Medway NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Inadequate
Are services at this trust well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Medway NHS Foundation Trust serves a population of approximately 400,000 across Medway and Swale. The trust became a foundation trust in April 2008 and has a workforce establishment of 4,139 staff; at the time of this inspection, there were 3,683 staff employed by the trust. The trust has two locations registered with the Care Quality Commission (CQC): Medway Maritime Hospital which is the main acute hospital site and was the focus of this inspection and the Woodlands Special Needs Nursery which did not form part of this inspection.

Medway Maritime Hospital hosts a Macmillan cancer care unit, the West Kent Centre for Urology, the West Kent Vascular Centre, a regional neonatal intensive care unit and a foetal medicine unit, as well as providing a dedicated stroke service the local population.

The trust reports that the healthcare needs of the local population are greater than most other parts of Kent. Medway Local Authority was ranked 136th of 326 local authorities in the English Indices of Deprivation 2010 (1st is the 'most deprived'). The Public Health profile for the local population indicates that Medway is significantly worse than the England average for 13 of 32 indicators (41% of indicators) including smoking prevalence, percentage of physically active adults and recorded diabetes. Male and female life expectancy is also significantly worse than the England average.

Medway NHS Foundation Trust was identified as a mortality outlier for both the hospital standardised mortality ratio (HSMR) and the summary hospital mortality indicator (SHMI) for 2011 and 2012. Consequently, Professor Sir Bruce Keogh (NHS England National Medical Director) carried out a rapid responsive review of the trust in May 2013; the findings from the review resulted in the trust being placed into special measures in July 2013.

In response to information of concern received, we undertook unannounced inspections of the maternity service in August 2013 and the emergency department in December 2013; CQC utilised its enforcement powers and issued a range of warning notices which required the trust to make significant improvements within a specified period of time. The CQC undertook a comprehensive inspection of Medway Maritime Hospital in April 2014 because the trust was rated as high risk in the CQC's intelligent monitoring report and because the trust remained under special measures. We rated the trust as inadequate overall; the emergency department had made insufficient progress since we had issued warning notices in December 2013 and was rated as inadequate as was the core surgery service. We found that the maternity service had made significant improvements although there was limited evidence to demonstrate sustained improvement. The service was rated as requiring improvement along with medical care, end of life care and outpatients. Critical care and care of children and young people had been rated as good.

We re-inspected the emergency department in July and August 2014. As a result of those inspections we undertook enhanced enforcement action and imposed conditions of the providers registration which required them to undertake an initial assessment of all patients who presented to the emergency department within 15 minutes of their arrival. During this most recent inspection we were satisfied that the trust was meeting this condition and have since removed this from the trusts registration.

This most recent announced inspection took place between the 25th and 27th August 2015, with follow up unannounced inspections taking place on 8, 9 and 13 September 2015.

Overall, Medway NHS Foundation Trust has been rated as inadequate. We have rated it good for being caring but improvements were required in providing effective care. The safety, responsiveness to patients' needs and leadership of the trust remained inadequate despite a prolonged period of the trust being in special measures.

Three of the eight core services have been rated as inadequate; emergency department; medicine and surgery. Three services required improvement; critical care; end of life care and outpatients. Maternity and gynaecology and services for children and young people were rated as good.

Our key findings were as follows:

Safe

Summary of findings

- Whilst we acknowledge that incident reporting had improved in some areas we remain concerned that not all incidents were being reported. We are also concerned that senior staff responsible for reviewing and investigating incidents did not always have the time to carry out these duties across all departments because of staffing levels.
- Safety was not a sufficient priority across the trust; whilst there had been improvements in some clinical areas with regards to the reporting of incidents, there were concerns that not all staff reported incidents. Further, the process for learning from, and embedding changes to practice as a result of incidents was poorly established. A high level of "Silo working" was noted across the hospital which further impacted on the ability of the organisation to move forward with regards to learning from incidents. There was little evidence of robust trust-wide learning and whilst the trust had undertaken initiatives to tackle key areas of clinical concern including the management of sepsis, these initiatives delivered little in the way of improved patient safety.
- Facilities across the organisation was observed to be in a poor state of repair; the trust acknowledged that the estate required significant remedial works to ensure the property was fit for purpose.
- Whilst the clinical areas we visited were visibly clean in the main, compliance against national cleaning standards was found to be poor.
- Staffing levels across the hospital were insufficient to meet people's needs. This was also identified at the last inspection. The trust remained heavily reliant on the good will of staff to undertake extra shifts and temporary agency and bank staff in the interim to ease the pressures. There was a lack of robust induction procedures and records for these staff.
- Children who received treatment and care at the hospital were kept safe; their safety was assured through vigilant monitoring of any deteriorating child and in providing optimum staffing ratios; the effectiveness of services were geared to reducing emergency re-admission rates and the caring was evident throughout the whole service where a team multidisciplinary approach to care prevailed.
- Maternity and gynaecology safety performance showed a good track record and steady improvements. There were clearly defined and embedded systems, processes and standard operating procedures to keep women safe and safeguarded from abuse.

Effective

Summary of findings

- Staff practice did not always comply with the requirements of the Mental Capacity Act, Deprivation of Liberties Safeguards. We also found staff were not always supported in their development through appraisal in some areas of the trust.
- Performance against national audits was varied. Clinical audits are designed to drive improvements in the delivery of care to patients; we found that whilst there had been improvements year-on-year in some clinical audits, a number of specialities were failing to sustain improvements, outcomes in some audits being reported as being worse than preceding years performance.
- The trust continued to remain as an outlier for mortality against a range of composite indicators including but not limited to: respiratory conditions, infectious diseases (sepsis), gastrological and hepatological conditions.

Caring

- There was a limited approach to obtaining the views of patients.
- Staff were caring and supportive with patients and those close to them. Staff responded with compassion to patients in pain or emotional distress, and to other fundamental needs. Staff treated patients with dignity and respect and people felt supported and cared for as a result.

Responsive

Summary of findings

- Patients were unable to access the care they needed because of inadequate management of demand and patient flow through the hospital. The flow of patients through the hospital did not function as intended. Patients were frequently treated in mixed-sex wards.
- The trust was consistently not meeting their two week targets for patients suspected with cancer and in addition to this there was an inequality in waiting times between patient groups. The latest referral to treatment time's data revealed that the trust was below the NHS England target. Increasing numbers of investigations were being sent to external agencies for reporting, but the trust had no robust assurances of its own that the quality of reporting.
- The patient service centre was not always able to give patients appointments within the target times set by NHS England and the clinical commissioning groups. At the time of our inspection we were unable to see any clear strategies to develop robust systems and processes to be able to monitor and maintain these targets.
- The End of Life Care Policy (2014) provided by the trust was not robust as it was aimed at care of the dying patient only and there were no prerequisites for advance care planning. There was little consideration given to setting ceilings of care.
- Discharge planning was inadequate and there were high levels of delayed transfers of care.
- Staff were unaware of complaints at a directorate level which had influenced change.

