

East Kent Hospitals University NHS Foundation Trust Kent & Canterbury Hospital

Quality Report

Kent and Canterbury Hospital
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and unannounced 21st September 2016
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement	
Urgent and emergency services	Good	
Medical care (including older people's care)	Requires improvement	
Maternity and gynaecology	Not sufficient evidence to rate	
End of life care	Requires improvement	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Kent and Canterbury Hospital (K&C) is one of five hospitals that form part of East Kent University Hospitals NHS Foundation Trust (EKUFT). EKUHFT provides local services primarily for the people

living in Kent. The Trust serves a population of approximately 759,000 and employs approximately 6,779 whole time equivalent staff.

The Kent and Canterbury Hospital is an acute hospital providing a range of elective and emergency services including an Urgent care (UCC). This hospital provides a central base for many specialist services in East Kent such as renal, vascular, interventional radiology, urology, dermatology, neurology and haemophilia services.

We carried out an announced inspection between 5th and 7th September 2016, and an unannounced inspection on 21st September 2016.

This is the third inspection of this hospital. This inspection was specifically designed to test the requirement for the continued application of special measures to the trust. Prior to inspection we risk assessed all services provided by the trust using national and local data and intelligence we received from a number of sources. That assessment has led us to include four services (emergency care, medical services, maternity and gynaecology and end of life care) in this inspection.

We rated The Kent and Canterbury Hospital as Requires Improvement overall

Safe

We rated The Kent and Canterbury Hospital as Requiring improvement for safe because:

- There was a shortage of junior grade doctors and consultants across the medical services at the hospital. This meant that consultants and junior staff were under pressure to deliver a safe and effective service, particularly out of hours and at night.
- The trust did not use a recognised acuity tool to assess the number of staff needed on a day-to-day-basis.
- We found poor records management in some areas. Staff did not always complete care records according to the best practice guidance
- We found there were nursing shortages across the hospital.
- The trust did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance.

However

- Staff reported incidents and adverse events that were investigated through robust quality and clinical governance systems. Lessons arising from these events were learned and improvements had been made when needed.
- Staff followed cleanliness and infection control procedures. Potential infection risks during the building works were anticipated and appropriate responses implemented and measured

Summary of findings

Effective

We rated The Kent and Canterbury Hospital as Requiring improvement for effective because:

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

However

- We saw good examples of multidisciplinary working between doctors, nurses, ENPs and other healthcare professionals, including colleagues from the other emergency departments.
- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Comfort rounds had been performed and audited. These provided good assurance that pain assessments had been performed, analgesia administered.

Caring

We rated The Kent and Canterbury Hospital as Good for caring because:

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

Responsive

We rated The Kent and Canterbury Hospital as Requiring improvement for responsive because:

- Patients' access to prompt care and treatment was worse than the England average for a number of specialities. The trust had not met the 62-day cancer referral to treatment time since December 2014. Referral to treatment within 18 weeks was below the 90% standard as set out in the NHS Constitution and England average for six of the eight specialties from June 2015 to May 2016.
- We found the hospital was not offering a full seven-day service. Constraints with capacity and staffing limited the responsiveness and effectiveness of the service the hospital was able to offer.
- Admission criteria for the UCC appears to be an ongoing issue of confusion to some parts of the local community, as evidenced by inappropriate 'walk in' patients arriving at the department.

However

Summary of findings

- There was an average of 17 60-minute breaches in ambulance handover times per month over the last four months. This represented 2.2% of the total number of patient handovers and was better than the regional average of 3%.
- The trust employed specialist nurses to support the ward staff. This included dementia nurses and learning difficulty link nurses who provided support, training and had developed resource files for staff to reference. Wards also had 'champions' who acted as additional resources to promote best practice.

Well led

We rated The Kent and Canterbury Hospital as Requiring improvement for well led because:

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

However

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

We saw several areas of outstanding practice including:

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

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

Importantly, the trust must:

- Ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times. This includes medical, nursing and therapy staff.
- Have systems established to ensure that there are accurate, complete and contemporaneous records kept and held securely in respect of each patient.
- Ensure that all staff have attended mandatory training and address gaps in training records that make it difficult to determine if training meets hospital policy requirements.
- Ensure generalist nurses caring for end of life patients undergo training in end of life care and the use of end of life care documentation.

Summary of findings

- Take steps to ensure the 62-day referral to treatment times for cancer patients is addressed so patients are treated in a timely manner and their outcomes are improved.
- Ensure that patient's dignity, respect and confidentiality are maintained at all times in all areas and wards.
- Ensure the trust's agreed audit programme is completed and where audits identify deficiencies that clear action plans are developed that are subsequently managed within the trust governance framework. To have assurance that best practice is being followed.

Action the hospital should take to improve

- Ensure the administration of pain relief medication is provided to patients in a timely manner in the urgent care unit and minor injury unit.

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

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Good



Why have we given this rating?

We rated this service as Good because:

- Staff reported incidents and adverse events that were investigated through robust quality and clinical governance systems. Lessons arising from these events were learned and improvements had been made when needed.
- Staff followed cleanliness and infection control procedures. Potential infection risks during the building works were anticipated and appropriate responses implemented and measured.
- Care pathways, policies and guidance were readily available to staff through the trust's intranet. The care delivered was measured through national audits to improve quality and patient outcomes.
- Patients told us they were treated with dignity and respect. People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.
- The trust had clear vision and strategy for improvement, which engaged staff. Staff engagement was reflected in the developing strategy for emergency services where clinicians, staff and patients' opinions were taken into consideration. Trust managers were candid about the improvement challenges and involved all staff in moving action plans forward.
- There was an average of 17 60-minute breaches in ambulance handover times per month over the last four months. This represented 2.2% of the total number of patient handovers and was better than the regional average of 3%.

Summary of findings

However,

- There were gaps in mandatory and additional training records that made it difficult to determine if training met policy requirements. Appraisal rates were worse than the other locations we inspected and the number of staff who had completed training in major incidents; safeguarding, consent and the Mental Capacity Act were low.
- We saw delays in the administration of pain relief medication.
- At our last inspection, we saw adult patients being seen in the paediatric treatment area. This practice was still happening.
- Reception and initial screening processes had improved and we saw that building works were underway to help address issues such as patient flow and safer, more dignified care. Delays had occurred that were beyond the control of the trust, but it meant that we could not fully evaluate the results of the new layout and anticipated improvements.
- Resuscitation trolleys were not always checked daily, which raised the risk that they would not be fully operational for immediate use and an outdated copy of the British National Formulary (BNF) from 2014-15 was near the paediatric resuscitation trolley. An out-of-date BNF had been found in the department at our last inspection.
- Although building work was underway to enhance the layout, the department still had challenges related to security of access, adults being treated in child cubicles and minimal child friendly décor.
- Admission criteria for the UCC appears to be an ongoing issue of confusion to some parts of the local community, as evidenced by inappropriate 'walk in' patients arriving at the department.

Summary of findings

While some aspects may remain outside the trust's influence and control, improved signposting and information should be made available to the public. For instance, signage at the location varied from 'emergency care' to 'accident centre' and terms used on public websites such as 'A&E' and 'urgent care centre'.

At our last inspection, we rated the service as requires improvement. On this inspection we have given a rating of good because we saw improvements in local innovation, staff engagement, staff recruitment, updated systems, policies and procedures and improved governance.

Medical care (including older people's care)

Requires improvement



We found the medical services at the hospital required improvement because;

- Although the trust had recruited overseas nurses, there remained staffing shortages on the wards. On medical wards staffing numbers have been increased and the trust monitors safe staffing levels. However, there was a lack clarity amongst staff about the acuity based tool (to assess appropriate staffing for the complexity of patients cared for) and leaves staff convinced that there is still insufficient staff on duty for many shifts.
- There was insufficient numbers of junior grade doctors and consultants across medical services at Kent and Canterbury Hospital. This meant consultants and junior staff were under pressure to deliver a safe and effective service, particularly out of hours and at night.
- Staff did not always complete care records in accordance with best practice guidance from the Royal Colleges. We found gaps and omissions in the sample of records we reviewed.

Summary of findings

The trust did not have a robust system in place to audit, monitor and review care records to ensure they always gave a complete picture of the assessments and interventions undertaken.

- The trust did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance.
- The trust had not completed its audit programme. The hospital performed poorly in a number of national audits such as the stroke and diabetes services.
- We found the hospital was not offering a full seven-day service. Constraints with capacity and staffing limited the responsiveness and effectiveness of the service the hospital was able to offer.
- Patients' access to prompt care and treatment was worse than the England average for a number of specialities. Waiting times are set out in the NHS Constitution; in addition, there are waiting times performance targets measures, which are monitored by NHS England.
- The trust was not meeting the 62-day cancer referral to treatment time since December 2014. Referral to treatment within 18 weeks was below the 90% national standard and the England average for six of the eight specialties from June 2015 to May 2016.
- Although the trust had put measures in place to promote positive behaviour and eliminate bullying, staff still reported incidents of inappropriate behaviour from colleagues.

However;

- The trust had a robust system for managing untoward incidents. Staff

Summary of findings

were encouraged to report incidents and there were processes in place to investigate and learn from adverse events. The hospital measured and monitored incidents and avoidable patient harm and used the information to inform priorities and develop strategies for reducing harm.

- Management prioritised staff training, which meant staff had timely access to training in order to provide safe care and treatment for patients.
- There were systems in place to maintain a clean and therapeutic environment. Staff effectively managed infection control and appropriately maintained the environment.
- Medical care was evidence based and adhered to national and best practice guidance. Management routinely monitored that care was of good quality and adhered to national guidance to improve quality and patient outcomes.
- Patients were supported through consultant led care and effective delivery of care through multidisciplinary teams and specialists. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- Overall Staff treated patients with kindness and compassion.
- The trust had plans in place to ensure that medical services across the county were sustainable and fit for purpose. The trust was engaging with all stakeholders to implement any changes. The trust had taken action to address the delays to the patient pathway, such as rapid access clinics, rapid discharge team and outsourcing diagnostic investigations.
- Staff provided good provision of care for patients living with dementia and patients' different needs were taken

Summary of findings

into account. Staff admitted the majority of patients to the correct bed for their speciality and did not move beds or wards for the entirety of their stay.

