services outside the area. For example, the care of children with cancer was shared with the Royal Marsden Hospital, a specialist oncology hospital, and a specialist nurse was available to support the staff at the trust.

Services for children and young people

- When children had difficulty breathing and needed artificial ventilation, we saw that there were appropriate arrangements in place to transfer them to another specialist service outside the area
- Clinicians told us that one of the main challenges to providing an effective and well-managed children's service was the geography and the need to travel between three hospital sites. They told us they spent a lot of time travelling, which was not a good use of their time or resources.

Environment

- There was parent accommodation available if required.
- On Padua ward there were single-sex areas for adolescents that had easily access to shower rooms.
- There was a sensory room with equipment to help relax and divert anxious children.
- There were age-appropriate play facilities available.
- On the neonatal unit, parents told us that staff were very caring and gave examples such as they had been given parking passes which "helped enormously".

Maintaining flow through the department

- We saw that the paediatric procedure pathway included a discharge checklist that included ensuring parents had a supply of painkillers and finding out if they had any questions about the care of their child.
- We did not see evidence that managers audited and monitored the discharge arrangements to ensure they were effective.
- The parents we spoke with did not raise any concerns about the discharge of their child from the inpatient units. On the children's ward, we saw that staff facilitated a parent's request to speed up their child's discharge. Parents particularly praised the neonatal unit for providing them with help and support during the discharge of their baby from the unit.
- An electronic discharge summary was given to the parents on discharge with a copy sent to their GP.

Meeting individual's needs, care of vulnerable patients

- Children and their families were supported to make choices with information leaflets that were readily available on the hospital and various conditions.
- There was no evidence that any information leaflets were readily available in other languages or formats.
- Staff told us the leaflets could be translated if required, but this did not always meet the immediate needs of patients and their families attending the hospital.
- In the day surgery unit, while a child had a learning disability 'passport', which helped staff to and understand their individual needs when providing care, none of the staff in this unit had training in caring for children with any kind of disability.
- Parents told us that the staff in the child health and surgical care teams were helpful and made reasonable adjustments whenever possible for children and their parents to access the service.
- The trust had a leaflet called 'Talk to us", which gave contact details of the patient experience team and information about how to raise a concern. These were available in other languages.
- Across the trust, staff told us that there was an issue with children accessing mental health services in the area.
- Children and young people with mental health problems were often kept on the children's ward or in A&E while awaiting suitable help and support in the community. Staff in the hospital were not trained to look after children with mental health problems.
- Senior staff told us that the biggest risks were the care of children and adolescent mental health service (CAMHS) and looked after children in the trust. However, neither of these two risks identified by senior staff were on the paediatric risk register.

Communication with GPs and others

- Medical notes and care plans demonstrated that a child's GP was involved in their care and kept informed of any issues. For example, we noted that in one set of notes a GP had been phoned to clarify a point, and the steps taken from the GP's initial referral to information about the procedure undertaken in the discharge information were clearly documented.
- The clinical governance reports included complaints about the care received by children at the hospital with a number of concerns raised linked to outpatient appointment issues.
- Staff told us that children were not always seen at the beginning of clinic lists and may be kept waiting for an hour and a half. We were told that some of the clinics did not provide toys, and alternative sources of keeping children engaged and entertained had not been explored.

Services for children and young people

Complaints

- Staff on the children's wards and neonatal unit told us they were encouraged to resolve all complaints at ward level. They said this meant they could act quickly to intervene and address any issue quickly, which demonstrated that they were proactive in dealing with concerns.
- Parents of children receiving care in the hospital told us they were aware of the complaints process but had not needed to use it. One parent told us they knew where to find the complaints procedure on the trust's website if needed.
- We saw that the trust had a leaflet called 'Talk to us'. This was available in all areas throughout the hospital and on the trust's website. The leaflet gave contact details of the patient experience team and information about how to raise a concern.
- The complaints log for child health showed that four of the eight complaints raised in February 2014 referred to the WHH. One related to the neonatal intensive care unit and three related to the children's ward. The issues raised concerned medication errors and clinical practice.
- All complaints received fed into the hospital's clinical governance processes. The complaints were reviewed on a monthly basis and the statistical information included in the quarterly report to the trust board. The complaints log and monthly reports did not include the action taken to resolve the complaints or demonstrate any learning.
- The trust continually monitored the complaints information it received. However, the reports did not provide assurance that the complaints had been handled in a timely way or that that there had been any action taken in response.

Responsiveness to local needs

- The trust website had mechanisms in place that enabled patients to give feedback on the care they had received. This included a link to the NHS Choices website.
- On the children's wards and neonatal unit there were questionnaires available for parents and children to comment on their care. However, we did not see that the individual wards had received feedback on the information provided or used this to improve their service.
- The staff told us that meeting the needs of looked after children in the local area was a challenge; strategies had not been put in place to address their particular needs. For example, we did not see monitoring of their attendance at outpatient clinics with a procedure to follow if they did not attend.

Are services for children and young people well-led?

Inadequate

Vision and strategy for this service

- The trust did not have documented strategic objectives for the care and treatment of children and young people. The frontline staff we spoke with were unaware of the trust's vision and values regarding the provision of care.
- Staff working in the children's services told us that the executive team were not visible.
- Senior managers with responsibilities for child health told us that they were aware of the difficulties of children receiving care in A&E but thought the business case to address the issues had been put on hold.
- Senior staff told us that they were unaware of issues with children in the day surgery unit because this was not part of their area of responsibility. They stated that there were paediatric nurses on the day surgery unit; this was not the case at the time of our inspection.
- Children were seen in the outpatient clinics arranged by the inpatient children's ward. However, managers were aware that children were seen in other outpatient clinics in the hospital.

Governance, risk management and quality measurement

- We saw evidence that, when clinicians had raised concerns about the care of children in the trust, little action had been taken. For example, serious risks to children had been brought to the chief executive's attention in 2011 and during this inspection remained outstanding.
- Clinicians told us concerns about the paediatric service offered had been raised at various meetings but the paediatric skills across the trust were not communicated or used.