Well-led

- The vision and values of the organisation were not well developed or understood by staff at the time of our inspection. The Trust had plans **for over 500 staff to attended focus groups and workshops in January 2016 when they planned to launch the new Vision and Values across the Trust.**
- Strategic planning and operational management were hindered at all levels by the lack of reliable, easily understood data. Staff satisfaction was mixed, and some staff reported feeling bullied including members of the executive team.
- The capability of the board to drive the level of improvement required at Medway NHS Foundation Trust was questionable. Key posts including the Chief Nurse and Medical Director were both filled by interim appointments. Concerns were raised over the abilities and skill set of non-executive directors; the ability of the non-executive team to robustly hold the executive team to account, especially in relation to quality and safety concerns, and more specifically the long-standing poor performance against mortality outcomes was further impeded by the provision of data which was poorly understood and which had been historically unreliable.
- Whilst the executive was assured that progress had been made against the 18 month recovery plan, the inspection team was not so assured. Reported actions had been listed as "Complete" however we judged that specific actions and changes to practice had not been sustained. Further, there was mixed assurance received from the board with regards to the ability of the 18 month recovery plan to deliver the expected outcomes. The plan was described as "Aspirational" by more than one member of the board; there was limited evidence to reflect whether the current format of the 18 month plan had been challenged, especially in light of the reservations voiced by both board members and front-line staff.
- The leadership of core services and divisional leads was lacking consistency and in the latter case, substantive appointees to fill the posts. The structure of the organisation had undergone various reviews since our previous comprehensive inspection; there remained uncertainty about the divisional structures of the organisation, which remained at consultation stage during the inspection.

Summary of findings

- Whilst the appointment of the chief executive was seen as a pivotal moment in ensuring the leadership of Medway NHS Foundation Trust was sustainable in the long term, there remained key leadership roles which were filled by interim appointments, with little or no forward vision or plan of how these roles would be appointed to by substantive individuals in the future.
- There was a significant delay or lack of response in acting upon recommendations made from external reports which were specifically related to mortality reviews.
- Staff morale had been left in a poor state as a result of ineffective engagement, management and constant changes to directorate teams. The results of the most recent staff survey continued to raise concerns about staff welfare, moral and organisational culture at the trust.
- The outpatient nursing team demonstrated good clinical leadership, competent staff, forward thinking and planning with regards to capacity issues. They regularly assessed their environment, sought feedback from and worked with patients regularly to improve the patient experience.

We saw several areas of outstanding practice including:

- The orthotics department demonstrated a patient centred approach. They had been identified by NHS England as a service to benchmark against, because of the waiting times (90% of all patients seen the same day or next day), low cost per patient and clinical evaluation of each product they used.
- The maternity team had "Team Aurelia", a multidisciplinary team that provided support for women identified in the antenatal period as requiring an elective caesarean section. The team undertook the pre-operative review prior to admission for elective caesarean section.
- Women were seen by an anaesthetist prior to surgery and an enhanced recovery process was followed to minimise women's hospital stays following surgery. The hospital play areas for children were very well equipped with a commendable outdoor play area that was well used.
- The neonatal intensive care unit was found to continuing to be providing components of outstanding care pre-term and term neonates.

Summary of findings

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

Importantly, the trust must:

- Take immediate action to improve patient flow. This must be achieved without impacting other services provided within the departments and have a risk balanced approach so not to impede on other services delivered.
- Review the environment within the emergency department (ED) to meet patient demand effectively. Take actions to ensure patients are discharged from the unit within four hours of the decision to discharge to improve the access and flow of patients within the critical care services.
- Ensure that staffing levels across the hospital are sufficient to meet the needs of patients.
- Ensure that patient records are accurate to ensure a full chronology of the care patients have received has been recorded.
- Ensure that major incidents arrangements are suitable to ensure patients, staff and the public are adequately protected and that patients were cared for appropriately in the event that a major incident occurred.
- Urgently review the two week cancer pathways for each speciality and ensure that there is clinical oversight of those patients waiting in order to mitigate the risks to those patients.
- Provide clinical oversight of patients waiting on incomplete pathways to ensure they are seen on a basis of clinical need in accordance with the trust Access Policy.
- Review and provide assurance that processes that are in place to ensure that World Health Organisation (WHO) checklists are completed prior to an interventional radiology procedures.
- Ensure that trust wide incident reporting processes and investigations are robust, action plans are acted on and systems are in place to ensure that lessons are learned.
- Have robust procedures in place to give assurance of the quality of radiology reporting done by external companies.
- Address the risks associated with reducing exposure to radiation in the diagnostic imaging departments. This specifically relates to the wooden door frames supporting the protective lead doors; the frames were observed to be cracking under the weight. Although entered on the risk register there were no plans in place to address this potential breach of radiation protection regulations.

Summary of findings

- Ensure that MHDU complies with the Department of Health best practice guidance: Health Building Note HBN-04.01.and intensive care core standards.
- Ensure that governance and risk management systems reflect current risks and the services improve responsiveness to actions required within the risk register.
- Ensure clinical areas are maintained in a clean and hygienic state, and that the monitoring of cleaning standards falls in line with national guidance.
- Review mortality and morbidly in those specialities where outcomes are below national averages to determine if there are any contributing practice considerations to address.
- Ensure that all staff understand their responsibilities under the Deprivation of Liberties Safeguards (DoLS) and discharge these in line with legal requirements.
- Improve the quality of discharge planning to decrease the number of delayed transfer of care.
- Improve the timeliness of responses when managing to formal complaints.
- Ensure that governance meetings, including mortality meetings are held as scheduled and ensure that the structure of meetings is consistent across the organisation.
- Improve the quality and availability of performance and safety information to all departmental managers and the divisional management team.
- Ensure patients undergoing cardiac procedures where they required sedation are treated by appropriately competent staff at all times as outlined in national guidance to minimise the risk to patients.
- Review its current handover practice. This should include a focus on the structure, quality, and format of the actual handovers. The trust should also review the process to ensure that patients dignity, privacy and confidentiality is not compromised.
- Review the capacity of the safeguarding team and ensure more effective communication and working collaboration from the safeguarding team.
- Ensure that local policy and protocol around EOLC are reviewed to ensure they are consistent with national and best practice guidance.
- Review the quality of the senior leadership to ensure efficient, supportive and quality leadership.
- Review its current strategy to improve engagement, morale, recruitment and retention. It must also ensure that it reviews the bullying reported to ensure staff welfare.
- Store medicines according to the manufacturer's instructions.
- Ensure that inappropriate medicines are not stored in ward areas. Ensure it complies with FP10 tracking as dictated by national guidance.
- Produce a critical medicines list to comply with NPSA/2010/RRR009. Improve mandatory training compliance rates.
- Ensure staff follow trust policy for the administration of anticipatory medication for EoLC patients.
- Manage allegations of bullying and whistleblowing, and performance management in line with agreed policies. The trust must also ensure it is meeting its duty of care toward staff who are under the care of Occupational Health.

In addition the trust should:

Summary of findings

- Provide a stable and focussed leadership in divisional teams.
- Ensure all staff understand the organisations strategic recovery plan and their personal role and responsibilities in delivering the plan.
- Engage patients in the planning, design, delivery and monitoring of services.
- The trust statement of vision and values should be translated into a credible strategy with well-defined objectives that are understood and acted upon by staff working in critical care services.
- Review the results of the annual infection control audit undertaken in all outpatient and diagnostic imaging areas and produce action plans to monitor the improvements required.
- Introduce a policy and protocol to ensure that clinic letters to GPs are dispatched in a timely manner with audits to maintain assurance.
- Tracheostomy equipment trolley on SHDU should be checked using a checklist, and a record kept of those checks, to ensure it is readily accessible and fit for purpose.
- Ensure all storage areas are fit for purpose and that items are store appropriately. Consider how the fabric of clinical areas is maintained.
- Ensure records of 'intentional rounding' are consistently completed. Benchmark its acute medical unit performance against the standards set by the Society of Acute Medicine.
- Ensure that 'as required' pain relief is adequately evaluated. Progress the use of specialised pain assessment tools for those with cognitive impairment. Complete and implement the 'Percutaneous Endoscopic Gastroscopy Nutrition Policy'.
- Ensure all staff receive an annual appraisal and that there are arrangements for clinical supervision for those who require or request it.
- Consider how ward staff could be assured of the clinical competencies of agency staff.
- Consider how seven day therapy services could be provided on the stroke unit.
- Study the level of service required in ambulatory care to better understand the level of demands and how to meet it.
- Audit the dementia friendliness of the design of clinical areas and take appropriate remedial actions.
- Consider how 'Better Care Together' and matron visit initiatives could be used to drive improvements. Continue to work towards full provision of seven day services for EOLC.
- Children's services should enhance play specialist provision in line with national guidance.
- Assure itself that staff understand the new Duty of Candour regulations.
- Assure itself that agency staff are reporting and know how to report an incident.
- Conduct a service review of pressure area care and urinary tract infections (UTI's) to identify any care failings or necessary improvements that are required.
- Take action to address the excessive temperatures patients and staff are exposed to on McCullough ward.
- Ensure that its medication prescribing policy is being followed.
- Review the quality of service provided by the new patient transport provider.
- Review the staffing levels in the pain team against the demands of the service to ensure it can meet people's pain needs and provide an appropriate level of support for ward staff.
- Review theatre start and finish times and staffing arrangements for over runs to ensure the department is working to maximum capacity to meet the demands of the service and to minimise the risk to patients from long referral to treatment times (RTT).