- The trust had a clear corporate vision and strategy. The trust reflected staff engagement when developing the strategy for medical services. Clinicians, staff and stakeholders' opinions were taken into consideration.
- The trust had clearly defined local and trust wide governance systems. There was well-established ward to board governance, with cross directorate working, developing standard practices and promoting effective leadership.
- The trust acknowledged they were on an improvement journey and involved all staff in moving the action plan forward. Staff felt engaged with the direction of the trust and took pride in the progress they had made to date.

At our last inspection, we rated the service as requires improvement. On this inspection we have maintained a rating of requires improvement but have seen improvements in incident reporting, staff training, infection control, staff engagement and ward to board governance.

Maternity and gynaecology

Not sufficient evidence to rate



We have also included our findings of the services at Kent and Canterbury Hospital in the William Harvey Hospital location report due to the limited number of maternity services at this location. Births do not take place at Kent and Canterbury Hospital with mothers going to either the William Harvey Hospital in Ashford, or the Queen Elizabeth the Queen Mother Hospital in Margate. Kent and Canterbury Hospital has a midwife led unit providing pre and postnatal services including education classes and breast feeding support.

Summary of findings

End of life care

Requires improvement



We have given Safe a rating of Requires Improvement because:

- Staff understood their responsibilities to raise and report concerns, incidents and near misses. They were clear about how to report incidents and we saw evidence that learning was shared across the teams. However, the IT system was slow with some staff suggesting not all incidents were reported because of this. This has not improved since the last inspection.
- Generally, we found out of date syringe driver prescription charts were no longer in use.
- A greater proportion of patients were identified as dying however; we found the decision often left staff confused as active treatments were still being delivered. Experienced staff were able to question clinical practice however, more junior staff would not.
- End of life training of the generalist staff was patchy, and many had received no training around the use of end of life care documentation. There was a gap in the skills set of the generalist staff delivering end of life care. This gap will continue to exist until the link nurse are fully training and performing their new support roles. Staff still found accessing the training modules difficult.
- No 7 day face to face access to the SPC team was available which meant that processes out of hours was often difficult, and time consuming which could delay treatment times for patients.
- Nursing records were poorly completed which meant it was unclear if patients were being reviewed regularly in line with national guidance.

However :

- We found portering training had improved since the last inspection. Porter's received training around new trust policies.

Summary of findings

- We were able to view the training records on the wards of the syringe driver's competency programme. This programme had been introduced since the last inspection.

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

Kent & Canterbury Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); End of life care;

Detailed findings

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Background to Kent & Canterbury Hospital

The Kent and Canterbury Hospital (K&C) is one of five hospitals that form part of East Kent University Hospitals NHS Foundation Trust (EKUFT). EKUFT provides local services primarily for the people

living in Kent. The Trust serves a population of approximately 759,000 and employs approximately 6,779 whole time equivalent staff.

The Kent and Canterbury Hospital is a 287 bedded acute hospital providing a range of elective and emergency services including an Urgent care (UCC). This hospital provides a central base for many specialist services in East Kent such as renal, vascular, interventional radiology, urology, dermatology, neurology and haemophilia services.

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

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

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

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

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

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

with care or patient experience).

How

Detailed findings

How we carried out this inspection

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

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

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

life care) in this inspection. The remaining services were not inspected as they had indicated strong improvement

at our last inspection and our information review indicated that the level of service seen at our last inspection had been sustained. Before our inspection, we reviewed a range of

information we held and asked other organisations to share what they knew about the hospital. These

organisations included the clinical commissioning groups, Monitor, Health Education England, General

Medical Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

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

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

members of hospital staff.

Facts and data about this tru

Facts and data about Kent & Canterbury Hospital

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

better than the England average. Deprivation is lower than average, however about 17.6% (48,300) children live in poverty. Life expectancy for both men and women is higher than the England average.

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

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

Our ratings for this hospital



Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Requires improvement	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Maternity and gynaecology	N/A	N/A	N/A	N/A	N/A	Not rated
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

Kent and Canterbury Hospital is one of five hospitals operated by East Kent University Hospitals NHS Foundation Trust (EKHUFT) to provide urgent and emergency services to the local community. The urgent and long-term conditions directorate is responsible to the trust board for the management of these services.

The hospital has an Urgent Care Centre (UCC), which includes a nurse-led Minor Injuries Unit (MIU) dealing with medical emergencies and minor injuries for adults 24 hours a day. The UCC accepts children of all ages between 9am to 4pm Mondays to Fridays and the MIU sees children over the age of one. About 121 patients a day attend the service, of whom 99.8% are aged 17 or over. Roughly half this number are seen at the UCC and half in the MIU.

On our previous inspection, we found the services required improvement. We had concerns about reception processes and flow of patients through the department. After-hours consultant medical cover was low and aspects of the environment did not facilitate safe or dignified care. Staff focused on providing a caring experience but there were gaps in training, audits and a number of clinical guidelines and policies were out of date. Some decisions taken at a senior level did not appear to relate to the experience of frontline staff. Since then, the trust has new chief executive and received support from NHS Improvement including the emergency care improvement programme (ECIP).

We conducted this inspection to follow up on these issues and assess the progress of the trust against the action plans that were in place. The inspection took place over three days, 5 – 7 September 2016. We visited the ECC on two separate occasions. We spoke with three patients, one relative and several staff, who included doctors, nurse practitioners and registered nurses, managers, ambulance crews, health care assistants and administrative staff. We reviewed documentary information supplied prior to our visit and provided on request during the inspection. In addition, we took into account feedback from focus groups and written communications from stakeholders. During our visit, we made observations of activity levels, staff interaction with patients and their relatives and made checks on the environment and equipment used. We reviewed three sets of patient records and we looked at policy documents, audit reports, staff training and appraisal records.

Urgent and emergency services

Summary of findings

We rated this service as Good because:

- Staff reported incidents and adverse events that were investigated through robust quality and clinical governance systems. Lessons arising from these events were learned and improvements had been made when needed.
- Staff followed cleanliness and infection control procedures. Potential infection risks during the building works were anticipated and appropriate responses implemented and measured.
- Care pathways, policies and guidance were readily available to staff through the trust's intranet. The care delivered was measured through national audits to improve quality and patient outcomes.
- Patients told us they were treated with dignity and respect. People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.
- The trust had clear vision and strategy for improvement, which engaged staff. Staff engagement was reflected in the developing strategy for emergency services where clinicians, staff and patients' opinions were taken into consideration. Trust managers were candid about the improvement challenges and involved all staff in moving action plans forward.
- There was an average of 17 60-minute breaches in ambulance handover times per month over the last four months. This represented 2.2% of the total number of patient handovers and was better than the regional average of 3%.

However,

- There were gaps in mandatory and additional training records that made it difficult to determine if training met policy requirements. Appraisal rates were worse than the other locations we inspected and the number of staff who had completed training in major incidents; safeguarding, consent and the Mental Capacity Act were low.
- We saw delays in the administration of pain relief medication.

- At our last inspection, we saw adult patients being seen in the paediatric treatment area. This practice was still happening.
- Reception and initial screening processes had improved and we saw that building works were underway to help address issues such as patient flow and safer, more dignified care. Delays had occurred that were beyond the control of the trust, but it meant that we could not fully evaluate the results of the new layout and anticipated improvements.
- Resuscitation trolleys were not always checked daily, which raised the risk that they would not be fully operational for immediate use and an outdated copy of the British National Formulary (BNF) from 2014-15 was near the paediatric resuscitation trolley. An out-of-date BNF had been found in the department at our last inspection.
- Although building work was underway to enhance the layout, the department still had challenges related to security of access, adults being treated in child cubicles and minimal child friendly décor.
- Admission criteria for the UCC appears to be an on-going issue of confusion to some parts of the local community, as evidenced by inappropriate 'walk in' patients arriving at the department. While some aspects may remain outside the trust's influence and control, improved signposting and information should be made available to the public. For instance, signage at the location varied from 'emergency care' to 'accident centre' and terms used on public websites such as 'A&E' and 'urgent care centre'.

At our last inspection, we rated the service as requires improvement. On this inspection we have given a rating of good because we saw improvements in local innovation, staff engagement, staff recruitment, updated systems, policies and procedures and improved governance.

Urgent and emergency services

Are urgent and emergency services safe?

Good



We rated Safe as Good because:

- There was good Infection control despite building work being carried out and the mental health crisis room identified at our last inspection as inappropriate was no longer in use.
- The Patient Led Assessments of the Care Environment (PLACE) for 2016 showed an 8.8% improvement since our last inspection and was 5.8% better than the England average of 93%.
- Waste and sharps disposal was managed in accordance with national guidance and medical equipment was well maintained and regularly checked.
- There were safe systems for ordering, storage and the administration of medicines and audits showed the department complied with the current trust policy. We saw clear policies and processes for the storage, recording and disposal of controlled drugs.
- Medical records were well documented, dated and signed and each patient had the appropriate care pathway documented. Patient personal information and staff records were managed securely, in line with the Data Protection Act.
- We saw examples of the new screening management and reporting tool (SMART Plus) in use, which identified high-risk vulnerable adults. This had been rolled out across the trust in conjunction with a revised policy (People at Risk, December 2015), along with improved access to flow charts and forms on the 'Staff Zone' hospital intranet.
- Mandatory training had improved across the whole directorate since our last inspection. Results were close to or above the trust target of 85%, with the exception of Deprivation of Liberty standards at 33% and Mental Capacity Act training at 26%.
- Since our last inspection a new Emergency Planning Policy had been which included a new online major incident awareness package as part of mandatory training. The policy provided assurance that frameworks existed that supported a high level of preparedness to any business-disrupting event or major incident.