- Staff felt disenfranchised with the reporting process and they did not consider the children's service to be well-led as the operational cover was spread over the three different sites, it had limited effectiveness.
- We found that many of the issues the staff raised as risks and concerns were either not on the trust's risk register or had been removed without being resolved for example, the lack of middle-grade medical cover and paediatric resuscitation training.
- In the day surgery unit, there were no systems or processes to look after the specialist needs of children undergoing surgery within an adult unit.
- The staff we spoke with did not demonstrate an awareness of the risks to children undergoing surgery in an adult unit.
- There was a clinical governance structure to monitor data from various sources such as patient safety incident reports, complaints, health and safety incidents, inquests, claims and clinical audits to build a picture of safety performance. Monthly meetings took place where this information was reviewed and then fed into quarterly board meetings. Several actions had been outstanding for a long time. For example, plans to update policies and guidelines, and to develop standard operating protocols for child health, had been outstanding for many months.
- Many identified issues were documented on the child health risk register and in action plans. However, we saw limited action had been taken to address these concerns. For example, in January 2010, staff raised a concern that the emergency care pathway did not meet the national service framework for children in A&E. The trust had set a target date of July 2014 for meeting the framework. Two other items on the risk register had been outstanding since 2009.
- We saw that in 2012 the trust expressed concern that there was insufficient middle-grade medical cover. However, this was removed from the risk register in September 2013 without being resolved.

Leadership of service

- Staff were not aware that there was a named board member with lead responsibility for the care of children and young people within the trust, in line with the recommendations in the National Service Framework for Children.
- Board members undertook 'walk arounds' on the wards and departments. However, the staff we spoke with were unaware of this and told us they rarely saw senior managers or board executives on the wards.
- We found that children were kept safe through effective communication between frontline staff. However, there was an issue at more senior levels with a lack of communication between the board and executive team and the frontline staff. The frontline staff did not feel that their concerns were listened to, and the executive team appeared unaware of many of the issues affecting the staff.
- Staff gave us examples of escalating concerns about a child's health to the medical staff and told us this was well managed.
- Staff had regular meetings with their direct line managers such as the matrons' forum and quarterly senior nurses meetings. There was also staff listening days and the executive briefs, which were another means of communication.
- The neonatal intensive care unit managers told us they were monitoring their staff appraisals and 70% of staff had completed their appraisals to date.

Culture within the service

- The management of the care of children and young people was not coordinated. For example, the paediatric matron told us that they were responsible for the care of children admitted to the children's ward, neonatal intensive care unit and special care baby unit only. However, the Chief nurse, Director of Quality and Operations stated that the paediatric matron was responsible for children's care across the trust.
- Senior nursing staff told us that they felt well supported by the trust's divisional leads and that their managers were visible and accessible.
- The nursing, support and therapy staff told us they had the opportunity to contribute their views to the medical team and that they felt valued and listened to.
- In the neonatal intensive care unit, staff spoke of strong medical leadership with no gaps in junior medical cover.
- Senior staff told us that their managers had an open door policy and they were always made welcome if they wanted to raise a concern.

Innovation, improvement and sustainability

- At ward level, there was limited evidence of innovation in dealing with issues and overcoming barriers to care.

Services for children and young people

- Staff we spoke with did not feel empowered to propose changes or make suggestions. For example, senior members of the paediatric staff had not investigated, assessed or monitored the care of children in the hospital to ensure that their health and welfare were considered and promoted wherever they were seen and treated, because they stated that this wasn't in their job description.

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

The William Harvey Hospital had a specialist palliative care (SPC) team, led by a nurse consultant in palliative care medicine who worked across all three sites. In addition there were six clinical nurse specialists (CNS) three counsellors and two social workers. The SPC team was supported by a medical palliative care consultant from the Pilgrim's Hospice.

We saw evidence there were systems for the referral of end of life (EOL) patients to the SPC team for assessment and review. This ensured that patients received appropriate care and support with up-to-date holistic symptom control advice for adults with advanced, progressive and incurable illness in their last year of life. We noted that the SPC team supported and provided evidence-based advice to other health and social care professionals, and we were told by ward staff that they were highly regarded across the trust. We saw evidence that urgent referrals were seen on the same day Monday to Friday.

We visited Cambridge K ,J and L, Richards Stevens and Kings B wards, the clinical decisions unit (CDU), bereavement office, hospital mortuary and hospital chapel. We reviewed the medical records of six patients at the end of life and 10 records of patients who had died in the past six months, we observed the care provided by medical and nursing staff on the wards, and spoke with three patients receiving end of life care and their relatives. We also spoke with members of the hospital's SPC team, ward staff, relatives' support officers (RSOs), chaplain and mortuary staff. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

End of life care

Summary of findings

The SPC team service provides specialist advice and guidance for individual patients and family members. The staff are experts in pain management and deliver a holistic approach including emotional, spiritual, and psychological care, as well as providing up-to-date advice on symptom control.

Since the removal of the Liverpool Care Pathway, we saw little evidence of strategic trust-wide leadership and support for end of life care, which we found to be disjointed across the wards and departments. Although individual staff were committed to delivering good care, the result was an ad-hoc reactive response to people who needed care at the end of their lives.

Are end of life care services safe?

Requires Improvement

Incidents

- The reporting process included attending a ward manager's peer group meeting, which was attended by a clinical governance person to identify and discuss complaints. Learning from this meeting were then disseminated to ward staff at staff meetings or in emailed to staff.
- The ward manager had found that there had been a difference in staff behaviour and practices since discussing complaints at ward level.
- We saw evidence that the hospital had responded to a Rapid Response Report, National Patient Safety Agency (NPSA)/2010 RRR019 Safer ambulatory syringe drivers: all syringe drivers had to be replaced by December 2014 because of the reporting of a fatal error. We saw evidence of the processes undertaken within the trust in a timely manner and new syringes arrived in February 2014. We saw that the McKinley T34 syringe drivers were being used across the Trust.
- A syringe driver training programme had been set up, but attendance from wards was poor; so subsequent online training was introduced and SPC nurses supported individual nurses on the ward when a patient required drug therapy through a syringe driver.
- One member of staff told us that she had not had syringe driver training so would call the intensive care unit (ICU) outreach team out of hours for support.

Cleanliness, infection control and hygiene

- Most patients receiving EOL care were cared for by nursing staff on the wards with support and advice from the SPC team.
- We saw that the wards, day units, and mortuary viewing area that we visited were visibly clean and well maintained. The surfaces and floors were covered in easy-to-clean materials that enabled high levels of hygiene to be maintained.

End of life care

Records

- We reviewed eight sets of medical notes of patients who had recently died. We found that the medical notes had no filing system and it was impossible to follow chronological care. It was difficult to find the relevant information regarding a patient's care.