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Medway NHS Foundation Trust

Medway NHS Foundation Trust has been a foundation trust since 1st April 2008. The trust employs 3,683 staff (budgeted establishment of 4,139 whole time equivalent (WTE) staff) and has 652 beds. The trust's turnover is £282 million; it reported a deficit of £30.5 million in 2014/15.

Medway NHS Foundation Trust was placed into 'special measures' in July 2013 to improve and rectify failings in patient care and governance as identified in the review under Professor Sir Bruce Keogh.

At the time of this inspection the executive team comprised four permanent executive positions and three interim executives. The chairperson was appointed in September 2014 after having joined the trust as a non-executive director in January 2014. The Chief Executive had been in post since May 2015. The positions of the Finance Director and Chief Nurse were interim appointments; the Chief Nurse was due to leave the trust in October 2015. We were told of conflicting reasons behind the absence of the Medical Director; the duties of the Medical Directors office was being fulfilled by a deputy and associate medical directors. The Chief Operating Officer was a substantive employee but had tendered their resignation shortly prior to the inspection; they had been in post since November 2014. The trust had appointed a Chief Quality Officer who took up post in June 2015.

As of June 2015 the trust is being supported through a formal buddying arrangement with Guy's and St Thomas' NHS Foundation Trust (GSTT). The scope of the agreement is for GSTT to provide advice and support to Medway NHS Foundation Trust to effectively and quickly improve their performance in a range of areas including clinical leadership, mortality, medical and surgical pathways, and access and flow across the acute service.

Our inspection team

Our inspection team was led by:

Chair: Tim Ho Medical Director

Head of Hospital Inspections: Nick Mulholland Care Quality Commission

The team of 49 included CQC inspectors, a planner, analysts and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics, anaesthetist, physician and junior doctors; midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses', paramedic, an imaging specialist, outpatients manager, child and adult safeguarding leads, estates and facilities directors and experts by experience.

How we carried out this inspection

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

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

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

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people

Summary of findings

• End of life care

• Outpatients and diagnostic imaging

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

Representatives from the hospitals Patient Advice and Liaison Service (PALS) and an inspector from the CQC facilitated a stall in the entrance to the hospital during the inspection where people stopped and shared their views and experiences of Medway Maritime Hospital with us. We also spoke with staff, patients and carers via email or telephone, who wished to share their experiences with us.

We carried out the announced inspection visit between 25 and 27 August 2015. We held focus groups and drop-in sessions with a range of staff in the hospital including; nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested. We talked with patients and staff from the majority of ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out unannounced inspections on 8, 9 and 13 September 2015. We looked at how the hospital was run out of hours, the levels and type of staff available and the care provided.

What people who use the trust's services say

The friends and family inpatient test recommended rate overall for this trust has consistently been worse than the England average for the previous 12 months. For July and August 2015, the percentage of patients who would recommend inpatient services was 83% and 84% respectively; this was worse than the England average of 96% for both months. Further, the number of people who would not recommend the service was significantly worse when compared nationally with both months reported as 9% of patients not recommending the service, as compared to the national standard of 1%.

In the cancer patient experience survey for 2013/2014, the trust performed in line with the top 20% of trusts in four of the 34 outcome measures. The trust performed in the bottom 20% of all trusts in 16 questions. Overall performance in the cancer patient experience survey was noted to be worsening when compared to the trusts performance of 2012/2013.

The trust performed "About the same" as other trusts in the CQC in-patient survey however the trust scored poorly in two areas specifically related to discharge processes.

Whilst scores in the Patient-led assessments of the care environment (PLACE) the trust performed generally worse than the England average however performance was seen to be improving when compared to previous years performance.

Facts and data about this trust

Local demographics

Medway local authority was ranked 136th of 326 local authorities in the English Indices of Deprivation 2010 (1st is 'most deprived'). The Public Health profile indicates that Medway is significantly worse than the England average for 13 of 32 indicators (41%) including smoking prevalence, percentage of physically active adults and recorded diabetes. Male and female life expectancy is also significantly worse. Additionally, nine of 32 indicators (28%) were similar the England average and 10 (31%) were significantly better than the England average.

Summary of findings

Activity

Between 2014 and 2015 the trust facilitated:

- 55,898 inpatient admissions
- 20,932 day case admissions
- 327,412 outpatient attendances.
- The emergency department had 99,162 attendances between April 2014 and March 2015.

Context

- Foundation trust since 1 April 2008
- Serves a population of approximately 400,000
- Employs around 3,683 staff with a budgeted establishment of 4,139 whole time equivalent staff

Intelligent monitoring - May 2015

- Number of risks: 16
- Number of elevated risks: 15
- Overall risk score: 46
- Number of applicable indicators: 9

Intelligent monitoring - Safe

- Risks: 3
  - Never event incidence
  - Composite of Central Alerting System (CAS): Dealing with CAS safety alerts in a timely way
  - A & E survey Q7: From the time you first arrived into the A&E Department, how long did you wait before you were examined by a doctor or nurse?

Summary of findings

Intelligent monitoring - Effective

- Risks: 8
  - Composite indicator: In-hospital mortality - Cardiological conditions and procedures
  - Composite indicator: In-hospital mortality - Endocrinological conditions
  - Composite indicator: In-hospital mortality - Gastrological and hepatological conditions and procedures
  - Composite indicator: In-hospital mortality - Conditions associated with mental health
  - Composite indicator: In-hospital mortality - Respiratory conditions
  - Composite indicator: In-hospital mortality - Trauma and orthopaedic conditions and procedures
  - Composite indicator: In-hospital mortality - Vascular conditions and procedures
  - Composite of hip related PROMS indicators (Patient Reported Outcome Measures
- Elevated Risks: 4
  - Summary Hospital-level Mortality Indicator
  - Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ration Indicators
  - Composite indicator: In-hospital mortality - Infectious diseases
  - SSNAP (Sentinel Stroke National Audit Programme) Domain 2: overall team centred rating score for key stroke unit indicator

Intelligent monitoring - Caring

- Risks: 3
  - Inpatient Survey Q68 (2014): "Overall..." (I had a very poor/good experience) (Score out of 10)
  - Inpatient Survey Q25 (2014): "Did you have confidence and trust in the doctors treating you?"
  - A&E Survey Q19: If you needed attention, were you able to get a member of medical or nursing staff to help you?
- Elevated risks: 4
  - Inpatient Survey Q66 (2014): Overall, did you feel you were treated with respect and dignity while you were in the hospital?" (Score out of 10).
  - A&E Survey Q14: Did you have confidence and trust in the doctors and nurses examining and treating you?"
  - A&E Survey Q22: If you were feeling distressed while you were in the A&E department, did a member of staff help to reassure you?"
  - A&E Survey Q42: Overall, did you feel you were treated with respect and dignity while you were in the A&E Department"