- There was no trained specialist sick children's nurse in the UCC but all nurse practitioners had received paediatric life support training and clinical scenarios were conducted every two months to ensure staff responded appropriately to emergencies.
- There were enough staff on duty to meet care needs and rosters showed that planned staffing levels matched actual numbers present.
- There were improvements in the way incidents and complaints are reported, lessons learned and changes made when needed.
- There was an average of 17 60-minute breaches in ambulance handover times per month over the last four months. This represented 2.2% of the total number of patient handovers and was better than the regional average of 3%.

However,

- In our last inspection, one of the paediatric cubicles was being used to treat an adult. We observed the same happening during this inspection.
- Resuscitation trolleys were not always checked daily, which raised the risk that they would not be fully operational for immediate use and an outdated copy of the British National Formulary (BNF) from 2014-15 was near the paediatric resuscitation trolley. An out-of-date BNF had been found in the department at our last inspection.
- We saw an unlocked door leading into the department from the waiting room. It was fitted with a swipe card access point, but this did not function. This increased the risk that unauthorised persons could gain access to the department.

On this inspection we have changed the rating to good, because we have seen improvements in the management of patients with mental health needs, assessments and improvements of the care environment, identifying high risk adults, training, preparedness for major incidents and incident reporting:

Incidents

- Staff reported incidents on an electronic reporting system and confirmed they felt more confident about using the system. We saw meeting minutes that showed staff discussed incidents and shared lessons learned. In addition, we saw a copy of the trust's clinical safety newsletter called 'Risk Wise' (Summer 2016) which

Urgent and emergency services

detailed case studies along with advice and guidance. This included information on how staff could access an electronic system that automatically sent email safety alerts to their mobile phones.

- There were no never events and 10 serious incidents (SI) reported across the directorate between July 2015 and June 2016. None of the serious incidents related to the UCC at Kent and Canterbury. Never events are serious, largely preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of never events or a pattern of SIs could indicate unsafe practice.
- The Duty of Candour (DoC) requires healthcare providers to disclose safety incidents that result in moderate or severe harm or death to patients or any other relevant person. Staff spoken with demonstrated a clear understanding of their duty under this legislation.
- We saw copies of the directorate clinical governance meetings minutes for January, March and May 2016. They stated that due to operational demands, the meetings in February and April were cancelled. We saw that mortality and morbidity summaries were missing from the minutes. This omission was identified by the trust.

Cleanliness, infection control and hygiene

- We observed building works underway at the location. Access was controlled and temporary walls and solid doorways effectively partitioned off the worksite from the rest of the department. We did not see any ingress of dust or dirt into the clinical areas. Overall, the areas we visited appeared tidy and clean which meant the staff had maintained good infection control practice despite the disruption.
- There were no reported cases of MRSA, Clostridium difficile (C. diff) or Escherichia coli (E. coli) in the period April 2015 – March 2016. These serious infections have the potential to cause harm.
- Flooring was seamless, smooth, slip-resistant and provided with an easy clean finish. This complied with Health Building Note (HBN) 00-09: Infection control in the built environment (Department of Health, March 2013).
- Disposable curtains fitted on rails between bays and cubicles were labelled, showing the date they had been

changed in accordance with HBN 00-09. Frequently changed disposable curtains helped to reduce the chances of germs passing from one person or object to another.

- Medical equipment and trolleys were visibly clean throughout the department, which indicated that staff followed good cleaning practice.
- The department's decontamination of toys checklist in the paediatric cubicle showed that staff had cleaned toys daily.
- We saw wall mounted dispensers for aprons and gloves and hand-sanitising gel at strategic points. Posters were displayed nearby which explained hand washing technique in line with World Health Organisation guidance.
- All clinical areas had hand washbasins that complied with Health Building Note (00-10 (2013): Part C – Sanitary assemblies).
- We also saw recent examples of completed infection control audits showing 88% compliance. This compared with the trust average of 87% and indicated that staff were following trust policy and procedures.
- The most recent 'Bare below the elbows' audit showed 100% compliance by support staff, 99% for nurses and 92% for medical staff. While on inspection we saw that staff followed bare below the elbows policy.
- The Patient Led Assessment of the Care Environment (PLACE) audit for 2016 showed the department scored 98.8% for cleanliness, which was just better than the England average of 98%.
- All single-use items we saw were in date. Storage and stock rotation ensured the sterility of items was maintained and risks of cross contamination was reduced.
- Waste was separated into different coloured containers to show the different categories of waste ready for disposal in accordance with the Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health (COSHH) and health and safety at work regulations.
- Secure sharps bins were available in treatment areas and used in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The bin labels included clear instructions for staff on safe disposal.

Environment and equipment

Urgent and emergency services

- There were two entrances to the department. One automatic door led from the ambulance bay to the UCC and another entrance accessed the waiting room leading to the MIU and GP service.
- Building works were in progress to create a single entrance with enhanced facilities designed to improve patient access and flow into the department. This included a new reception area, assessment rooms, separate waiting room for children and their parents and a paediatric resuscitation area. Managers had contributed to this design. Purpose-built equipment was ready for installation.
- The previous building contractor had ceased trading during the project, which had delayed completion. New builders were on site and work had recommenced.
- The unit currently comprised of a resuscitation area with space for four trolleys, a central nursing and medical station, a 'minors' area with four bays that included one fitted with plastering equipment. There were an additional four paediatric cubicles leading to the MIU. There was also an eye examination cubicle and storage spaces. There was an external GP service, all of which were accessed via a waiting room with reception area.
- The mental health crisis room identified at our last inspection was no longer in use. An office is temporarily used, but patients were never in there alone. Staff explained that patients were 'specialised' by a mental health nurse and a nurse from the UCC. A new mental health crisis room is currently under construction designed specifically to meet NICE guidelines.
- On our last inspection, one of the paediatric cubicles was being used to treat an adult. We observed the same happening during this visit. Staff assured us that this was a rare event, but it resulted in this cubicle not being available when needed and also meant children could see and hear adults injured or in distress.
- We saw environmental audit results for the area (March 2016) that showed 91% compliance for the UCC and 94% for the MIU. These results were a significant improvement compared to the previous year (64% and 88%).
- The Patient Led Assessments of the Care Environment (PLACE) for 2016 showed the hospital scored 98.8% for the condition, appearance and maintenance, which is another improvement on last year (90%) and better than the England average of 93%.
- The bays and cubicles were visibly clean and free from clutter with partitions and curtains to help ensure privacy.
- None of the staff we spoke with had concerns about equipment availability and if anything required repair it was fixed. We saw a facilities folder mounted on the wall, which contained a 'repairs log' and clear instructions on how to contact the on-call repairs team at the hospital.
- Patient trolleys and couches, furniture and equipment were labelled with asset numbers and service or calibration dates. This helped to provide assurance that items were maintained in accordance with manufacturer recommendations.
- The Medicines and Healthcare Products Regulatory Agency's Managing Medical Devices (April 2015) states that healthcare organisations should risk assess to ensure that the safety checks carried out on portable electrical equipment are appropriate and reasonably practical. These include pre-use testing of new devices in addition to subsequent maintenance tests. We checked several devices in each of the areas we visited. These devices were labelled with the dates of the most recent electrical testing, which indicated to staff that the devices were safe to use.
- There were a resuscitation trolley in the resuscitation area and by the paediatric cubicles. Both trolleys were locked. Records showed the trolleys were not always checked daily, which raised the risk that they would not be operational for immediate use. The automatic electrical defibrillator and suction equipment were in working order.
- There is a single security guard present in the hospital at all times. Some staff had concerns that a single guard was insufficient to respond to incidents. However, there had been no security incidents reported for this location.
- We saw an unlocked door leading into the department from the waiting room. It was fitted with a swipe card point next to the door, but this did not function. This increased the risk that unauthorised persons could gain access to the department.

Medicines

Urgent and emergency services

- The department had safe systems for ordering, storage and the administration of medicines. Local and organisation-wide audits were completed which showed the department complied with the current policy.
- Storage and record keeping of controlled drugs was consistent with the Misuse of Drugs Regulations, 2001. There was a clear process to order controlled drugs and making entries in the register for the administration of CD on the unit had a secondary signatory. This complied with legal and regulatory standards including Nursing and Midwifery Council (NMC) Standards for Medicines Management.
- There was evidence of daily controlled drugs stock checks in the UCC controlled drug register. Staff we spoke to were familiar with policies regarding the safe destruction of controlled drugs.
- Medicines requiring storage in a temperature-controlled environment were held in designated and lockable drug fridges. These incorporated digital thermometers that allowed temperatures to be monitored. Daily checks were recorded on a standardised form. Staff could describe the process of dealing with out of range temperatures and showed us the policy explaining the process, which included reporting it as an incident on the electronic reporting system.
- We found an outdated copy of the British National Formulary (BNF) from 2014-15 near the paediatric resuscitation trolley. While staff had access to an online formulary, retaining old books increased the risk that prescribers used out of date information. An out of date BNF had been found in another area of the department at our last.

Records

- We saw the medical records of three patients. The records were tidy with no loose filing, legible, dated and signed. Each patient had the appropriate care pathway documented.
- The department used a combination of electronic records and paper files. We saw patient personal information and staff records managed safely and securely, in line with the Data Protection Act. When not in use, patients' notes were kept in a locked trolley.
- MIU staff audited one another's records on a monthly basis to ensure they were fully completed and up to date.

Safeguarding

- The trust's adult safeguarding team is called the people at risk team (PART). We saw the annual PART report confirming that no safeguarding allegations were made against the UCC last year.
- We saw examples of the new screening management and reporting tool (SMART Plus) which is a form used by staff to identify high-risk vulnerable adults. This had been rolled out across the trust in conjunction with a revised policy (People at Risk, December 2015) and improved access to flow charts and forms on the 'Staff Zone' hospital intranet.
- The trust reported a particular challenge due to problems with the learning and development tracking system. After a delay of over a year, figures obtained in May 2016 showed all areas were below the target of 85%. According to the trust, the urgent and long-term conditions directorate achieved 61% for level 1 training and 56% for level 2, which was slightly better than the trust average of 47%.
- The figures were much better children's safeguarding training. 87% of staff had received children's training this year and the figure had improved since our last inspection. Staff had safeguarding training at the appropriate levels for their roles and all we spoke with were alert to any potential issues with adults or children.