Staffing and training

- The End of life care strategy, published by the Department of Health in 2008, promotes high-quality care for all adults at the end of life in England. To deliver this vision, the trust had developed a specialist palliative team that could provide timely SPC and advice for people approaching the end of life (NICE, 2011 Manual for cancer services, 2004).
- Staff within the SPC team told us that, with the present staffing levels, it was not possible to support all patients receiving EOL care across the trust, so care was provided to those patients whose symptoms could not be managed in a timely way by their usual care team, but who might benefit from SPC.
- Staff stated they lacked training in areas such as communication skills training around "difficult conversations" and training around end of life care and advanced care planning.
- The SPC team have an end of life care module on line but on speaking to frontline staff it became evident that staff were not aware of this.

Medical staffing

- A medical consultant from the Pilgrim's hospice who specialised in palliative care supported the SPC nurse consultant on a part-time basis. This role provided all the trust's healthcare professionals with specialist management advice for patients with complex symptoms.
- In reviewing the minutes we received, we saw that the palliative care medical consultant played an integral role in reviewing and managing inpatients by actively being involved in two ward rounds per week where five patients across the hospital would be reviewed.
- We saw that the palliative care medical consultant was a core member of the SPC multidisciplinary meeting (MDM) that met every Monday morning, and also the EOL board where his specialist skills supported the development of the trust's palliative care service.
- The Liverpool Care Pathway (LCP) had been used in the past to support EOL patients. After guidance from the Department of Health (October, 2013) the trust had stopped using it. The SPC nurse consultant had undertaken a recent audit and found no patients on the LCP.
- From our discussions with staff and our review of medical records, it was clear that there was confusion and a lack of clarity around what had replaced the LCP.
- We reviewed eight sets of medical records of patients who had passed away between November 2013 and March 2014. In all of the medical records we found, except for three patients who were under the SPC team, care was very ad-hoc and did not follow a structured approach. However the patients under the SPC team had a clear approach to EOL care with regular reviews and advanced care planning.
- We observed posters on hospital notice boards communicating the trust's response to the removal of the LCP as 'End of life care – getting it right' quality standards, in which it was stated that 'the trust expects all staff to continue to maintain the principles of palliative and end of life care'.
- We were told by one ward manager that since the end of the LCP "we feel in limbo".
- On Cambridge J Ward, the ward manager explained that it was only patients who required symptom control who would be referred to the SPC team, and that other patients receiving EOL care would be managed and cared for by the ward staff
- We looked at the medical records of one patient receiving EOL care in Cambridge J Ward. We found the medical records poorly arranged, however, we did find appropriate records about the patient's medical and nursing needs.
- We saw a continuing care checklist that the nurses completed in communication with the patient and their family. In this case, all the relevant information was in place.
- On reviewing 17 individual DNA CPR forms, 11 of these were not signed by an appropriately senior health professional.
- On one DNA CPR we saw that there was no Mental Capacity Act (2005) assessment in place, which was required because the completing doctor had expressed that the patient lacked capacity.

Are end of life care services effective?

End of life care

Requires Improvement

Evidence-based care and treatment

- We saw that the trust had followed the Manual for cancer services (2004) which reflected the recommendations of the National Institute of Health and Care Excellence's (NICE) quality standards for Improving supportive and palliative care for adults with cancer (2004) guidance and had a specialist palliative care (SPC) team
- We saw evidence that the SPC team supported and provided evidence-based advice to other health and social care professionals by undertaking training such as medication training for junior doctors and the development of policy to guide staff nursing EOL patients.
- The SPC team had an operational work plan in place, which demonstrated an integrated and equitable approach to SPC provision across the trust's three sites, and the challenges the team faced to support the whole of the EOL pathway.
- Within the SPC operational policy, we saw that the delivery agenda of the EOL clinical commissioning groups' (CCGs) working group around EOL care matched the work programme of the SPC team.
- We saw further evidence that the team had an integrated approach to EOL care as demonstrated through the 2012 peer review process and the successful launch of an EOL board.

Care plans and pathways

- We found inconsistencies in the management of patients reaching the end of life if the SPC team had not been involved and on discussion with ward staff, it was clear that, because patients were no longer on the LCP, staff found it difficult to identify who was receiving EOL care.
- On some wards we observed good care, such as on the clinical decisions unit (CDU) where a structured EOL pathway was in place that focused on decision making. The pathway, after all the patient's symptoms had been effectively managed, was around keeping the patient comfortable and ensuring regular communication take place between the family and medical team.
- We noted that there was little detail of regular checking of symptoms and assessments in medical records. We were told by a nurse that training was due to be undertaken on the new syringe drivers, but no recent training had been undertaken on EOL care.

Multidisciplinary working

- We saw evidence in patients' medical records that MDT discussions were taking place around patients towards the end of life in areas including the ICU, the Richards Stevens Ward, and CCU.
- On visiting ICU, we observed that practices were in place, following national guidance, for the withdrawal of life-sustaining critical care treatment. The process could only begin after discussion had taken place with the relatives, patient, and the MDT.
- All decisions made by the MDT were documented. With this system in place, continuity in care could be maintained and active treatment removed in a safe environment.
- As part of the national peer review, an MDT had been set up by the SPC team. This specialist multi-professional team made decisions together about how someone was to be cared for during the course of their end of life care. The team would consist of core members, such as the medical palliative care consultant, CNS and other associate members.
- We saw that the SPC MDT took place across the trust on a Monday morning each week to discuss how best to meet the palliative needs of patients with cancer and non-cancer patients. Patients' management plans were reviewed and any changes noted in the patients' medical records on the wards.

Seven-day services

- Patients could be referred to the SPC team via telephone or the hospital management system, Monday to Friday 9am to 5pm. Families could ask to see the team via the ward staff. Out of normal hours and at the weekend, the local hospice gave advice and support. This meant that patients receiving end of life care had access to specialist skills to support their palliative needs.

End of life care

Are end of life care services caring?

Good

Compassionate care

- After the patient had died, we were told by staff on Cambridge J Ward that relatives could stay as long as they chose. There was no relatives' room on the ward but we were told that they could use the sister's office where they would be offered tea.
- Before leaving the hospital, relatives were given a bereavement booklet and told to contact the RSO the following day when they would be told when the death certificate would be available.
- The family could collect any property when the certificate had been collected. We were told that relatives were walked out of the ward by a member of staff so that they were not left without support.
- On Richards Stevens ward we noted that a patient was moved to a side room and that their family were supported by a nurse when the patient passed away. Bereavement information was given to the family. This showed that the patient and their family were treated with dignity and respect in the last days of their relative's life.
- On the unannounced visit, porters told us that training had been undertaken by all staff to safely transfer patients to the mortuary. One porter was able to describe the transfer process and how staff respected and ensured that the dignity of the deceased was maintained at all times. We were told that all documentation would be completed by both ward and portering staff both before leaving the ward and in the mortuary.