Summary of findings

Intelligent monitoring - Responsive

- Risks: 1
  - Composite indicator: Referral to treatment
- Elevated risks: 3
  - A&E Survey Q18: Were you given enough privacy when being examined or treated?
  - Composite indicator: A&E waiting times more than 4 hours
  - CQC concerns and complaints

Intelligent monitoring - Well-led

- Risks: 1
  - GMC - Enhanced monitoring
- Elevated risks: 3
  - Monitor - Governance risk rating
  - Monitor - Continuity of service rating
  - Snapshot of whistleblowing alerts

Summary of findings

Intelligent monitoring - Cross cutting indicators

- Elevated risks: 1
  - Composite of PLACE indicator

Patient Led Assessment of the Clinical Environment (PLACE) scores for 2014 for food were 75.5 %, the national average for 2014 being 88.8%. PLACE scores for 2015 were 85% the national average for 2015 being 88%. There had been a 9.75% improvement in the 2015 score against the 2014 score suggesting that the catering service had improved since we last inspected.

Trust-wide indicators

Safe

- Four never events reported in previous 12 months (May 2014 -April 2015)
- 65 STEIS Incidents reported (May 2014 - April 2015)
- Incidents reported VS national reporting averages (April 2014 -September 2014):

Summary of findings

Category	Medway Maritime Hospital	England Average (as percentage of all of all incidents)
Deaths	25 (0.8%)	0.1%
Severe harm	10 (0.3%)	0.4%
Moderate harm	196 (6.5%)	4.0%
Low harm	643 (21.5%)	21.8%
No harm	2,123 (70.8%)	73.7%

- Three trust-assigned MRSA infections reported during 24 month period.
- Low but persistent rates of C.diff and MSSA; rates similar to England average.
- A consistently high prevalence of pressure ulcers categories 2-4 over a twelve month period.
- High prevalence of Catheter related urinary tract infections

Effective

HSMR Weekday: Higher than expected

HSMR Weekend: Higher than expected

HSMR Overall: Higher than expected - 111.2 (April 2015 – June 2015)

SHMI Overall: 1.24(January 2014 – December 2014)*

* The SHMI figure of 1.24 was subject to a known submission error. The Trust calculated the correct figure to be 1.18.

Summary of findings

Caring

- Performing worse than other trusts for discharge delays.
- Patient Led Assessments of the Care Environment (PLACE) scores were worse than the England average in all catagories of cleanliness, food, privacy, dignity and wellbeing, condition, appearance and maintenance.
- Trust rated in the bottom 20% of Trusts for 16 of the 34 indicators for cancer patient experience survey results for the last two years.
- 'Friends and Family Test' (Mar 2014 – Feb 2015) showed the trust was consistently below the England average.
  - CQC inpatient survey:
    - No. of items in top 20%: 0 (0%)
    - No. of items 'average': 40 (67%)
    - No. of items bottom 20%: 20 (33%)

Responsive

- Bed occupancy consistently higher than the England average over the last year.
- Number of complaints in 12 months: 535, June 14 – May 15
- RTT non admitted (completed pathways):62%, June 15 only
  - RTT admitted (completed pathways): 83%, June 15 only
- Cancer 2 week wait: 72.1%, April – June 15
- Cancer 31 day wait: 95.1%, April – June 15
- Cancer 62 day wait: 78.3%, April – June 15

Summary of findings

Well Led

- GMC Survey 2015 showed worse than expected results for doctors induction and feedback.
- NHS Staff Survey 2014 Key Findings showed 9 Negative RAG ratings.

Staff survey:

- Overall response rate 41%
- No. of items in top 20%: 3 (10%)
- No. of items average: 19 (66%)
- No. of items bottom 20%: 7 (24%)

Staff Survey key finding 18: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months:

- 28% of staff reported experiencing harassment, bullying or abuse from patients, relatives or staff; this was higher (worse than) the national reported average of 25%.
- Of note, 27% of staff who reported experiencing this form of harassment, bullying or abuse described themselves as "White" versus 33% of black and minority ethnic (BME) staff.

Summary of findings

Staff Survey key finding 19: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months:

- 28% of staff reported experiencing harassment, bullying or abuse from staff; this was higher (worse than) the national reported average of 22%.
- Of note, 26%of staff who reported experiencing this form of harassment, bullying or abuse described themselves as "White" versus 33% of black and minority ethnic (BME) staff.

Staff Survey key finding 28: In the last twelve months have you personally experienced discrimination at work?

- 12% of staff reported personally experiencing discrimination at work; this was marginally higher (worse than) the national reported average of 11%. However, whilst the overall rate is similar to the national average, there was a statistically significant variance between the number of BME staff who reported experiencing discrimination in this category; 25% of BME staff versus 7% of white staff.

CQC Inspection History

- Maritime Medway Hospital has been inspected 12 times since November 2010.
- The most recent trustwide inspection was a routine inspection in April 2014, and was conducted under the new methodology. The April 2014 inspection resulted in an overall rating of 'Inadequate' for the trust.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated the safety of services in the trust as inadequate. The trust lacked a systematic approach to the reporting, analysis and learning from incidents. In an attempt to safely care for patients, the trust was reliant on temporary nursing staff to support services. We found that not all temporary staff had access to computer systems in order to report incidents which led to missed opportunities in the trust being able to identify, analyse and resolve incidents which were likely to reoccur. Further, where serious incidents had taken place and investigated, there was a lack of sustained improvement or changes to practice, thus reintroducing risks to patients. The trust was operating with significant staff vacancies leading to an over-reliance of agency and locum staff, especially within the medical and surgical nursing workforce. There was some inconsistency in ensuring that all temporary nursing staff underwent comprehensive local inductions on commencement of their temporary employment. The management of patients attending the emergency department was not always well managed. Deteriorating patients were not always escalated in a timely way which led to patients not always receiving treatment in line with national standards or best practice recommendations. The trust was not complying with national cleaning standards; some areas of the estate were in a poor state of repair with a lack of risk mitigation in place to protect patients from the risk of harm. Whilst there was evidence that staff were complying with their statutory duties in relation to their duty of candour, the trust acknowledged that improvements were required to ensure that the trust policy was consistently applied. Safeguarding arrangements required significant improvement to ensure that the overall process for safeguarding vulnerable people was sufficiently robust and effective. Uptake of safeguarding vulnerable adults and children training was below the trust's set standard of 95% and had been logged as a risk on the corporate risk register for a significant period of time, with a lack of effective risk mitigation in place to address the issue.	Inadequate 

Summary of findings

Duty of Candour

- The trust had a policy in place which signposted staff to best practice guidance with regards to the requirements of the Duty of Candour. An entry into the corporate risk register identified that the process for implementing the policy requirements of the duty of candour was not being systematically followed nor had the policy been embedded across the trust. One executive described the policy as "Clunky" which had led to varied practice across the trust in relation to how the requirements of the policy were followed.
- There was varied understanding amongst front-line staff regarding the requirements of the duty of candour. Some staff were able to describe the entire process, including not just the requirement to be "Open and transparent" but also the requirement to support patients or "Relevant persons" as part of the overall process.
- Maternity and gynaecology services were able to robustly evidence how they fulfilled their obligations to meet the requirements of the duty of candour.