Mandatory training

- Reporting of mandatory training was not included in the Clinical Governance minutes. This meant that managers and senior staff could not assure themselves that concerns had been consistently identified or addressed.
- With the exception of safeguarding courses that were classroom based, mandatory training was completed and recorded on the trust intranet. Staff maintained individual electronic staff records and their managers had authority to access the record to monitor compliance. Staff told us there were issues with ensuring the electronic record was current but it was better than the previous system.
- The figures achieved had improved across the whole directorate since our last visit. Most of the results were close to or above the trust target of 85%. Compliance with mandatory training for the UCC was as follows:
 - Fire training 87%
 - Moving and handling training 100%

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- Health and Safety training 100%
- Infection control prevention 100%
- Equality and Diversity 100%
- Safeguarding children 100%
- Safeguarding adults 46% (band 6 and 7), 34% (band 5) and 31% (health care assistants)
- Information governance 80%
- DoLs 33%
- MCA 26%

Assessing and responding to patient risk

- There was an average of 17 60-minute breaches in ambulance handover times per month over the last four months. This represented 2.2% of the total number of patient handovers and was better than the regional average of 3%.
- There was an agreement with the local ambulance service about the criteria used to decide which patients were brought to the UCC. We saw copies of the admissions criteria document dated May 2016 (version 2) on display in the unit.
- One of the three ambulance crew we spoke with had some confusion about what cases the UCC could see and what had to be redirected to Queen Elizabeth Queen Mother Hospital or William Harvey Hospital. However, we found that the ambulance service phoned ahead to have discussion with a clinician about suitability of patients. If a patient arrived and was found not to be suitable they would be treated (stabilised) and transferred to the appropriate A&E. This decision was discussed with clinicians and the Bronze commander of the local ambulance service.
- Local residents still arrived at the UCC with broken limbs and conditions such as alcohol toxicity. The trust worked to clarify this by the use of posters and leaflets in reception and information published on the hospital website.
- The trust had developed a protocol called 'Urgent Care Centre (Minor Injuries stream and Minor Illness Stream) and Acute Medical Unit - The Patient Journey', which specified care pathways for different categories of patients arriving at reception.
- The hospital used the National Early Warning Score (NEWS) and escalation flow charts to identify patients whose condition was, or was at risk of, deteriorating. NEWS is a simple scoring system for physiological measurements, such as blood pressure and pulse, for patient monitoring.
- Observation of records showed NEWS scores were correctly calculated at the required frequency. We also noted the use of paediatric early warning scores (PEWS) in the unit. This meant that children attending the unit were being assessed using a national warning score tool so that any deterioration in their condition would be rapidly detected.
- Mental health and other vulnerable patients were risk assessed using the SMART Plus tool and their condition graded as red, amber, yellow or green. This then stipulated what actions would be taken next. Staff explained that anyone graded amber or above had a nurse allocated to them for supervision purposes. We did not see any patients requiring this level of support at the time of our visit.
- According to the Standards for Children and Young People in Emergency Care Settings (Royal College of Paediatrics and Child Health, 2012), where nurses work autonomously to see and treat patients (ENPs) these nurses should undergo an assessment of competencies in the anatomical, physiological and psychological differences of children. We saw that all nurse practitioners had received paediatric life support training and noted that one child in the previous 18 months had come to the department requiring resus and they were brought in by the parents.

Nursing staffing

- According to trust data, the nursing establishment for UCC nurses was 54.79 whole time equivalent (WTE). There were four vacant posts, which represented eight per cent of the workforce. Bank and agency staff were employed to make up any shortfall in numbers and according to data supplied this averaged 6.8% last year, which was better (lower) than the other two locations we inspected. Health care assistants (HCAs) were "up to establishment" according to the matron.
- Managers explained that no national staffing tools existed for use in the UCC. The directorate had undertaken staffing reviews taking account of the RCN baseline emergency staffing tool and NICE guidance. Staffing calculations also took into account patient acuity (the severity of their illness and care needs) which were measured using the patient's NEWS scores. These meant managers could identify and respond by allocating staff from other areas of the hospital.

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- At the time of our inspection, we observed enough staff on duty to meet care needs and on reviewing rosters for the last month saw that planned staffing levels matched actual numbers present.
- The MIU nursing establishment was 17.70 WTE and we saw that three emergency nurse practitioners (ENP) worked in the department during the day and one at night, assisted by a health care assistant (HCA).
- We saw trust reports showing that staff turnover for the department averaged 13% from March to June 2016. Sickness absence had increased to 4.07%, although this was lower than other parts of the trust.
- The trust had taken positive action to recruit and retain staff. The recruitment strategy included investment in advertising, social media and recruitment agencies both here and in Europe. Staff told us there were signs of improvement. For example, one nurse felt “positive about the changes” and said “progress was being made”

Medical staffing

- Managers told us that eight ED specialty doctors had recently accepted offers of employment trust wide and another four were “under negotiation”. The consultant establishment for the UCC is two. When at full establishment, consultant level cover was provided from 08:00 – 20:00 seven days a week and a consultant was on-call outside these hours.
- However, one consultant was on sick leave and another position was vacant. Other specialists covered the department and the staff reported they have had no issues with requesting help from those consultants.
- Junior and middle grade doctors provided cover 24 hours, seven days a week. One doctor described a “punishing” rota with frequent late finishes and early starts over the last few weeks, compromising adequate rest breaks between shifts. When we checked rosters for the last few weeks, we did not see a consistent pattern or practice in this department or the other locations in the directorate.
- The medical staffing skill mix showed the trust has a higher percentage of junior grade staff but the percentage of consultants is lower when compared to the England average. Across the trust, 20% of medical staff were consultants compared to the England average of 26%, 17% were 'middle career' compared to 15% in England and 63% were registrar or below compared to 41% in the rest of the country.

- Locum cover for the UCC averaged 31% for the past year, although this was not as high as QEQM (42%) or WHH (36%).

Major incident awareness and training

- Since our last inspection, a new Emergency Planning Policy was introduced by the trust (January 2016). This included a new ‘major incident awareness package’ added to the mandatory training list.
- In addition, annual ‘table top exercises’ commenced along with a requirement for selected emergency staff to update their training and competence every year. Managers told us that training was monitored and provided by the trust’s emergency planning team and staff described participating in scenario-based training events.
- According to trust figures for May 2016, 56% of ‘target staff’ at the UCC had either received the DVD-based awareness training or completed the classroom-based course. This was better than QEQM (44%) but worse than WHH (79%). The trust average was 62% and the trust target of 100%.
- The policy provided assurance that frameworks existed within the trust that supported a high level of preparedness to any business-disrupting event or major incident, regardless of source. Staff were made aware of the trust’s major incident plan, which was published on the trust’s intranet.
- Clinical scenarios also practiced included resuscitation of children conducted in the department every two months by the trust’s resuscitation training officers to help ensure staff responded appropriately to emergencies.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement 

We rated Effective as requires improvement.

- Staff followed established patient pathways and national guidance for care and treatment. However, they did not always complete pain assessments. This meant patients sometimes experienced a delay in pain relief.

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- Documents and records supporting the learning needs of staff were not always completed and there were gaps in the records of training achieved. Training compliance on consent and the Mental Capacity Act 2005 (MCA) was low across the directorate.
- Reported appraisal rates were worse than the trust target and other locations.
- Trust wide auditing had improved since our last visit, although action plans were not always submitted in a timely manner, fully implemented or communicated widely throughout the department. This meant the department did not have full assurance that best practice was being followed or that problems were being identified and responded to.

However,

- We saw good examples of multidisciplinary working between doctors, nurses, ENPs and other healthcare professionals, including colleagues from the other emergency departments.
- We found that care pathways, policies and guidance were readily available to staff through the trust's intranet. The care delivered was measured through national audits to improve quality and patient outcomes.

On this inspection we have maintained the rating of requires improvement, because improvements are still needed in completion of pain assessments, MCA training and completion of appraisals.

Evidence-based care and treatment

- The trust provided staff with intranet access to a range of care pathways that complied with the national institute for health and care excellence (NICE) and royal college of emergency medicine (RCEM) clinical standards.
- We saw evidence of recent updates and research references contained in the documents that showed these were current and based on best practice. Pathways were audited trust-wide.

Pain relief

- In the last CQC A&E survey, for the questions "staff did everything they could to help control your pain" 77% of

patients said they did and 55% were satisfied with the time taken to receive pain medication after requesting. These results were about the same as other hospitals in England

- Patient group directives for pain relief medication were available and processes in place for early administration, however, of the five cases we looked at in the UCC, two did not have pain scores assessed during observations or were offered pain relief promptly.

Nutrition and hydration

- We saw a range of food items available to patients, including options suitable for people requiring gluten free diets or special diets for patients requiring cultural or religious preferences.
- We saw a tea trolley 'round' that offered patients food and drinks if requested.
- Nurses and support staff we spoke to understood the needs of patients they were caring for and the importance of ensuring they had adequate food and drink, however there was limited documentation in the patient notes about who had been offered food and drink and what their intake had been.

Patient outcomes

- The rate of unplanned re-attendances from UCC was 7% from March to June 2016, which was better than the other A&E sites over the same time. Lower figures can indicate that the care and treatment received is appropriate and effective for the patient's condition.
- Nurse practitioners undertook audits of their own practice and clinical decision-making and shared these at the emergency nurse practitioners (ENP) forum, which met every quarter. This enabled ENPs to share best practice and draw lessons from each other to improve the care they provided.
- We saw data from a number of audits such as the royal college of emergency medicine (RCEM). Results indicated that the trust scored between the upper and lower England quartiles for initial management of the fitting child; the lower England quartile for mental health in ED and between the upper and lower England quartiles for assessing the cognitive impairment in older people.
- According to the trust, 24 audits were progressed in the directorate during the 2015/16 audit programme. Audit

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managers reported that action plans were not always being submitted in a timely manner and where there is an action plan the actions are not always implemented. Communications were seen as an issue to be improved.