Emotional support

- We were told by the SPC team that emotional support for families was through the social workers in the team and the counsellor or psychologist who offered direct contact with patients and their families.
- We were told that one of the social workers was a 'trusted assessor' who could speed up the discharge process for those who wished to die at home so that their wishes and preferences could be met in a timely manner and prevent further distress.
- Emotional support was also delivered through the chaplain's office. We saw leaflets advertising the service and how they offered to support patients and relatives. The chaplaincy could be contacted via the ward staff and patients could request to see a chaplain at any time because they provided a 24 hour service.

Are end of life care services responsive?

Requires Improvement

Access to the palliative care team

- EOL care across the hospital was a developing service. Many of the wards we visited were providing it for patients and their relatives without support from the SPC team.
- The SPC team told us they provided wards and departments across the hospital with up-to-date holistic symptom control advice for patients in their last year of life. At present, their case load was 60% of patients with cancer and 40% of patients without cancer.
- There were two clinical nurse specialists (CNS) covering each site. We were told by one staff member that this had led to inevitable pressure on the team in spread themselves across the hospital to assess many EOL patients, but most patients were referred to the SPC team in the last 48 or 72 hours of life.
- We reviewed five sets of medical records of patients referred to the SPC team. We saw the patients had been visited on the same day because they were classified as urgent. The CNS told us non-urgent referrals were seen within 24 hours Monday to Friday and they encouraged the wards to make referrals to them before 3:30pm on a Friday afternoon so that patients could be reviewed before the weekend.

Meeting the needs of all patients

- We reviewed the EOL board minutes and saw that the SPC team had highlighted that conversations with patients and families was not always being documented, and we confirmed this when we reviewed medical records across the wards we visited. To respond to this, the SPC team had developed a proforma, "a record of end of life conversation", to gather the

preferences and wishes of EOL patients irrespective of whether they had been referred to the palliative team or not. The proforma had to be completed by a medical consultant.

- On visiting Cambridge L Ward, we found that staff were aware of "the end of life conversation form" and told us "it's a very good guide but doctors need help with it".
- The SPC team told us the proforma was having a phased introduction and would be launched at the WHH on 13 March 2014. By introducing this conversation form, the SPC team were aiming to ensure patients had their wishes and preferences recorded.
- We were told that the chaplaincy was the referral point for other faith leaders and organisations.
- On Cambridge J Ward, staff said they had access to a "major faiths of the world" book and were able to support different faiths before and after death. Regular services were held in the chapels and the chaplains prayed with and for patients and their relatives.
- Funerals and memorial services took place and we saw records that confirmed that there had been an increase in the number of funerals performed by the chaplaincy over recent years.
- We were told by staff on Cambridge L and J Wards and the CCU that there were palliative and dementia link nurses on the wards. Staff told us they attended study days and meetings with senior staff. Information was passed down to frontline staff through ward staff meetings and training sessions. We were told on Cambridge L Ward that staff undertook EOL training on the ward and have kept the "good elements of the LCP". They had stopped observations but made sure patients were comfortable and "where they want to be".
- The ward manager told us that visiting hours were flexible and that relatives could stay by the bedside on a chair or in the relatives' room on the neighbouring ward. We observed flexible visiting hours for relatives of a patient receiving EOL care. Relatives were given a direct phone number to the ward and were told they can phone at any time.
- We were told that the nursing staff completed a relative's information sheet concerning their wishes if the patient deteriorated during the night. For example, "Do the relatives want to be contacted?". This information was placed on the handover sheet so staff were aware and relatives' wishes were observed.

Records

- All 17 medical records reviewed containing 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms included a standard form for decisions to be recorded on and these were filed at the front of the notes, allowing easy access in an emergency.
- We saw that there were variations in the completeness of the forms across the hospital: seven had no record of discussion with the MDT and a summary of communication with the patient or their relatives was completed in only 11 of the 17 forms that we reviewed.
- The SPC team had undertaken an audit across the trusts of EOL documentation at the end of 2013; all of the 58 patient records audited had DNA CPR forms in place, but 13 of the forms had no discussion with patient, relative or carer documented about DNA CPR status.
- We saw that the electronic handover sheet contained all relevant information such as DNA CPR status, current medical issues, and the patient's and relatives' wishes.

Support for relatives

- We were told that the chaplaincy office's activity was audited, which required the chaplain to complete a visiting record sheet after each consultation. This gave evidence of the type of consultation undertaken, but no indication of the quality and effectiveness of the service the chaplaincy provided.
- The bereavement team carried out the administration of a deceased patient's documents and belongings, providing practical advice and signposting relatives to support services such as funeral directors. The office was open limited hours, Monday to Friday, but situated in the main reception. The office was organised and the RSO had a courteous and calm manner when speaking to relatives on the phone and staff visiting the office.
- The RSO aimed to produce death certificates within 24 hours, but this could be extended if the doctor was on nights and not returning to the hospital for two days. We were told that on the day of the inspection three patients' certificates had been completed immediately. The RSO has the use of a small office to speak to relatives on a one-to-one basis, and was able to support relatives who wished to visit their deceased relative in the mortuary.
- We were told that there was no training given in this role but support was available from the chaplain if needed.

End of life care

The RSO was aware of managing a system that dealt with upset and distressed people, and felt able to guide "people through formalities" and to discuss individual and cultural needs.

- The chaplaincy department provided the hospital's bereavement service, with administrative support from the RSO. We saw information booklets available around the chaplaincy/spiritual care service that the trust offered, which was available to patients, relatives and staff. We were told that the service was open to everyone.
- We visited the hospital chapel and spoke with one of the four chaplains who worked across the trust. The chaplaincy operated a 24-hour on-call system across the three sites. We were told that the chaplain had recently been called in four times at the weekend to see two patients receiving EOL care on ICU, as well as two other distressed patients.
- We were told that the chaplains had an important role in the pastoral support of staff and were involved in "Dignity at work", providing support and advice to staff and offering training on issues of "spirituality, ethics, bereavement and loss". The team had a group of volunteers who provided support across the hospital.
- We saw on the Richard Stevens ward that a "reflective room" was available for staff to talk privately with families or to have conversations that involved breaking bad news. This meant that families were able to have difficult conversations in a quiet and private area. On Cambridge L Ward, we were told that a relatives' room was not available but an office would be made offered for private discussions with a patient's family.