Safeguarding

- Both prior to, and during the inspection, concerns were raised with us regarding the ability of the trust to effectively manage safeguarding concerns. The safeguarding team was found to be under-resourced with three whole time equivalent posts unfilled. Recruitment into these posts had not been agreed or advertised by the trust. External agencies raised concerns with us that they had found it increasingly difficult to engage the trust with investigating safeguard concerns, specifically relating to vulnerable adult investigations.
- Front-line staff were able to describe the process for identifying and reporting concerns associated with the vulnerable adult or child. Arrangements in the ED in relation to the safeguarding of vulnerable children was robust however we noted that there had been significant delay in the amendment of a clinical pathway associated with the management of specific bone fractures in children which could be associated with physical abuse. Further the uptake of level 3 vulnerable child training amongst nursing staff within the ED was below the trust standard of 95%.
- Uptake of both vulnerable adults and children training was poor across the trust. Compliance with this training had been identified as an area of concern by the trust and had existed on the corporate risk register since June 2013; whilst there were actions listed to control the risk, there was a lack of rigour or focus on resolving this long standing risk.

Summary of findings

Incidents

- There were 6,590 incidents reported between 1 August 2014 and 31 July 2015; this was in line with the England average.
- 92% of incidents were classified as no or low harm; 5% were classified as moderate harm and 1% were classified as severe harm or resulting in death.
- The trust reported 4 never events in the previous 12 months. (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures are implemented). Of the four never events, 2 related to wrong site surgery.
- Throughout the inspection, most substantive staff were aware of their roles and responsibilities in reporting incidents. However, this was not always the case for temporary staff, for which the trust relied heavily upon. Temporary staff reported that they could not routinely access the electronic incident reporting system. The trust advised that a paper based system was available however we found that this was not consistently used. Temporary workers reported that they therefore would not always report incidents despite them having witnessed or having been involved in events which they knew required reporting.
- Whilst there were systems and processes in place for staff to receive feedback, performance across the trust was inconsistent. There was a high level of "Silo working" with little in the way of trust wide learning taking place. Further, where significant incidents had taken place which had resulted in patients experiencing severe harm, or where incidents had resulted in the death of a patient, learning and recommendations from such incidents had not been embedded in practice.

Staffing

- As of June 2015, the trusts' nursing and midwifery workforce establishment was reported as 1,448 wte posts. This was a budgeted increase of the total establishment by 90 whole time equivalent (WTE) nurses and midwives when compared to 2014/2015. As of May 2015, the trust reported a registered nurse vacancy rate of 223wte nurses, approximately 17% of the total nursing workforce. 21% of vacancies sat within the medicine division and17% within surgery.
- There was a vacancy rate of 10% within the clinical support worker workforce (55wte posts); the majority of these vacancies sat within medicine.

Summary of findings

- Whilst the overall nursing workforce establishment had been uplifted, the trust reported having fewer nurses in post in April 2015 when compared to June 2014 (1,127 WTE nurses were reported as being in post in April 2015 as compared to 1, 148 wte in June 2014 (-21 WTE difference)).
- The use of agency staff was seen to have doubled when compared between June 2014 and April 2015 (161 wte reported in April 2015 vs 87 wte in June 2014).
- Both substantive and temporary staff raised concerns regarding the frequency with which they were moved from ward to ward in order to cover staffing shortfalls. Nursing staff reported that whilst they acknowledged the reasons behind the moves, they were uncomfortable with being asked to provide nursing care to patients with specific conditions, and for which nurses did not consider themselves to have the necessary skills to care for such patients.
- All staff that we spoke with recognised that both recruitment and retention of staff was a significant issue and posed a significant risk to the provision of effective clinical services. Recruitment processes had been identified by the executive team as requiring significant improvement to ensure that candidates were appointed into posts expeditiously. A new HR tracking system was being introduced to aid in the timeliness of which vacancy approval times could be reduced.
- On some wards, clinical support workers reported that they were often the only substantive employee working on the ward, with registered nursing posts filled by agency staff; this was identified during our unannounced inspection.

Environment and equipment

- The trust had identified risks with fire safety due to deficiencies with building fire compartmentalisation this includes damage to fire doors though out the estate. A programme of replacement fire doors has been implemented with a significant number of doors having been replaced. The risk has been reviewed by the trusts Fire Safety Advisors in collaboration with the local fire brigade. We were advised by the Fire Safety Advisor (ACT) that they were in constant liaison with the Kent Fire & Rescue regarding the current fire risk mitigation measures being employed by the trust.
- The early warning fire detection system did not have the capacity to provide L1 coverage. A new system was being installed however it is not known when this system would be

fully operational. The fire alarm detection system together with the above ceiling compartmentalisation deficiencies and the continuing fire door damage posed significant risks in the event of a fire.

Medicines

- The storage of medicines required review to ensure that they were kept in line with manufacturer recommendations.
- The trust was not complying with National Patient Safety Agency alert number 1183 (Reducing harm from omitted and delayed medicines in hospital) because it did not have a list of critical medicines. A self-audit conducted by the trust identified that the number of patients with an omitted medication was significantly worse than the England average; the trust reported that 55% of audited patients had at least one omitted dose of medication during a 24 hour period; the England average was 30%. The number of patients who had an omitted dose excluding those omitted for clinical reasons or because the patient refused was 18%; this was worse than the England average of 8.5% and was worse than the trusts previous audit performance results (January 2015; 13.1%). 8% of patients had a critical medicine omitted; this was a significant improvement on the trusts audited performance from October 2014 when 24% of patients had a critical medicine omitted however performance remained was worse than the England average of 5.3%.

Cleanliness, infection control and hygiene

- The trust had undertaken a legionella risk assessment and was undertaking a programme for the removal of dead legs across the site. They had also established a 'Water Management Group'. Regular flushing of taps was undertaken by facilities staff and recorded centrally.
- The trust were not cleaning or auditing cleaning to required standards. We checked nine very high risk areas over the preceding five months to our inspection (March 15 to July 15). This amounted to 45 audits, as the trust was auditing very high risk areas monthly. The National Specification for Cleanliness in the NHS (NSC) states that very high risk areas should be audited weekly. The trust was not meeting the audit frequency for very high risk areas as defined in the NSC. National Specification for Cleanliness in the NHS requires trusts to achieve a pass percentage of 98% in this risk category. Out of the 44 audits carried out 25 achieved the criteria giving a percentage of

56.8% achieved the criteria which meant that 43.2% of audits failed to meet the NSC required standard. Oliver Fisher Ward, Renal and Delivery suite did not achieve the required percentage at all during this period.

- We checked 25 high risk areas over the preceding five months (March 2015 to July 2015) effectively 125 audits. The trust was auditing these areas monthly which is in line with the NSC auditing frequencies. The NSC requires trusts to achieve a percentage pass rate of 95% for this risk category. Out of the 125 audits checked 54 failed to meet the percentage required by the NSC, effectively 43.2% of audits. Keats ward did not achieve the standard required at all during this period. Waverly, Arethusa, Pembroke, Pheonix and Dickens wards only achieved the standard once during this period. Although we did not see any audits for significant risk areas we were told that due to staff shortages this risk category was being audited every 4 months. The NSC requires this risk category to be audited every 3 months.
- We saw the vacancy panel submissions for June where the domestic department had put forward 30.8 whole time equivalent vacancies; the 'outcome of panel' response was recorded in the form as 'on hold'. We were told that if the department was allowed to recruit the manager was confident they would be able to fill the vacancies as they perceived there were no recruitment problems in the area for this grade of staff. The manager also told us that the recruitment was on hold until a value for money exercise had been completed; there was no information as to when this would be completed at the time of our inspection.

Mandatory training

- Mandatory training uptake across the trust was varied. Data for the 2014/2015 indicated that 78% of the nursing workforce had completed their mandatory training; this was below the trust standard of 95%.