- We saw policies and guidelines in place to help staff in the management and escalation of patients who presented with, or who were suspected of being septic (a potentially life threatening condition).

Competent staff

- The trust had recruitment and employment policies and procedures together with job descriptions. Recruitment checks were made to ensure new staff were appropriately experienced, qualified and suitable for the post. On-going checks took place to ensure continuing registration with professional bodies and this process was monitored by divisional managers assisted by human resources.
- We reviewed three appraisals chosen at random, which were in date and complete. Trust data shows an average of 53% appraisals completed for UCC nursing, clinical and administrative staff groups (April 2015 to March 2016). This is worse than for the same period the year before and indicated that staff performance was not always monitored or development needs identified.
- We saw an induction checklist for agency staff which indicated temporary staff were orientated to the unit. The agency contracted with the trust to ensure staff provided were competent for the roles they were assigned. Managers said they tried to use regular agency staff that were familiar with the department.
- All staff we spoke to told us they had regular team meetings and felt supported with their continuous professional development and revalidation. ENPs were able to access further training and development through professional forum and links with the local university.

Multidisciplinary working

- The trust had worked with the local ambulance service to develop criteria for the types of conditions for patients brought to the UCC for treatment. We saw a poster on display that clearly listed a series of illnesses or conditions that were accepted or excluded and we spoke with ambulance crews who confirmed knowledge of the policy. Staff from both the UCC and ambulance service emphasised this agreement as a good example of multidisciplinary working at trust and local levels.

- We also saw a number of interactions between UCC doctors, nurses, MUI nurse practitioners and ambulance crews that supported this view.
- Staff also reported good links with colleagues at the other emergency departments, which showed that effective channels for communication existed in the trust.

Seven-day services

- Consultant cover was provided on a seven-day basis between the hours of 8.00 am and 8.00 pm, with robust on call arrangements out of hours.
- In addition, the trust had responded to increasing numbers attending the department by the introduction of a GP service located next to the MIU. The trust had contracted this service to operate 24 hours a day.
- The trust also provided full seven-day cover for pharmacy, diagnostic imaging and pathology services.

Access to information

- We saw that there were no visible waiting times so patients did not know how long they might have to wait.
- The hospital used a combination of computer software and paper notes to document care, treatment and observations.
- There was no direct link between the software system and other services in the community. For example, GP's had to wait for the discharge summary to be sent to them via post.
- Clinical guidelines and policies were available via the trust intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Although there were no patients requiring this at the time of our inspection, the trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details of the Mental Capacity Act 2005 (MCA) guidance and treatment checklists.
- Training on consent and the Mental Capacity Act 2005 was available on the trust intranet. The figures for the directorate showed a low compliance. According to records provided by the trust, only 26% of band six and seven nurses had completed the training. The trust reported that they were implementing revised DoLS training in the light of a recent Supreme Court ruling

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(2015). The trust had adopted a package of tools developed by the association of directors of adult social services in England (ADASS) to assist the effective prioritisation of DoLS assessments and the trust continued to work to raise awareness about clinical restraint. In addition, the trust used a contracted service that provided specialist staff to support patients with challenging behaviours.

- Staff we spoke to were aware of their responsibilities under the Mental Capacity Act 2005 and DoLS and were able to describe the arrangements in place should the legislation need to be applied.
- Staff explained that a new web page had been created on the trust intranet with hyperlinks to guide personnel through the safeguarding process (including female genital mutilation), the mental capacity act, Domestic abuse, DoLS and clinical restraint.
- Staff were confident with the consent process and could explain how consent to treatment was obtained.

Are urgent and emergency services caring?

Good



We rated caring as good, because:

- Patients and relatives feedback was positive about the care provided from all of the staff. Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.
- We observed interactions which showed staff were welcoming, caring and supportive. Staff expressed pride in their work and responded compassionately when patients needed help and supported them to meet their needs.
- We saw that staff maintained patient privacy and dignity, although there was limited privacy in the front cubicle of the paediatric area, as people had to pass by to access other parts of the department.
- A number of support services were available to assist patients and their families and these were well publicised within the department.

At our last inspection, we rated the service as good and we have maintained the same rating.

Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. The latest results available for the A&E Friends and Family test showed the trust scored worse than the England average (June 2015 – May 2016).
- We saw that FFT information was displayed on notice boards in the department.
- The trust was rated as “about the same as other trusts” for all questions in the CQC ED survey 2014.
- Patients and relatives we spoke with were complimentary about the nursing and medical staff. We observed care given was considerate and kind.
- During our inspection, the team followed the treatment of three adult patients and a child. We saw good examples of compassionate care, although delays occurred with pain relief medication in two instances.
- We saw other examples of good staff interaction with patients. We observed how the nurses assisted patients compassionately and with kindness.

Understanding and involvement of patients and those close to them

- The relative of a patient said they were treated with care and compassion. Patients we spoke with said they felt involved in their care and participated in the decisions regarding their treatment.
- We saw good stocks of patient leaflets made available and we saw examples of staff explaining procedures and providing information and reassurance to their patients.

Emotional support

- Staff knew of the need for emotional support to help patients and their relatives cope with their treatment and the department had arrangements in place to provide support when needed. This included the use of a ‘quiet room’ where relatives could be away from the main unit.
- Posters displayed details of a variety of support groups or services such as domestic violence support, mental health support and community social support for elderly people.

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- The hospital offered a 'take home and settle service', where patients were escorted home and helped to settle in. The service ensured that patients had a support network in place, a supply of everyday items such as milk and bread and that the home was suitable.
- Staff confirmed they had access to the end of life team and previous referrals had been acted upon promptly.
- Staff also described a hospital chaplaincy service, which provided spiritual, pastoral and religious support for patients, relatives, carers and staff. The service was contacted via the main hospital switchboard.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Good



We rated responsive as good because:

- The department achieved the target for patients seen within four hours.
- There was good provision for those living with dementia and their different needs had been taken into account. We saw better facilities for people requiring mental health assessments and the way complaints were handled and lessons learned disseminated to staff.
- Staff were aware of the complaints process. Reporting and investigation was robust and there were mechanisms in place for shared learning from complaints through the staff meetings and safety briefings.

However,

- Although building work was underway to enhance the layout, the department still had challenges related to security of access and adults being treated in child cubicles. Toys were not always offered to children in the paediatric area.
- Admission criteria for the UCC appears to be an ongoing issue of confusion to some parts of the local community, as evidenced by inappropriate 'walk in' patients arriving at the department. Although some aspects may remain outside the trust's influence and control, improved signposting and information should be made available

to the public. For instance, signage at the location varied from 'emergency care' to 'accident centre' and terms used on public websites such as 'A&E' and 'urgent care centre'.

On this inspection, we have changed the rating to good, because we have seen improvements in the provision of care for people living with dementia and in improvements in how practice changed as result of learning from complaints.

Service planning and delivery to meet the needs of local people

- Although building work was underway to enhance facilities, the department still had challenges related to security of access and adults being treated in child cubicles.
- From March to June 2016, the department averaged 96% of patients seen within four hours. This was better than the trust target of 95% and the England average of 88% - 95%.
- The percentage of unplanned re-attendances averaged 7.2% over the same period. This was slightly worse than the trust target of 5%
- The percentage of patients leaving before being seen across the directorate was worse than the England average between May 2015 – March 2016.
- The total time in A&E (Median) was worse than the England average between April 2015 – March 2016. We were not able to obtain site-specific data for these figures.
- According to trust reports, delayed discharges remained a concern. The trust had established integrated discharge teams to help speed this process and other initiatives to support safer discharges had been implemented, such as the 'Home First' scheme. Staff said these had a positive impact.

Meeting people's individual needs

- We saw a number of leaflets and useful information available on display to help patients and their relatives understand their conditions and the treatment options. The printed information was only available in the English language.
- Staff told us that an interpreter service was available for those patients whose first language was not English. They said the service worked well and emphasised that staff or relatives were not asked to interpret.

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- We were shown an example of the sepsis screening tool that had been printed on the reverse of the frailty screening tool which was easy to follow and use.
- Staff described examples of the frailty assessment in use and how the adjoining GP service supported patients, seeing them in the department if they lacked the mobility to get to the consulting room.
- We saw that patient details were electronically marked (flagged) to alert the learning disabilities link nurse whenever a patient with learning disability was referred through the department for admission.
- We were shown 'distraction quilts' made by a hospital volunteer and used to help patients with dementia. Other dementia care initiative included the 'This is me' scheme and dementia champions within the department.
- Staff had access to a mental health liaison team to provide input to any patients who required mental health assessments. Staff said mental health nurses were called in as required but the time taken for them to arrive contributed to delays in treatment. We checked the complaints log for last year and could not find any concerns raised about this.
- On one occasion, we observed a child and family in one of the paediatric cubicles. No toys or distractions were offered to the child.

Access and flow

- The department was working towards a single entranceway from which patients can be streamed depending on their condition. Currently patients arrived by ambulance or walked in through separate entrances. We noted direction signs at the location that 'emergency care' and 'accident centre' as well as 'emergency care centre. Information referring to the UCC on the trust's public websites appeared to change between 'A&E' and 'urgent care centre'
- We saw that patients who 'walked in' met the receptionist, who used streaming guidelines to direct patients who met specific criteria or appeared unwell. For example, some patients with a minor injury were sent straight to MIU and any GP referrals sent straight to the acute medical unit (AMU). The AMU is the first point of entry for patients referred to hospital as emergencies by their GP and those requiring admission from the UCC. It was located in the same complex as the UCC and MIU, which meant patients could access the facility quickly and conveniently.