Discharge arrangements

- Patients under the SPC team who wished to return to their home, hospice or care home were put on the fast-track discharge pathway.
- Access to community packages of care varied, but the average time taken to arrange such a package was four to five days with delays often occurring due to the many people involved in the process.
- The SPC sent a copy of the DNA CPR form and a request to the GP for the patient to be put on the community palliative care register.
- We were told discharge checklists were available for all staff to access and were part of the hospital's discharge policy. We were told that patients would only be discharged home or to a nursing home once suitable community packages of care had been put in place.
- We were told by the SPC team, and saw evidence to support this in the SPC annual report, that they were developing an electronic record system ('Share my care' [EaPaCs] to be implemented and linked to GPs.
- At present, the SPC and medical staff needed permission to access GP records, which meant consistencies in care might be lost.

Are end of life care services well-led?

Requires Improvement

Leadership of service

- The trust had an end of life board that over saw all end of life care in the trust, collaborating with external agencies.
- The lack of trust board direction is observed in a non-unified approach to EOL care across the wards and departments. Therefore, although individual staff are committed, the result is an ad-hoc reactive response to unplanned EOL events.
- We observed different approaches to and methods of recording in medical records, different hospital/ward/department forms being used and obsolete forms still in use.
- The SPC team were leading on a trustwide project to respond to a medical device alert. They had negotiated funding, purchased new syringe drivers and were implementing a new policy and training. However, staff were unable to attend training as ward managers could not release them.
- We spoke to staff about the SPC team; they told us that they felt supported by the SPC nurse consultant who was both "supportive and approachable". They felt that they worked as a team and that they were kept informed about what was happening within the team.
- We were told that they could access counselling services through occupational health. Good team spirit and good support across the team were evident, and resulted in an engaged and committed team.

End of life care

- We found little evidence of support for the EOL agenda above the level of the EOL board. There was no EOL champion at trust board level to strategically lead the EOL agenda through a rigorous implementation process to deliver the national End of life care strategy (2008) objectives.

Public and staff engagement

- A project to obtain feedback from bereaved families was underway, as at present it was only bereaved families who had been though ICU who were asked about their experiences, and the EOL board wished to introduce a way of extending this to all bereaved relatives across the trust.
- The EOL board was actively involved in developing operational processes and procedures to support the national guidance. However, we found that the message was not being heard across the trust because many frontline staff we spoke to were unaware, for example, of the quality standards, which meant that inconsistent practices were being applied across the trust.

Innovation, improvement and sustainability

- The team had introduced electronic palliative care records that allowed timely access to patients' records by all healthcare professionals, and enabled safe and consistent care to be delivered at all times.
- Integrated working with the Pilgrim's hospice has been enhanced by leadership from the nurse consultant and patients benefited from streamlined pathways of care across both the hospital and the community.
- The current model of SPC and EOL care was not sustainable; a review was under way, linking with local hospices, but tension with funding, especially to provide integrated health and social care, was a challenge because of the dissolution of the cancer networks, shared intelligence and expertise across Kent had been diminished.
- Other initiatives included an 'amber care bundles' pilot on the renal ward and panel discussions with junior doctor.

Outpatients

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Outpatient services were located on the ground floor with four outpatient areas. These all shared one reception area, which was located at the entrance to the department. The trust offered outpatient appointments for all of its specialties when assessment, treatment, monitoring, and follow-up were required. There were clinics for general surgery, respiratory, medicine, neurology, dermatology, diabetes, pain, vascular, gastroenterology, women's health, and health care of older people.

During our inspection, we spoke with nine patients, one relative and 15 members of staff. These staff included reception and booking staff, clerical and secretarial staff, nurses of all grades, doctors, and consultants. We observed care and treatment. We received comments at our listening events, and we reviewed performance information about the department and trust.

Summary of findings

All the patients we spoke with told us they felt they had been treated with dignity, and that they had found staff in the outpatients department polite and caring. We found that some clinics were very busy and that staff routinely overbooked patients for clinics because the number of appointment slots did not always reflect patients' needs. Patients could therefore experience long waiting times, although they were kept informed about the expected length of delay.

Patients who required follow-up appointments told us that they often had these appointments cancelled, moved to a later date and often there was a significant delay in patients receiving a follow-up appointments. Staff told us that when appointments needed to be cancelled, they generally cancelled follow-up appointments as this did not affect the trust's targets for the two and 18-week referral to appointment. We found that staff were collecting data on waiting times and overbooked clinics but, despite this, they felt unable to make improvements.

Outpatients

Are outpatients services safe?

Good

Incident reporting and learning

- Staff in the OPD used an online reporting tool to record any accidents, incidents or 'near misses' that occurred. We were told that all staff had received training on this system, and had passwords so that they were able to access and use the tool.
- We saw that staff had used the reporting system for a variety of incidents that included misfiled patient records, late starting clinics, and patient falls. The OPD manager told us that they would feed back any learning from incidents and accidents to staff during their daily morning staff meeting. They said that, once they had submitted an incident report, the person investigating would send an email outlining their investigation outcomes. However, they said that they did not consistently receive this feedback.
- The matron told us that feedback from surveys showed patients did not feel that they were kept informed by staff about waiting times for clinics. Therefore the department had reviewed procedures and staff training in this area. As a result, the department had produced guidelines for staff on meeting and greeting patients on arrival, along with a competency assessment that all staff had completed.
- The manager gave us an example of when the OPD had responded to a patient accident and made changes to the running of the department in response to the investigation that followed. As a result of a patient falling from a manually operated couch during repositioning, the OPD had made two service improvements. They had been given funding for six electronic bariatric treatment couches and they now undertook operational checks of treatment before the start of each clinic.