Records

- Patient care records were not always completed in accordance with trust policy. In some instances, records lacked sufficient detail to ensure a full chronology of the care patients had received.
- Patient records were not always stored securely; this meant there was a risk of people's records and personal details being seen or removed by unauthorised people.

Summary of findings

Assessment of risk

- The trust utilised the national early warning score system to identify patients whose clinical condition may be deteriorating. Whilst application of the scoring system was in the main seen to be used, there were examples and incidents whereby clinical observations had not been recorded and timely medical reviews had not taken place as a result.

Are services at this trust effective?
Overall we have rated the effectiveness of the services in the trust as requires improvement.

Requires improvement

Whilst staff had access to protocols, policies and guidelines, audit data demonstrated that there were inconsistencies in staff providing treatment in line with those documents and treatment pathways.

The trust continued to alert on a number or mortality outliers. Whilst there was a trust wide document aimed at addressing the persistently high mortality rate, there was little in the way of robust evidence to demonstrate that this was having a sustained impact on mortality rates.

Performance against a range of national audits demonstrated a mixed picture with regards to clinical outcomes. Improvements had been noted in a number of areas including the trust attaining a rating of "D" in the National Stroke audit; this placed the trust in the same category as approximately 46% of other trusts and had been an improvement on the trusts previous rating of "E". Audits however did show that where improvements had been required, these improvements had not taken place with re-audits demonstrating a worsening picture for clinical outcomes.

Understanding of the Mental Capacity Act and the associated best practice guidance was mixed amongst front line staff. Some staff were well versed in the process of ensuring that people's mental capacity was assessed and where required, applications to legally deprive an individual's liberty was made however, this did not happen in all cases.

Evidence based care and treatment

- Core services, in the main, had access to protocols, polices and guidelines which had been developed with reference to appropriate best practice. The majority of the core services conducted audits against the clinical guidance to determine whether staff were routinely following national standards in delivering care in a consistent way. Outcomes of these audits was varied across the core services with some patients consistently receiving care which was in line with

nationally recognised treatment pathways, and others who received care which fell outside the scope of pathways. Where audits had identified areas or improvement, actions had ben developed however this had not always led to sustained improvement, with some re-audits demonstrating worsening performance.

Patient outcomes

- The Hospital Standardised Mortality Ration (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than expected. The trust is reported as continuing to be a negative outlier in this measure. Whilst the trust have introduced a range of initiatives to resolve the persistently high HSMR, there has been little change for the previous two years. Further, there was a disconnect between the view of the executive and the front line clinicians as to why the HSMR remained high. Clinicians reported that the coding of patients and a local demographic with health needs which were significantly higher than the rest of Kent was a driving factor. The executive reported that this was not the sole case and "Did not accept coding or an unhealthy population" as the reason. Whilst the executive had accepted the possibility that clinician capability and the lack of strict adherence to national care pathways may have been a contributing factor, frontline clinicians were dismissive of this as a reason.
- The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports mortality at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The trust has flagged as having a SHMI higher than expected for four years and continues to flag as of July 2015, where the trust SHMI was reported as 1.18 versus a national expected norm of 1.0. The trust reported 1,906 deaths between April 2014 and March 2015 versus an expected number of 1,613.

Competent staff

- The provision of induction for temporary staff or newly appointed substantive staff was varied across the various core services.
- Staff reported that the continued shortfalls in substantive workforce numbers had meant that accessing training was

often difficult. Further, staff reported that access to the on-line e-learning software, which we were told could be accessed remotely was also difficult and therefore hindered staff completing their training.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The process and documentation of DNACPR (Do not attempt cardio-pulmonary resuscitation) required improvement across the trust to ensure that decisions are made in line with the requirements of the Mental Capacity Act.
- Whilst the majority of staff understood the concepts of the Mental Capacity Act and Deprivation of Liberty Safeguards, we found that the processes supporting the application of the requirements of this legislation was poorly understood and required improvement.

Are services at this trust caring?

Good

Performance against the national friends and family's test was consistently worse than the England average however there were signs that this was slowly improving.

Whilst performance against a range of surveys which were used to measure people's personal experience of the care they received required improvement when compared to the performance of other, similar sized acute NHS organisations, staff were observed to provide compassionate care in almost all of the episodes of care we observed. Patients spoke positively about their interactions with staff and told us that they considered that their privacy and dignity had been maintained in the majority of cases.

Compassionate care

- Our observations and feedback from the patients and relatives with spoke with during the inspection was generally good.
- Some environments and staff practices did not support the provision of dignified care, notably within the emergency department. In one example, the privacy and dignity of a patient was observed to be significantly compromised.
- Performance against the privacy, dignity and wellbeing criteria within the Patient led assessments of the Care Environment Audits (PLACE) for both 2013 and 2014 was worse than the England average for both years (trust performance for 2013 and 2014: 80% and 82%; national performance 88% and 87% respectively).

Summary of findings

Understanding and involvement in patients and those close to them

- The trust used the NHS Friends and Family Test (FFT) to obtain feedback from patients. This was a single question survey which asked patients whether they would recommend the NHS service they had received to friends of family members who required similar care or treatment. The FFT recommended rate overall for this trust was consistently worse than the England average for 2014 and up to August 2015.
- In the Cancer Patient Experience Survey (2013/2014), the trust performed worse in 16 out of 34 indicators when compared to trust performance for the same audit in 2012/2013.
- The trust performed the same as the England average in the CQC In-patient survey when asked about:
  - Did doctors or nurses talk in front of you as if you were not there?
  - When you had important questions to ask a nurse, did you get answers that you could understand?
  - Were you involved as much as you wanted to be in decisions about your care and treatment?

Are services at this trust responsive?

Inadequate

We have judged that the trust was inadequate in how it responded to the needs of the local population.

Demands on the services provided by the hospital outstripped the planned capacity of the organisation; this was leading to patients who were referred for urgent appointments not always being seen within nationally set timescales.

Patients who required unplanned emergency care were not always admitted in to the right bed at the first time; this led to patients being moved frequently before they were admitted to clinical areas designed to treat specific clinical conditions. This had the potential to impact on the timeliness which patients received the appropriate medical treatment. Further, the poor management of waiting lists, including frequent short notice cancellations of clinics was leading to a backlog of waiting lists.

Once patients had been admitted to hospital, discharge arrangements were not sufficiently robust which led to patients experiencing delays in being discharged, especially when individuals required ongoing care and treatment. This again led to backlogs at the front door, especially within the emergency department, which led to patients experiencing delays in being admitted to an appropriate hospital bed once a decision had been made that a patient required ongoing hospital treatment.

Summary of findings

Service planning and delivery to meet the needs of the local population

- The trust had failed to conduct robust capacity and demand modelling in order to help them plan services which met the needs of the local population. Whilst this work had been scheduled to commence at the time of the inspection, there had been little consideration given to the importance of capacity and demand modelling when developing the 18 month recovery plan and so arrangements to deliver key aspects of the 18 month plan were set against current activity as compared to future activity and so increased the risk of changes in service provision not being suitable for the longer term needs of the increasing local population.

Meeting individual needs

- The trust had a range of information available for patients, however some key pieces of information were not available in a multi-lingual format. Further, whilst translation services were available, we observed that these were not always utilised despite there being occasions when the service was available.
- There was a dementia strategy in place and the trust engaged the "Butterfly Scheme". The majority of staff that spoke with us displayed a good level of understanding with regards to the care needs of patients living with dementia. We noted however that some clinical areas were not suitably designed to ensure that those patients living with dementia received appropriate stimulation.
- Outpatient clinics were often cancelled with less than six weeks notice.
- The premises had been suitably designed to meet the needs of children receiving care and treatment.
- The provision of end of life care required significant improvement; the capacity of the service was not sufficient to meet the individual needs of the local population; less than half of all patients who died in hospital were referred to the end of life care team during 2014/2015.