- A band 5 'streaming nurse' saw all the other patients. They conducted a rapid assessment based on agreed guidelines. Depending on the result of the assessment, the patient was assisted to resuscitation, directed to the MIU or the GP-led minor illness service.
- In the last A&E survey, the trust was rated about the same at other English hospitals for questions about how long patients waited with the ambulance crew prior to being seen or waiting to see a doctor or nurse.
- The trust as a whole failed to meet the emergency department four hour access targets between June 2015 and May 2016. However, performance at K&C had met the standard.
- The trust has developed business intelligence to support the implementation of its urgent care improvement plan. This data is site specific and provides a detailed breakdown of key performance indicators for access and flow. The trust provided data covering the period March – June 2016.
- For K&C, the average performance against the 4 hour target was 97% for that time period. Performance for minors patients was 98% and 95% of majors patients were treated within 4 hours.
- 80% of patients were triaged within 15 minutes, only 44% had a clinician first assessment within 1 hour.
- Across the trust, the percentage of patients leaving before being seen was worse than the England average (March 2015 to March 2016), as was the total time spent in A&E. In the last CQC A&E survey, the trust was rated about the same at other English hospitals for questions such as how long patients waited with the ambulance crew prior to being seen; or waiting to see a doctor or nurse.
- The percentage of patients leaving before being seen was higher than the England average in the same period as was the total time spent in A&E.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. We were told that if a patient or relative wanted to make an informal complaint, then they would speak to the shift coordinator. If staff could not resolve this locally, patients were referred to the patient experience team (PET), who would formally log their complaint. Complaints were acknowledged within three working days and patients advised of the process towards resolution and estimated timescale.

Urgent and emergency services

- Staff were aware of the complaints process and knew how to direct patients correctly. The complaints process was outlined in information leaflets, which were available in the department and in addition, contact details and 'on line' complaint forms were published on the trust website.
- Senior staff such as the clinical lead investigated complaints related to a member of the medical team.
- The matron monitored complaints and discussed these at departmental clinical governance meetings. There were mechanisms in place for shared learning from complaints through the staff meetings, trust briefings and safety briefings.
- Between June 2015 and June 2016, the UCC received 36 formal complaints and the MIU six complaints. This totalled 15% of all received by the directorate and according to managers, was a similar figure to last year.
- Across all A&E departments, the most frequent complaints were:
 - Unhappy with treatment - 48 (17%)
 - Missed fracture or other medical problem - 27 (10%)
 - Delays in being seen in A&E - 19 (7%)
 - Problems with nurse's attitudes – 18 (6%)
 - Misdiagnosis - 18 (6%)
- Staff gave examples of learning from complaints, such as the provision a daily supply of sandwiches and use of housekeeping staff to offer drinks. We saw posters informing patients and relatives to ask staff for a drink, because complaint feedback had indicated that people were reluctant to ask 'busy staff'.
- The management of complaints was included on the corporate risk register. The issues included an increase in the number of complaints, delays in response time, poor written responses and poor communication. The trust was investigating a web based complaints system to improve response times and communication between divisions and departments.
- The department reviewed complaints in depth on a quarterly basis. The clinical governance minutes demonstrated that senior managers reported investigated and learned from complaints at trust, division and speciality levels. The top three themes for complaints received were for delays, concerns about clinical management and problems with communication.
- A trust wide complaints newsletter was produced to share the learning from complaints to staff in the Trust. The first issue was sent out in June 2015 and was

attached to the trust newsletter. The newsletter contained the complaints, compliments data for the quarter for each division, and includes case studies identifying service improvements made as a result.

Are urgent and emergency services well-led?

Good



We have well led as Good because

- The trust had clear vision and strategy for improvement, which engaged staff.
- Staff engagement was reflected in the developing strategy for emergency services where clinicians, staff and patients' opinions were taken into consideration.
- The department had a philosophy of care, which was displayed and enacted by staff at all levels. Departmental staff felt engaged with the direction of the trust and took pride in the progress they had made so far.
- The trust had clearly defined local and trust wide governance systems. There was a well-established governance structure, with cross-directorate working, developing standard practices and promoting effective leadership.
- Staff felt supported by their immediate managers. Front line staff noted and appreciated the visible and engaged approach of the board (in particular the chief executive) and senior trust members.

On this inspection we have changed the rating to good from requires improvement at our last inspection, because we have seen improvements in staff engagement, clearer management in the department and a good governance structure.

Vision and strategy for this service

- The trust's vision was to provide 'Great healthcare from great people', with the mission statement 'together we care: Improving health and lives'. We saw various examples of the vision statement published on printed matter and posters around the hospital, which illustrated the board's intention to inform and promote the values to both service users and staff. This

Urgent and emergency services

information was readily available for staff, patients and the public on the trust's internet pages. Managers told us of the trust's "improvement journey" and staff we spoke with knew and understood the terminology.

- We inspected the trust in 2014 and 2015 and found UCC/MIU required improvement. Since the last inspection, the trust had a change of chief executive and support from outside agencies such as Monitor and the ECIP to implement improvement. The trust wide improvement plan identified 30 actions and this is reported monthly on their progress against the action plan to all relevant stakeholders.
- The trust had commissioned a number of external reviews to assess the trusts progress and the effectiveness of the changes put in place. A report from July 2016 found that there was increased visibility of the senior managers and board; there was improved site management and safety, better staff engagement, stable divisional structures and strengthened leadership across the trust.

Governance, risk management and quality measurement

- The trust operated a divisional governance model, which meant governance activities were divided into four divisions. These were surgery, urgent and long-term conditions, clinical support services and specialist services.
- A local governance structure was in place and it was clear that this fed into the overall governance system. We saw examples of minutes of meetings and a copy of the risk register for the directorate, which included links to both the divisional and corporate risk registers for some of the issues affecting the separate departments.
- Monthly ward and department governance meetings fed into divisional safety and quality meetings, which then reported to the executive safety and quality committee. We saw UCC meeting minutes that showed this in practice.

Leadership of service

- 'Triumvirate working' had been introduced and was a structure designed to ensure both clinicians and managers were involved in the management and planning of hospital activities at every level. The triumvirate model consists of a lead clinician, a senior nurse and a manager.

- The Matron gave us a clear description of the leadership structure as detailed above. Matron felt well supported by her senior managers and in turn believed she was able to support her own team. She expressed pride in her team, the improvements they had made so far and said the whole team was now engaged in delivering the best care.
- Managers and clinical leaders were positive about support that the trust had provided. For instance, one nurse said "Training has improved over the past two years" and another thought the way the trust had obtained support from a local university was good and also spoke about an NHS clinical leadership course called 'AIM', that was being offered to band 6 staff.
- We saw organisational charts displayed on staff notice boards and picture posters showing key staff displayed in entrances. All grades of staff spoke about the visibility and approachability of the senior management team and staff felt free to raise any issues with them directly or through their line manager. In addition, staff told us about monthly open forums led by the Chief Nurse where nursing issues could be discussed.

Culture within the service

- After our last inspection, the trust commenced a "great place to work" initiative. According to staff we spoke to, this included projects such as an executive development programme, a "respecting each other" campaign and health and wellbeing group.
- The Matron was aware that bullying and harassment in the trust had been an issue identified on previous inspections. Staff we spoke to supported this view. However, all agreed "things had improved" and spoke positively about projects like "Respecting each other", which included a confidential report line.
- The June 2016 Family and Friends Test indicated that 80% of staff had never experienced bullying or harassment and the majority of staff would feel confident in reporting such issues. Ninety six per cent of staff were aware of the trust's anti bullying initiatives.

Public engagement

- The trust's website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and the public a wide range of information about the safety and governance of the hospital.

Urgent and emergency services

- Patients and members of the public were included in developing services by involving them in the planning, designing, delivering and improvement of services. We saw examples of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch, feedback from the Friends and Family Test, inpatient surveys, complaints and the 'How Are We Doing?' initiative.
- We were also shown an example of the "members' area" on the trust website that contained news and information designed to support the hospital volunteer program.
- The "hello my name is ..." initiative was widely practiced by staff and during our visit and we heard examples of staff using this when talking with patients. This is not public engagement this is about dementia and is in responsive

Staff engagement




- Staff satisfaction surveys were conducted in line with national policy. The latest published survey results demonstrated an improvement in communication (up by 12%), decision making (up by 11%) and managers acting on feedback (up by 13%). The trust recorded the highest staff engagement score for five years.
- The trust recorded a positive staff friends and family test result with 57% of staff recommending the trust as a good place to work (up by 8%) and 78% recommending the trust as a good place to receive treatment (up by 4%).
- All the staff we spoke said they understood the trust whistleblowing policy and would feel comfortable using

- it if necessary. We also saw information displayed on staff noticeboards advising staff of the whistleblowing procedure. This suggested that the trust had an 'open culture' in which staff could raise concerns without fear.
- We also saw examples of posters and newsletters in staff areas. This included a monthly "Trust News" publication that was also available in electronic form. We were shown the "staff zone" part of the trust website that contained a wide variety of information on policy, procedures, careers and the "improvement journey" campaign. Staff told us it was possible to 'log in' to secure sections from home to access contact information, training, guidelines and procedures, which made for added convenience and choice when trying to access work-related information.

Innovation, improvement and sustainability

- Innovation and improvement hubs had been established at each hospital starting in April. The Kent and Canterbury hub was located at the rear of the staff restaurant and opened every Wednesday from 10.00 to 2.00 pm. Led by frontline staff who volunteered their time, the hubs presented improvement displays themes around topic such as care of people with dementia, sepsis and staff wellbeing. The hubs were supported by a fortnightly newsletter.
- Staff we spoke to were aware of the hub and had attended at least one of the sessions. Departmental leaders were positive about benefits they saw in terms of improved communication and a newer emphasis on staff engagement.

Medical care (including older people's care)

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

Information about the service

The Kent and Canterbury Hospital is a location of East Kent University Hospitals NHS Foundation Trust. It is an acute hospital, providing a range of medical care services. These include cardiology, gastroenterology, respiratory medicine, medical oncology, general medicine, nephrology, stroke and specialist rehabilitation services. The hospital also provides services to elderly patients. There is an 18 bedded Clinical Decision Unit (Medical CDU) and Medical Assessment Unit (MAU) described by the trust as an Emergency Care Centre (ECC).

Between March 2015 and February 2016, there were 32,987 medical admissions. Of these the majority were emergency (47%) with 5% elective and 48% admitted as day cases. The majority of admissions were for general medicine, with dermatology, geriatric medicine and other specialities accounting for the remainder.