Cleanliness, infection control and hygiene

- There were systems to reduce the risk and spread of infection.
- Patients we spoke with all told us that they felt the department was cleaned to a good standard.
- We observed that all the patient waiting areas, some clinic rooms, patient toilets, 'dirty' utilities, and corridor areas were visibly clean and free from unnecessary clutter. There was a lead for infection control in the department, and we were shown that all staff had received their mandatory annual infection control training.
- Staff we spoke with demonstrated an understanding of infection control and of their roles in preventing the spread of infection. The latest hand hygiene audit for the department showed that the OPD had received a 100% score for hand hygiene.
- Clinical staff were responsible for cleaning the clinic rooms and clinical equipment after use. We were shown checklists as evidence that this was completed.
- The manager told us that the facilities team leaders completed cleaning audits every two weeks and that clinical staff were involved in the auditing process.
- The department was cleaned by facilities staff each morning; this meant that cleaning staff were available in the department until 12 noon.
- The manager told us that although the department did not have a dedicated cleaner during afternoon clinics, if they had any concerns and needed a cleaner, they could ring a dedicated helpline number and a cleaner would be sent to the department. The manager said that cleaners always attended when asked and therefore this did not create any issues for the department.

Environment and equipment

- We were shown the health and safety risk assessments for the area. We were told by the manager that, when something was considered a risk following assessment, it would be placed on the trust's risk register.
- Although the OPD had started a programme to replace its manually operated couches, the department still had some manual couches that posed a potential risk to patients.
- The OPD had a link person for health and safety who had taken on extra training and responsibility in this area. This person attended meetings every quarter and fed any information from these meetings back to the rest of their team.
- Building maintenance was managed by the estates department for the hospital. We were told that when issues arose these would be reported to the estates department who would log the requirements and issue the department with a job number.

Outpatients

- The OPD kept a log of the work that they had reported to the estates department and kept track of when and how issues were resolved. We were shown the department's log book, which showed that staff were reporting and tracking maintenance issues.
- When equipment failed, staff followed guidance for decontamination and arranged for the electronics and medical engineering department (EME) to collect, repair and return the item. We were told by the manager that when this happened they would borrow replacement equipment from other areas of the hospital or EME would lend them a replacement item while they made their repairs.
- We were told that the department had enough essential equipment. The manager told us that when they needed more equipment they would ask the relevant division to supply this.
- The manager also said that the hospital's League of Friends was always supportive when the department asked for funding for equipment.

Medicines

- Medicines were stored in locked cabinets within the department.
- All medicines were ordered by nursing staff through the hospital pharmacy.
- When nurses were required to administer medicines such as analgesia, these would be prescribed by the clinician and recorded in medical records. The nurses would then sign and date the records to confirm that they had administered the medication.
- FP10 prescription pads were stored in a locked cabinet.
- When clinicians wrote patient prescriptions, the OPD kept a log that identified the patient, the doctor prescribing and the serial number of the prescription sheet used. This ensured the safe use of prescription pads.

Records

- The manager told us that an ongoing safety issue in the OPD was the misfiling of patient notes. This meant that patient records on occasions contained other patients' notes.
- In the past month, seven incidents of misfiled patient records had been reported to the health records manager.
- The manager told us that each time notes were misfiled this would be recorded and investigated through the incident system. Any learning from misfiled notes was shared in daily staff meetings. The manager said, "I am working hard to raise staff awareness on this issue."
- Feedback from the investigation of these incidents included training issues with new staff, and escalation of the incident system to the division responsible for the error in misfiling patient records.

Management of deteriorating patients

- We were shown policies and procedures for dealing with emergencies. Staff we spoke with were aware of their role in a medical emergency.
- We saw evidence that all nursing staff in the department had received resuscitation and life support training within the past year. This training had been delivered in line with the trust's policy.
- We saw evidence that equipment stored in the department to assist staff during an emergency had been checked regularly by staff who had signed to say that the equipment had been checked and was available and within its expiry date.
- Staff also had access to procedures including flow charts that outlined their responsibilities during other medical emergencies. We were shown examples of these procedures for head injuries, and patients with low blood sugar.

Nursing staffing

- The manager told us that the department had recently been under pressure with its staffing because of long-term staff sickness.
- On the day of our inspection, the department had two full-time and one part-time trained nurse off work on long-term sick leave. We were told that this put pressure on other staff who were working extra hours and needed to be flexible with their shifts in order to cover their colleagues' work.
- The manager told us that they had received support from the trust's human resources department in managing the long-term sickness issues in the department.
- Nursing staff told us that although they were busy they felt that they were able to deliver good and safe patient care. They also said that they felt supported and listened to by their manager.

Outpatients

- Staff absences were either replaced by staff within the department who would work extra hours or alternative shifts, or the department gave shifts to particular NHS professional staff who had been trained in the competencies required to work within the department.
- When talking to us about using non-permanent members of staff, the manager said, “Although it does not affect patient safety, I think that it can affect the patient’s experience in the department.”

Are outpatients services effective?

Not sufficient evidence to rate

Use of national guidelines

- The National Institute for Health and Care Excellence (NICE) guidance for smoking cessation had been followed within the department.
- The outpatients department (OPD) assessed each patient who accessed the service to establish whether they would benefit from a referral to the smoking cessation service. In order to ensure compliance with NICE guidelines, the department had made this a part of the ‘meet and greet’ procedure for staff and included it in staff competency assessments.

Multidisciplinary team working

- We were told that the OPD made referrals to other disciplines when appropriate. We saw referrals to smoking cessation clinics, district nurses, the falls team and specialist nurses.

Seven-day services

- The OPD was operational Monday to Friday, with occasional Saturday clinics arranged on an ad hoc basis.

Are outpatients services caring?

Good

Compassionate care

- We observed staff interactions with patients as being friendly and welcoming.
- We saw staff stopping in clinics to greet patients who they knew and ask after their well-being.
- We observed that patients who attended clinic regularly had built relationships with the staff who worked there.
- Staff were trained and expected to keep patients informed of waiting times and the reasons for delays. We saw this happening in all areas of the outpatients department (OPD).
- The hospital ran a one day customer care course for all nursing and reception staff which covered topics such as privacy and dignity, communication, patient experience and complaints..
- The course attended by all nursing staff in the OPD had been evaluated positively. One person said, “It helps you to stop and think. It made me reflect on the way I might come across to patients. I found it very helpful.”

Patient understanding and involvement

- All the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand.
- Patients told us that they felt included in decisions that were made about their care and that their preferences were taken into account. One patient said, “They are all very good. I have not a bad word to say. I have just had a very good session with the consultant who took the trouble to explain everything to me.” Another patient said, “They are very good at consulting me on my care plan.”