Access and flow

- There were significant issues with capacity and flow within the organisation meaning that patients spent longer in the emergency department; this impacted on the ability of the emergency department to meet the national performance target of ensuring that 95% of patients were seen, treated, admitted or discharged within four hours.

Summary of findings

- Bed occupancy was consistently above 95%; occupancy levels reached 99.1% between January and March 2015; this is much higher than the generally accepted range of 85%.
- The average length of stay for patients was seen to be worse than the England average.
- The trust had suspended reporting of their Referral to Treatment times due to high levels of concern regarding the validity of data used by the trust. Prior to the inspection the trust had undertaken an intense data validation initiative and had recommenced reporting of their RTT performance nationally; the trust was failing to meet any of the national benchmarks as at June 2015.
- Performance for those patients referred under the two week-wait suspected cancer pathway was worse than the England average
- In many areas, we observed discharge planning to be poorly undertaken which led to patients experiencing delays in being discharged. The trust reported a high volume of patients who experienced delays of 10 days or more, commonly referred to as Delayed Transfer of care (DTOC). The most common reason for DTOC was due to family choice and a lack of appropriate social care nursing placements.
- The ability of the trust to effectively direct patients through their relevant clinical pathways was hindered due to poor bed management. Access and flow across the organisation was reported as a "Daily struggle" by many staff. Whilst initiatives including the frailty pathway had been introduced as a means of addressing the capacity issues faced by the hospital, these had had little impact on the overall performance of the organisation.

Learning from complaints

- The executive responsible for overseeing patient complaints reported that the process for managing complaints was "Not fit for purpose" in it's current form and as such, had commissioned a review of the service by an external agency. The trust was not meeting expected response timescales and the quality of responses was observed to be of a defensive nature as compared to being open, transparent. This was a missed opportunity to allow the trust to learn from the personal experiences of patients and relatives who used the service.

Are services at this trust well-led?

We have rated that the leadership and governance of the trust was inadequate.

Inadequate

Summary of findings

Whilst a substantive chief executive had been appointed, key leadership roles remained filled with interim appointments; this has been an on-going issue within the trust and has led to front line staff reporting a sense of "Change fatigue" and "Inconsistent leadership".

Governace arrangments were not sufficiently robust and so there was the potential for clinical incidents to reoccur. Management of long-standing risks, including ensuring that all staff undertook statutory vulnerable children training as an example, was poorly managed and remained as a risk on the organisations corporate risk register.

Vision and strategy

- The trust vision and values of the organisation were not well understood by many members of front-line staff. Whilst staff were aware of an 18 month recovery plan, staff were not able to articulate clearly exactly what the plan involved nor could they describe how the plan was being used to drive the trust to a stable "Starting block" position.
- The position of the executive team and board with regards to the 18 month recovery plan was to enable the hospital to achieve a stable operational platform from which the trust could then commence an organisational wide quality improvement project. Some described the 18 month recovery plan as "Aspirational at best" with "Unrealistic timescales" being set.
- The Chairperson and Chief Executive both acknowledged that the current position of Medway NHS Foundation Trust was "Inadequate" and that there remained a high level of "Dysfunction" amongst the workforce, particularly regarding the clinical (medical) workforce.

Governance, risk management and quality measurement

- We were not assured that the management of risk and patient safety within the organisation was being appropriately managed. Whilst the trust had introduced initiatives to drive improvement including morbidity and mortality meetings, there was an inconsistent approach to how these meetings were structured.
- Output measures were not consistently reported and whilst there was central oversight through the trust wide mortality review committee, actions resulting from these minutes were not logged or reviewed to ensure that those responsible at a divisional level for the quality and safety of services had shared pertinent learning points to improve the service overall.
- Data collection across the organisation had been a significant area of concern. The appointment of the Chief Quality Office

was seen as a key move to ensure that significant improvements could be made in how data was captured and used to drive improvement. Front line staff reported that whilst they engaged in inputting data into the NHS Safety Thermometer, ward level data was not made available to clinical leaders to help them drive improvements on their individual wards. The chief executive acknowledged that this had been identified as an area of concern and work was being undertaking to resolve this issue.

- Concerns were raised by members of staff both on the front line and at board level that the existing serious incident process was flawed; staff reported that learning from serious incidents was inconsistently applied across the organisation and that changes to practice had not been embedded.
- There was a lack of management of corporate risks with some risks having existed on the corporate risk register since 2011; there was little evidence that robust action was being taken to resolve such longstanding issues.

Leadership of the trust

- Executive members of the trust consisted of both substantive and interim appointments; this remained as a consistent theme when considering the history of the executive team at Medway NHS Foundation Trust. Both the medical director and chief nurse posts were supported by interim appointments, with the secondment of the chief nurse finishing in October 2015; whilst a substantive candidate had not been appointed, the chief executive reported that it was her intention to appoint the deputy chief nurse into the post for a period of no less than 12 months, whilst ensuring the individual was supported by the Director of Nursing from Guys and St Thomas' NHS Foundation Trust.
- Executive members of staff and stakeholders reported a lack of confidence in key members of the board; some reported that individuals lacked the competence, gravitas or the necessary attributes which were required to ensure that Medway NHS Foundation Trust had strong leaders to drive forward the wider improvement programme.
- We were not assured that there were effective coaching and development opportunities for members of both the executive and non-executive team.
- Staff on the front-line reported that the appointment of the Chef Executive was a positive moment in the history of Medway NHS Foundation Trust. Whilst some staff reported that the new chief executive had been visible in clinical areas, other reported that this was not always the case.

Summary of findings

- Staff working in the Emergency Department reported that the leadership of the hospital was not visible when "The pressure was on" and so long-standing issues including access and flow remained unresolved.
- Whilst the individual members of the Council of Governors (CoG) acknowledged that much work was required to improve the quality of the organisation, there was no unified or consistent approach or single voice amongst the CoG as to how this could be achieved.
- Key divisional director roles had remained unfilled for a significant period of time, leaving divisions rudderless and without clinical leaders. The newly appointed chief executive reported that they were undertaking a consultation with staff to revise the divisional structure of the organisation. Restructuring of the divisions and reviews of key roles had been taking place since September 2014 and whilst the chief executive was assured that a new structure would be in place by October 2015, there remained confusion and anxiety amongst front-line staff about what this would like and whether the restructure would deliver the required changes and enhanced leadership which staff required and yearned for.
- Front line staff reported that frequent changes amongst the middle management tier had led to increased levels of instability and consistency. There was a high sense of "Change fatigue" amongst staff across the majority of core services; children and young people services and maternity and gynaecology services reported that their management and leadership team were stable and provided clear leadership, with quality and safety "Top of the agenda".
- Stakeholders and members of the executive acknowledged that the trust lacked sufficient numbers or clinical leaders who had the sufficient leadership skills to drive forward the required improvements at Medway NHS Foundation Trust.

Culture within the trust

- The majority of staff we spoke with were friendly and welcoming to the inspection team, and from the observations we observed during episodes of care.
- A small minority of staff reported feeling bullied or harassed by members of the executive. Concerns were also raised across the hospital of staff feeling bullied, harassed or intimidated by colleagues. One person's view was that if you "Talked, you walked".

Summary of findings

Fit and proper persons

- There were processes and procedures in place for ensuring that only fit and proper persons were appointed in to lead director roles within the organisation. We noted however that the documentation regarding the recruitment processes for individuals was fragmented and located in various different places and so, whilst the relevant documents were held by the trust, they were difficult to locate and not always at hand. We noted that the organisation did not have a record of the Chief Nurse' registration with the Nursing and Midwifery Council and were advised that this was because the post-holder was on a secondment from another NHS organisation; this does not remove the requirement of the organisation to ensure that individuals are registered with their relevant professional body.