On our previous inspection, we found the medical services at the Kent and Canterbury Hospital required improvement because of medical and nurse understaffing. We had concerns about the care of patients whose condition was deteriorating, medicine management, the storage of records and infection control. We had concerns that a large number of medical patients had been admitted to non-specialty beds and staff had not managed discharge from the hospital in a timely manner.

We conducted this inspection to follow up on these issues and assess the progress of the trust against the action plans that were in place. In order to do this, we

reviewed information data supplied by the trust, visited Harbledown and Kingston Ward, the Clinical Decision Unit and the discharge lounge. We spoke with staff and observed care being delivered. The CQC held focus groups where staff could talk to inspectors and share their experiences of working at the hospital. We spoke with over 16 members of staff working in a wide variety of roles including divisional directors, the chief nurse, matrons, ward managers, nurses, health care assistants, therapy and domestic staff. We spoke with patients and their relatives. We reviewed 13 sets of patients' records as well as other documentation. We also received information from members of the public who contacted CQC to tell us about their experiences both prior to and during the inspection.

Medical care (including older people's care)

Summary of findings

We found the medical services at the hospital required improvement because;

- Although the trust had recruited overseas nurses, there remained staffing shortages on the wards. On medical wards staffing numbers have been increased and the trust monitors safe staffing levels. However, there was a lack clarity amongst staff about the acuity based tool (to assess appropriate staffing for the complexity of patients cared for) and leaves staff convinced that there is still insufficient staff on duty for many shifts.
- There was insufficient numbers of junior grade doctors and consultants across medical services at Kent and Canterbury Hospital. This meant consultants and junior staff were under pressure to deliver a safe and effective service, particularly out of hours and at night.
- Staff did not always complete care records in accordance with best practice guidance from the Royal Colleges. We found gaps and omissions in the sample of records we reviewed. The trust did not have a robust system in place to audit, monitor and review care records to ensure they always gave a complete picture of the assessments and interventions undertaken.
- The trust did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance.
- The trust had not completed its audit programme. The hospital performed poorly in a number of national audits such as the stroke and diabetes services.
- We found the hospital was not offering a full seven-day service. Constraints with capacity and staffing limited the responsiveness and effectiveness of the service the hospital was able to offer.
- Patients' access to prompt care and treatment was worse than the England average for a number of specialities. Waiting times are set out in the NHS Constitution; in addition, there are waiting times performance targets measures, which are monitored by NHS England.

- The trust was not meeting the 62-day cancer referral to treatment time since December 2014. Referral to treatment within 18 weeks was below the 90% national standard and the England average for six of the eight specialties from June 2015 to May 2016.
- Although the trust had put measures in place to promote positive behaviour and eliminate bullying, staff still reported incidents of inappropriate behaviour from colleagues.

However;

- The trust had a robust system for managing untoward incidents. Staff were encouraged to report incidents and there were processes in place to investigate and learn from adverse events. The hospital measured and monitored incidents and avoidable patient harm and used the information to inform priorities and develop strategies for reducing harm.
- Management prioritised staff training, which meant staff had timely access to training in order to provide safe care and treatment for patients.
- There were systems in place to maintain a clean and therapeutic environment. Staff effectively managed infection control and appropriately maintained the environment.
- Medical care was evidence based and adhered to national and best practice guidance. Management routinely monitored that care was of good quality and adhered to national guidance to improve quality and patient outcomes.
- Patients were supported through consultant led care and effective delivery of care through multidisciplinary teams and specialists. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- Overall Staff treated patients with kindness and compassion.
- The trust had plans in place to ensure that medical services across the county were sustainable and fit for purpose. The trust was engaging with all stakeholders to implement any changes. The trust had taken action to address the delays to the patient pathway, such as rapid access clinics, rapid discharge team and outsourcing diagnostic investigations.

Medical care (including older people's care)

- Staff provided good provision of care for patients living with dementia and patients' different needs were taken into account. Staff admitted the majority of patients to the correct bed for their speciality and did not move beds or wards for the entirety of their stay.
- The trust had a clear corporate vision and strategy. The trust reflected staff engagement when developing the strategy for medical services. Clinicians, staff and stakeholders' opinions were taken into consideration.
- The trust had clearly defined local and trust wide governance systems. There was well-established ward to board governance, with cross directorate working, developing standard practices and promoting effective leadership.
- The trust acknowledged they were on an improvement journey and involved all staff in moving the action plan forward. Staff felt engaged with the direction of the trust and took pride in the progress they had made to date.

At our last inspection, we rated the service as requires improvement. On this inspection we have maintained a rating of requires improvement but have seen improvements in incident reporting, staff training, infection control, staff engagement and ward to board governance.

Are medical care services safe?

Requires improvement 

We rated the hospital as requires improvement for safe because;

- Although the trust had attempted to address staff shortages through the recruitment of overseas nurses, there remained staffing shortages on the wards. The trust did not use a recognised acuity tool to assess the number of staff needed on a day-to-day-basis.
- The trust acknowledged and it was identified in the directorate's risk register there was a shortage of junior grade doctors and consultants across the medical services. This meant consultants and junior staff were under pressure to deliver a safe and effective service, particularly out of hours and at night.
- We found poor management of records, with records not always held securely. Staff did not always complete care records in accordance with best practice guidance from the Royal Colleges. We found gaps in the sample of records we reviewed. The trust did not have a robust system in place to audit, monitor and review care records to ensure they always gave a complete picture of assessments and interventions undertaken.
- The trust did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance.

However;

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

Medical care (including older people's care)

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

At our last inspection, we rated the medical services as requires improvement. On this inspection we have maintained a rating of requires improvement but have seen improvements in identifying and supporting deteriorating patients and infection control.

Incidents

- There was an incident reporting policy and procedure in place that was readily available to all staff on the trust's intranet. Staff were aware of the policy and were confident in using the system to report incidents, this included bank and agency staff.
- The trust reports all patient safety incidents through the National Reporting and Learning System (NRLS). When an incident is assessed as a serious incident, or a never event it is reported through the Strategic Executive Information System (StEIS). NHS England describes a never event as "Serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers."
- The trust reported 13,137 incidents between May 2015 and April 2016. This was better (7 per 100 admissions) than the national average (8.6 per 100 admissions). The trust rated 98 percent of the incidents reported to NRLS as low or no harm. This indicated a good reporting culture.
- The trust reported 75 serious incidents between July 2015 and June 2016, of which 13 related to medical services. Four of these were slips, trips or falls, which met the serious incident criteria; three were delayed treatment. The remaining incidents had various causes where there was no pattern or trend identified.
- There had been no serious incidents on the Stroke Unit at the Kent and Canterbury Hospital for the past 20 months.
- The trust reported seven never events between January 2015 and January 2016, of which one related to a medical ward in this hospital. The never event had been subject to a robust investigation and scrutiny by other public bodies. The trust had taken immediate action to address the issues identified, such as revision of protocols and staff training. We spoke with staff who described learning from the incident and we saw an action plan was in place and that staff were adhering to the new guidance.
- Following four never events between April 2011 and July 2015, there were concerns regarding the trusts compliance with national guidance in relation to the management of Patient Safety Alerts. In February 2016, the trust commissioned an external review of the systems and governance arrangements regarding the management of patient safety alerts. The review recommended that the trust put in place an escalation process and amend the management of safety alerts policy and procedures, to ensure stakeholder engagement together with robust management of alerts with effective oversight and scrutiny.
- We saw a copy of the revised Central Alert System and Internal Alerts Policy, which provided assurance that included the improved governance arrangements. The deputy director of risk, governance and patient safety received regular updates on any open alerts, which included the reason for delay in implementing the recommendations. The trust had a system in place to conduct random auditing of closed alerts to monitor compliance.
- Staff had access to training on incident reporting and this included 'Duty of candour' training. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff supported patients and relatives and informed them of outcomes in accordance with the trust's duty of candour. The majority of staff we spoke with were aware of their responsibilities under duty of candour. However, the trust had identified through reviewing the incident reporting system that staff had not always considered

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the duty of candour when investigating moderate or severe incidences. In response to this, the trust had provided additional training and support to improve the rate of reporting under the duty of candour.

- The trust had systems in place to learn from incidents and reduce the risk of reoccurrence. Staff discussed and monitored incidents at monthly governance meetings. Staff were given feedback through emails, clinical governance newsletters and team meetings. We saw copies of a staff newsletter, which gave details of learning from recent incidents. Staff also told us that the improvement hubs were good places to learn about any changes in practice. The trust had systems in place to learn from incidents, inform practice and encourage improvement.
- Regular mortality and morbidity meetings and case reviews took place across the medical services. We reviewed the minutes from a sample of these meetings and saw they were a forum for shared learning and development. Although the minutes did not always list the attendees, staff kept an action log which included the completion date and the clinician responsible.

Safety thermometer

- The hospital used the NHS Safety Thermometer. This is a national improvement tool for measuring, monitoring and analysing harm and the proportion of patients that experience 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism.
- The medical wards we inspected displayed their patient safety thermometer results on notice boards in public areas of the wards. This meant up to date patient safety information was readily available for patients, visitors and staff.
- Safety thermometer data for June 2015 to June 2016 demonstrated pressure ulcer damage, falls and catheter urinary tract infections had remained stable across the trust, although a slight increase was recorded trust wide in November 2015. The trust reported 44 pressure ulcer incidents over the past 12 months. Pressure ulcer damage is localised, acute ischaemic damage to any part of the body caused by the application of external force (either shear, compression, or a combination of the two).

The trust reported 45 falls between June 2015 and June 2016. The rate remained stable with slight increases noted in July and November 2015. We saw the action plans put into place following the 2015 National Inpatient Falls audit. There remained some outstanding and ongoing actions due to staff shortages and the trust had extended the deadline for completion to October 2016.