Dignity and respect

- All the patients we spoke with were complimentary about the way the staff had treated them. One relative said, “The care was very good; the nurses helped my husband to dress after his treatment and they were very kind and attentive.”
- Patients we spoke with told us that they had been treated with dignity in the department. One patient said, “I have always been treated with respect here.”
- The layout of the department meant that patients were sometimes weighed, their heights measured and their blood pressures taken in the OPD corridor as there was no specific room set for this purpose.
- The OPD reception was located in the busy main lobby of the hospital, Reception staff told us that when patients arrived for appointments their name, date of birth, address and telephone number were checked with them at this desk, which could be overheard by other people standing around or sitting in the area.

Emotional support

- We observed one clinic waiting area where patients had just been told that the waiting time for this particular

clinic had been delayed by an hour. Many patients became frustrated and told the healthcare assistant (HCA) managing the situation that they were unhappy. We saw that the HCA was open and honest with them and apologetic about the inconvenience that their wait was causing them.

- We saw that patients were offered hot and cold drinks, the use of a telephone and any further assistance they might need.
- The HCA offered everyone in the room a patient survey to complete and told them that the OPD would welcome their comments and suggestions about the service.
- We spoke with patients who were expressing anger. They told us that such delays often happened and that it was frustrating. One person said, "It's not the nurses' fault. They are brilliant. They always offer a cup of tea and a sympathetic ear."

Are outpatients services responsive?

Requires improvement

Responsiveness

- We received many complaints about the number of cancellations of follow-up appointments that patients had experienced.
- The trust operated under guidance that, other than in exceptional circumstances, clinics should not be cancelled without eight weeks' notice. However, data showed that 20% of cancellations did not comply with this guidance.
- 60% of new referrals were managed by the central booking team with the remaining appointments handled directly by the divisions themselves. However the trust were unable to provide data in relation to the compliance with the 18-week targets for first appointments booked directly through divisions.
- We were told that follow-up appointments were booked by the divisions. Data showed that 12% of booked outpatients' appointments in the past three months had been cancelled by the provider. However, data did not indicate whether these cancellations were first or follow-up appointments.
- Trustwide data showed that 85,013 patients visited the outpatients department (OPD) in January 2014. In the same month, the trust cancelled 10,984 patients' appointments.
- Staff in the OPD told us that when appointments needed to be cancelled it was generally the follow-up appointments that were moved because these did not affect the two-week and 18 week rules.
- Data provided by the trust showed that patients waited an average of nine weeks for their follow-up appointment.
- Patients we spoke with reported waiting much longer for their appointments. For example, one patient attending a neurological clinic said that their consultant had told them they would ideally like to give them a follow-up appointment six months later but, because of the waiting list for appointments, they would need to wait a year for their next appointment. The patient said that their appointment had then been cancelled and rescheduled twice, which meant they had waited 18 months for their follow-up appointment. They said, "The letters didn't tell me why my appointments were cancelled. It's hugely frustrating."
- The central booking department informed the divisions weekly of patients who had not been offered a follow-up appointment within the time frame required. Medical secretaries we spoke with confirmed that this was an ongoing issue.

Maintaining flow through the department

- Some of the patients we spoke with complained about the waiting times in clinics. Staff told us that this was an ongoing problem with some clinics' waiting times being worse than others.
- We were told by both staff and doctors that the main reason for long waiting times was either the overbooking of clinics or patients' appointments taking longer than anticipated.
- The clinic templates showing appointments were agreed by the division leads and medical or surgical teams, with involvement from the OPD team.
- Clinics were routinely overbooked. For example, in one gastroenterology clinic in March 2014, the clinic was overbooked by five patients. At 4pm four patients were booked to see one doctor. All the overbooked patients at this clinic were being seen for follow-up appointments.

Outpatients

- Staff completed a monthly '30-minute wait audit', which monitored how long patients were kept waiting for their appointments. We saw that most clinics had some delays. For example, of the 12 patients seen in a neurology clinic in February 2014: three were seen within 30 minutes, one within 51–60 minutes and eight patients were waiting for more than an hour.
- There was no data to reflect how many patients waited over an hour, as the audit only collected data up to one hour.
- The neurological clinic was delayed by an hour on the morning of our visit. One of the patients waiting told us this was a regular occurrence at this clinic. They said, "The problem is that patients like me with neurological problems can take a long time in appointments especially the first appointment. I don't begrudge them that time; I needed it myself when I first came here. But when they know that it takes so long why don't they schedule longer appointments for us? Especially first appointments. It's just not acceptable to have delays every time we come to clinic. We do have lives outside of this you know!"
- We saw on the afternoon of our inspection that waiting area 'C' was particularly crowded. Although everyone had a seat, they appeared to be squeezed in and tight for space. One patient confirmed this saying, "I prefer to stand; it's rather too claustrophobic in the seated bit."
- The manager told us that they had asked the estates department to cost the work that was needed to improve the environment of this waiting area. On the day of our inspection they had not yet received this information from the estates department.

Care of vulnerable patients, patients with dementia and patients with learning disabilities

- All the nursing staff, with the exception of staff on long-term sick leave, had attended annual safeguarding training in line with the trust's policy.
- The manager gave us an example of where staff had highlighted a concern about a patient's capacity to make decisions about an examination required for their diagnosis. This had included the staff contacting the trust lead in safeguarding for guidance.
- The manager demonstrated that staff had a good understanding of the Mental Capacity Act (MCA) 2005 and had applied its principles in the example given. Specifically, they had considered the least restrictive ways of caring for the patient concerned in accordance with the MCA and with Deprivation of Liberty Safeguards (DoLS).
- The manager told us that the majority of patients attending the department from supported living environments bought with them a 'Healthcare Passport' document. This outlined to staff how they should be supported with their care needs. If patients attended the department without this information, the OPD would meet their needs by contacting their carers or family for advice on ways that the department could best support them with their care. They told us they would provide a Healthcare Passport for these people for them to complete before their next visit. They said, "These documents give staff valuable information about the best ways to care for the patient. We encourage people to use them."

Meeting individual patients needs

- Translation services were available such as via telephone using the 'Big word' telephone translating system that could be accessed without any prior arrangement being required.
- The manager told us that, when patients needed a more complex consultation and it had been identified that telephone translation was not appropriate, the OPD staff were able to book face-to-face translators, although this service needed to be organised in advance.
- Patient's specific religious and cultural needs were met for example, when a female patient's culture or religion required that they only be examined by a female doctor, the OPD staff would ensure that this requirement was respected.
- The only disabled toilet facilities available to patients in the OPD was outside the entrance to the department.
- There were additional male and female toilet facilities in this area and these were clean and well maintained.