Public and staff engagement

- In the most recent NHS staff survey, the trust had three questions rated in the top 20%;19 were average and 7 were in rated as being the bottom 20%. A higher proportion of black and ethnic minority staff reported experiencing a form of bullying, abuse or harassment from other staff members.
- The chief executive had held a number of open sessions during which time she was able to meet with staff. It was reported that the chief executive was greeted with hostility during her first engagement with the consultant staff group; the chief executive reported that she had met with the chair of this group and set very clear expectations regarding the behaviours and attitudes she expected from all staff, particularly senior clinicians. The chief executive reported that the second meeting with the same group of individuals had delivered more fruitful discussions which were orientated towards the delivering the necessary improvements at Medway NHS Foundation Trust.

Innovation, improvement and sustainability

- Staff reported working towards constant fire fighting as compared to adopting a pro-active approach to resolving the long standing issues at Medway NHS Foundation Trust. The reliance on temporary staffing had limited the abilities of leaders to invest valuable time in delivering on innovative and improvement initiatives.
- A new clinical model was under consultation at the time of the inspection; it was the vision of the chief executive that a restructure of the organisation was pivotal if the trust was to remain viable for the future.

Overview of ratings

Our ratings for Medway NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate	Inadequate
Medical care	Inadequate	Inadequate	Good	Inadequate	Inadequate	Inadequate
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Critical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate

Our ratings for Medway NHS Foundation Trust

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

Notes

Outstanding practice and areas for improvement

Outstanding practice

The outpatient nursing team demonstrated good clinical leadership, competent staff, forward thinking and planning with regards to capacity issues. They regularly assessed their environment, sought feedback from and worked with patients regularly to improve the patient experience.

The orthotics department demonstrated a patient centred approach. They had been identified by NHS England as a service to benchmark against, because of the waiting times (90% of all patients seen the same day or next day), low cost per patient and clinical evaluation of each product they used.

The maternity team had Team Aurelia, a multidisciplinary team that provided support for women identified in the antenatal period as requiring an elective caesarean section. The team undertook the pre-operative review prior to admission for elective caesarean section. Women were seen by an anaesthetist prior to surgery and an enhanced recovery process was followed to minimise women's hospital stays following surgery.

The hospital play areas for children were very well equipped with a commendable outdoor play area that was well used.

Neonatal intensive care services were considered to still providing care which was of high quality and afforded good outcomes for neonates.

Areas for improvement

Action the trust MUST take to improve

Take immediate action to improve patient flow. This must be achieved without impacting other services provided within the departments and have a risk balanced approach so not to impede on other services delivered.

Review the environment within the emergency department (ED) to meet patient demand effectively.

Take actions to ensure patients are discharged from the critical care unit within four hours of the decision to discharge to improve the access and flow of patients within the critical care services.

Ensure that staffing levels within adult ED meet patient demand.

Ensure that all patient records in ED are accurate to ensure a full chronology of their care has been recorded.

Ensure there is an effective clinical audit plan in place.

Ensure that major incidents arrangements are suitable to ensure patients, staff and the public are adequately protected and that patients were cared for appropriately in the event that a major incident occurred.

Urgently review the two week cancer pathways for each speciality and ensure that there is clinical oversight of those patients waiting in order to mitigate the risks to those patients.

Provide clinical oversight of patients waiting on incomplete pathways to ensure they are seen on a basis of clinical need in accordance with the trust Access Policy.

Review and provide assurance that processes that are in place to ensure that World Health Organisation (WHO) checklists are completed prior to an interventional radiology procedures.

Ensure Trust wide incident reporting processes and investigations are robust, action plans are acted on and systems are in place to ensure that lessons are learned.

Have robust procedures in place to give assurance of the quality of radiology reporting done by external companies.

Address the risks associated with reducing exposure to radiation in the diagnostic imaging departments. This specifically relates to the wooden door frames supporting

Outstanding practice and areas for improvement

the protective lead doors that are cracking under the weight. Although entered on the risk register there were no plans in place to address this potential breach radiation protection regulations.

Ensure that the medical staffing levels in MHDU meet the requirements of the intensive care core standards.

Ensure that MHDU complies with the Department of Health best practice guidance: Health Building Note HBN-04.01.and intensive care core standards.

Ensure that governance and risk management systems reflect current risks and the services improve responsiveness to actions required within the risk register.

Ensure clinical areas are maintained in a clean and hygienic state, and that the monitoring of cleaning standards falls in line with national guidance.

Store confidential patient records securely.

Improve the completion of mandatory training rates.

Ensure there are adequate numbers of nurses on duty at all times to meet its own needs assessment and national guidance.

Review mortality and morbidly in those specialities where outcomes are below national averages to determine if there are any contributing practice considerations to address.

Ensure that all staff understand their responsibilities under the Deprivation of Liberties Safeguards (DoLS) and discharge these in line with legal requirements.

Improve the quality of discharge plans to decrease the number of delayed transfer of care.

Improve the timeliness of responses when managing to formal complaints.

Ensure that governance meetings, including mortality meetings are held as scheduled.

Improve the quality and availability of performance and safety information to all departmental managers and the divisional management team.

Ensure patients undergoing cardiac procedures where they required sedation are treated by appropriately competent staff at all times as outlined in national guidance to minimise the risk to patients.

Ensure clinical oversight of activity provided and ensure appropriate audit trails and quality measurement tools are in place.

Review its current handover practice. This should include a focus on the structure, quality, and format of the actual handovers. It should also review the process to ensure that patients dignity, privacy and Confidentiality is not compromised.

Review the capacity of the safeguarding team and ensure more effective communication and working collaboration from the safeguarding team.

Ensure that local policy and protocol around EOLC are reviewed to ensure they are consistent with national and best practice guidance.

Ensure robust leadership at board and non-executive level to provide an EOLC service as per national guidelines.

Take action to ensure that EOLC patients are not moved in their final hours.

A review of the competency levels of staff responsible for making these decisions should be undertaken and relevant training provided when deficiencies are noted.

A review of the out of hours discharges and frequent bed moves may be useful to identify trends and themes.

Improve the governance, risk and quality management processes in the surgical department.

Review the quality of the senior leadership to ensure efficient, supportive and quality leadership.

Review its current strategy to improve engagement, moral, recruitment and retention. It must also ensure that it reviews the bullying reported to ensure staff welfare.

Approved temperature monitoring devices in ICU and HDUs should be used to demonstrate compliance with recommended temperature ranges and to ensure the quality and integrity of medicinal products is not compromised during storage.

Ensure theatre lists are staffed by appropriately competent staff at all times as outlined in national guidance to minimise the risk to patients.

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Store medicines according to the manufacturer's instructions. Ensure that inappropriate medicines are not stored in ward areas. Ensure it complies with FP10 tracking as dictated by national guidance.

Ensure that IV morphine is not being administered in inappropriate opiate clinical areas by staff that may not be competent to deal with the side effects.

Produce a critical medicines list to comply with NPSA/2010/RRR009. Improve mandatory training compliance rates.

Ensure fridges and Medication storage temperatures are recorded in line with national guidance and best practice.

Ensure staff follow trust policy for the administration of anticipatory medication for EoLC patients.

Medicines in adult ED must always be stored in accordance with trust policy.

Manage allegations of bullying and whistleblowing, and performance management in line with agreed policies. The trust must also ensure it is meeting its duty of care toward staff who are under the care of Occupational Health.