Communication with GPs and others

- After a clinic appointment, a GP letter was sent to the patient's GP which included information about any further action that might be needed.
- The medical secretaries working in respiratory, gastroenterology and cardiology we spoke with told us the trust's 72 hour target was not consistently being met.

Outpatients

- The respiratory secretary told us that they were typing GP letters within five days on average; another said they took about a week. The two gastroenterology secretaries also told us they were typing letters in about a week. The cardiology secretary we spoke with said that their department took on average two to three weeks to turn around GP letters. All the secretaries said that delays were caused by staffing vacancies.
- Departments were currently recruiting to posts; however, one post in cardiology had been vacant for more than six months.
- There were a range of patient leaflets in each waiting area that gave information about the department, and about specific medical conditions.

Complaints handling

- Patients were provided with an opportunity to provide feedback about the OPD by completing a questionnaire and placing this in the comments box. These comments were reviewed by the manager and learning or changes to the service communicated to staff during the morning staff meeting.
- The results from the OPD survey were displayed on a notice board at the entrance to the OPD. The board included a section on what the department did well, and what they could improve on.
- The January/February 2014 OPD surveys showed that patients felt that staff were good at meeting and greeting them, informing them of clinic delays, and checking their identification and smoking status, but that the OPD needed to improve on explaining to patients why clinics were running late.
- The manager also collected information on patients' experience in OPD during a weekly 'walk the floor' audit. This audit identified 10 patients from each clinic and staff interviewed them to obtain their views on the OPD and their experience of care. The manager told us that they would analyse the results of this audit and when any patterns or trends were seen they would look to make service improvements.
- The manager had put a board up in the staff room called 'What your patients said about you this month'. They used this board to paste comments that had been made about staff in the OPD patients' survey forms.

Responsiveness to local needs, listening groups, user groups, patients' voice initiatives

- The OPD ran a patient user partnership group meeting bi-monthly. The minutes from the past two meetings showed that staff and patient representatives had discussed improvements that could be made to the service. The matron told us that they had invited patients who had previously complained about aspects of the service to join this group.

Are outpatients services well-led?

Requires improvement

Vision and strategy for this service

- The manager was able to describe to us the trust's vision.
- We were told that the executive team had never visited the department; all the nursing staff we spoke with told us that they had never met the chief executive of the trust. One member of staff said, "I can't remember his name, but I have seen his picture on the website. It would be nice if he visited us here. I would like to meet him."
- Staff spoke of loyalty to their department and their department manager. The felt supported by local managers, one staff member said, "If I had any worries, I would tell her."
- The manager had compiled a file of information for staff on tools available to help them with anxiety and stress. The file included the contact details for the trust's free and confidential counselling service.

Leadership of service

- The OPD held a monthly clinical governance meeting and produced a monthly governance report that was used to inform the trust's board and other stakeholders. During the meeting, all areas of governance were discussed and reported on, along with any learning or changes to the service.
- The OPD used a number of tools to gather the data needed to meet with the trust's governance arrangements. Incidents/accidents and near misses were recorded and investigated using the electronic recording system.
- We found that all the staff we spoke with were aware of this reporting system and were using it, but the output

was not being used. The number of incidents and their level (none, low, moderate, severe or death) were reported with the department's governance report which fed into the divisional's governance board.
- Health and safety was monitored using risk assessments and with staff noting risks on the trust's risk register when appropriate.
- We found that the department manager understood risk assessment and was able to describe items on the risk register to us.
- Complaints and compliments were investigated by the manager of the OPD, who reported to staff any service improvements that had been identified. The number of complaints along with a breakdown and analysis were included in the governance report and relayed to the board.
- The governance report also outlined staff attendance at mandatory training, staff sickness levels, and compliance with the department's audits, such as the hand hygiene audit.
- The manager of the department and the matron were able to outline the department's governance procedures. They were also able to tell us how their department was performing in all areas.
- The manager printed the trust's weekly newsletter and made it accessible to staff to try to engage them in trust-wide developments.
- All staff in the department had all completed their mandatory training requirements; a record of training was maintained on a staff training database.
- Ninety-six per cent of staff in the OPD had completed an annual appraisal.

Culture within the service

- Staff understood their individual roles and there were competency assessments of staff undertaken to ensure they understood and were able to perform their roles to a required standard.
- Patients felt well informed and stated that staff were both friendly and supportive of them.
- Staff we spoke with were aware the consultation process for the redesign of the department.
- Staff we spoke to were aware of the issues in the OPD around overbooked clinics and waiting times for patients however they felt disempowered to address these issues as decisions were made outside their department.
- Although there was awareness among all staff groups about overbooked clinic templates and patient waiting times, no improvements had been made to resolve these issues.

Innovation, improvement and sustainability

- None of the department's staff had attended or were aware of the trust's 'dragon's den' initiative, which encouraged staff to bring forward any ideas or initiatives that they felt would improve the service.

Outstanding practice and areas for improvement

Outstanding practice

We saw an area of good practice:

- The critical care unit monitored its performance and data from Intensive Care National Audit and Research Centre (ICNARC) and showed that patient outcomes were good.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.
- Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.
- Ensure all staff are up to date with mandatory training.
- Protect patients by means of an effective system for the reporting of all incidents and never events of inappropriate or unsafe care, in line with current best practice and demonstrate learning from this.
- Ensure that paper and electronic policies, procedures and guidance referred to by staff in the care and treatment they provide to patients are up to date and reflect current best practice.
- Ensure that the assessment and monitoring of patients' treatment, needs, and observations are routinely documented to ensure they receive consistent and safe delivery of care and treatment.
- Ensure that the environment in which patients are cared for is well maintained and fit for purpose.
- Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are completed appropriately to reduce the risk to patients.
- Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply and that in-depth cleaning audits are undertaken in all areas.
- Implement regular emergency drills for staff.
- Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.
- Review the provision of end of life care to ensure a coordinated approach.

Action the hospital SHOULD take to improve

- Ensure that patients are informed of the reasons why their appointments are cancelled.
- Ensure that letters to patients' GPs are provided within the timescales established by the trust.
- Aim to reduce the number of transfers between wards experienced by patients.
- Review discharge arrangements for patients to reduce the risk of re-admissions.