- There were 15-catheter urinary tract infections (CUTI) reported between June 2015 and June 2016. There were no reported CUTI's reported in August 2015 or May 2016.
- The trust produced a monthly 'heat map'. This identified the number of safety thermometer incidents together with other information such as staffing, friends and family test results and complaints. Management displayed results in an easy to access format, which staff discussed at governance meetings and results were shared across the trust. This demonstrated that there were systems in place to monitor incidents of patient harm across the trust.

Cleanliness, infection control and hygiene

- The trust had infection prevention and control policies readily available for staff to access on the intranet. Staff were aware of the policies and knew how to access them. These included waste management policies, which were monitored through regular environmental audits.
- We saw that clinical and domestic waste bins were available and clearly marked for appropriate disposal. Staff effectively managed and disposed of disposable sharps safely.
- The trust had arrangements in place to support the management of infection prevention and control. This included an infection prevention team with qualified infection control nurses and a doctor with infection control responsibilities. The team worked across the trust coordinating with other health-care professionals, patients and visitors to prevent and control infections. The infection control teams' responsibilities included giving advice, providing education and training, monitoring infection rates and audit infection prevention and control practice.
- The Infection Prevention and Control Team submitted monthly reports to the board, which demonstrated that effective surveillance took place. For example in May

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2016, the report identified that the team undertook post infection reviews to identify how any infection was acquired and if the action taken was effective. The report stated that there had been an overall decrease in ward-acquired MRSA cases across the trust.

- Each of the medical wards and units we inspected displayed their infection prevention and control audit results, so patients, visitors and staff had current infection control information available.
- Patient-led assessments of the care environment (PLACE) is a national initiative where teams of local people go into hospitals to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. The 2016 results for the hospital demonstrated an improvement from the 2015 results. The PLACE team rated cleanliness at the hospital at 90%, which was an 8% improvement from the previous year but below the national average of 98%. The trust developed an annual action plan from the PLACE feedback and comments. The Patient Experience Committee chaired by the chief nurse and Governors developed an annual action plan based on feedback from the report. In addition, the Patient Experience and Investment Committee included the report findings and feedback into the annual refurbishment and improvement capital plans.
- The safety thermometer Public Health observatory data for June 2015 to May 2016 reported low numbers (three) of MRSA for the trust compared to the number of MSSA cases (28). There were 29 cases of C. Diff. The number of cases per 10,000 bed days was generally better than the England average during this period with no trends identified.
- Infection prevention and control was included in the trust's mandatory training programme. Staff we spoke with all confirmed they had completed this training.
- The majority of areas we inspected where patients had access were visibly clean and tidy to the standard expected in the high-risk category of the National Specifications for Cleanliness in the NHS. Linen cupboards were clean and tidy with bed linen managed in accordance with best practices.

- On Harbledown Ward, all the moving and handling equipment was visibly clean and had "I am clean" labels in place. On Kingston Ward, two of the five hoists had "I am clean" labels attached.
- In both Harbledown and Kingston Wards, the majority of commodes in the sluice had "I am clean" stickers in place. However, in both wards, staff were unable to wash their hands in the sluices, as they were cluttered with commodes and equipment. Although hand gel and alternative hand washing sinks were available outside the sluice, this meant staff could not wash their hands immediately after handling contaminated or dirty equipment.
- We saw that personal protective equipment such as disposable gloves and aprons were readily available for staff to use. There were hand-washing sinks with sanitising hand gel available on the wards. The majority of staff followed infection control principles as demonstrated in the hospital's hand washing audits.
- Staff adhered to the hospital's "Bare below the elbows" policy. We observed staff wearing personal protective equipment (PPE) and saw that on the wards, they washed their hands in between patient contact. Patients confirmed that staff were always washing their hands or using hand gel.
- Patients told us that cleaners attended the ward twice a day and kept the ward clean. They told us that staff changed the bed linen daily.

Environment and equipment

- Harbledown Ward consisted of six four bed bays and two side rooms that were used for patients with an infection who required isolation. On the day of the inspection, both side rooms were in use. These side rooms did not have en suite facilities and had the use of a shared toilet in the corridor. This meant patients had to bath and wash at their bedside.
- Staff had appropriately decorated the patient dining area in Harbledown Ward to support patients living with dementia. Staff told us whenever possible, they helped patients to eat their meals in the dining room. Staff furnished the room in order to replicate a home environment. It was light, well ventilated and appeared clean and tidy. The hospital also used this room for relatives. The trust had plans in place to develop a separate relative's room.

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- Kingston Ward was funded to provide 22 beds; however, the ward had capacity to accept 27 patients. The hospital used the five extra beds for 'winter pressures', but staff told us they had been in use for the past 18 months. This meant that staff and resources were stretched to provide for the five unfunded beds.
- The 2016 Patient Assessment of the Care Environment (PLACE) rated the hospital at 88.97% for the facilities, which was lower than the England average of 90%. This score related to the condition, appearance and maintenance of the hospital including the patient environments, décor, tidiness, signage, lighting, linen, access to car parking, waste management and the external appearance of buildings and grounds. The Patient Experience Committee chaired by the chief nurse and Governors developed an annual action plan based on the feedback from the PLACE report. In addition the Patient Experience and Investment Committee included the report findings and feedback into the annual refurbishment and improvement capital plans.
- We found that the corporate COSHH (Control of substances hazardous to health) risk assessments were available for the cleaning products used in clinical areas.
- The trust had a planned preventative maintenance programme in place, which they monitored and risk assessed. The data supplied by the trust indicated there were a large number of medical devices not serviced or maintained within the designated time. The trust acknowledged they did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance. Achieving 95% planned maintenance compliance of all medical devices was included in the trust's Improvement Plan. At February 2016, the trust had 69% compliance with planned maintenance on the 20,611 devices that required planned maintenance.
- Staff on Kingston Ward reported they could get stock or equipment in an emergency within an hour. However, they told us a lot of time was spent chasing stock or borrowing from other wards or hospital sites. This included pressure relieving and manual handling equipment.
- We found there was adequate resuscitation equipment on most of the wards we visited. We saw the documentary checks on each ward confirming that staff checked the resuscitation equipment daily.
- However, on Harbledown Ward the resuscitation equipment was basic and consisted of intravenous and airway equipment. National guidance on resuscitation equipment availability states that equipment should be standardised across the organisation. We saw that staff recorded and checked oxygen and suction equipment daily.
- On Kingston Ward, the resuscitation equipment was recorded as checked twice daily. However, the trolley was overstocked with too much similar disposable equipment. This meant that in the event of an emergency staff would need to take out a lot of stock to reach the emergency drug box.

Medicines

- The hospital had medicines management policies, together with protocols for high-risk procedures involving medicines such as the intravenous administration of antibiotics. These were readily available for staff to access. Staff had access to relevant resources on medicines management such as an electronic copy of the British National Formulary.
- We found that staff generally managed medicines according to hospital policies and best practice guidance. This included patients own drugs, medicines requiring refrigeration and controlled drugs. However, we did note that on Kingston Ward in Bay D the medicines cupboard was unlocked and the sharps bin was open. We reported this to the nurse in charge who addressed the issues. On Harbledown Ward, there was no documentation available for a cannula inserted into a patient five days ago. This meant there was no record that staff were administering intravenous medication appropriately.
- Staff did not always record patient's weight on medication records and there was inconsistent countersigning of intravenous fluid (IV) medications. Eight of the thirteen IV medicine records reviewed were not countersigned. Although staff had completed the IV

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infusion therapy prescription in full, the infusion batch number had not been recorded. This meant should there be a problem with the therapy; staff could not trace the batch to the individual patient.

- We reviewed untoward incidents recorded since August 2015 and noted that staff in general reported medicine related incidents. The staff we spoke with understood how to recognise and report medicines related incidents.
- We spoke with a number of pharmacists and pharmacy technicians during our inspection and found that where a ward had a pharmacist available they were subject to regular audit. The pharmacists recorded the drug charts checks.
- We found that none of the medical wards routinely measured the ambient temperature of rooms where medications were stored. The majority of medicines have a maximum and minimum temperature that they should be stored this meant that some medicines may be stored at the wrong temperature and be ineffective.

Records

- We looked at a sample of records in each of the wards and units we inspected. We found that both nursing and medical records provided a personalised record of each patient's care and treatment. We noted there was not a space for past medical conditions to be included on the admission form. This meant that staff would not have easy access to all relevant information.
- Medical notes were generally legible and well completed in accordance with the General Medical Council guidance 'Keeping Records.' However, we found instances on each of the wards we visited where staff had not signed the medical handover form and there was no indication as to the profession or seniority of the healthcare professional making the entry in the medical notes.
- Staff did not always complete nursing records appropriately. We found that although staff dated, timed and signed entries, the records did not give the staff designation. We looked at a small sample of thirteen medical notes and found that staff rarely recorded MRSA screening; cannula, skin, catheter and next of kin details.

- The majority of records we reviewed had up to date risk assessments such as falls, skin and moving and handling. However, there were gaps such as infection control risk assessments not completed and lack of documentation regarding cannula. Cannula are small tubes inserted into a veins to give fluid, drugs or take bloods. On Harbledown Ward, there was no documentation available for a cannula inserted into a patient five days ago. This meant there was no record that staff were caring for the patient appropriately.
- Staff recorded allergies on medication records, however, we found that the patient's weight was not always recorded on drug charts and there was inconsistent countersigning of intravenous fluid (IV) medications. Eight of the thirteen IV medicine records reviewed were not countersigned. Although the IV infusion therapy prescription was completed in full, the infusion batch number had not been recorded. This meant should there be a problem with the therapy, staff could not trace the batch to the individual patient.
- Managers told us that regular records audits took place. However, on further investigation we found that only a small sample of records were checked four times a year. This meant there was not a robust system in place to ensure that all medical and nursing records met professional and best practice standards.
- At the last inspection, we found records were not always stored securely. Although there was some improvement with records now usually kept at the nursing station, on Harbledown Ward we found four out of five notes trolleys were stored unlocked in the patients' bays. On Kingston Ward, we saw patients records kept in unlockable storage with some folders on a windowsill or on a table unattended. This meant that the hospital did not always keep confidential records safe and secure in accordance with the Data Protection Act 1998 and the NHS Code of Practice.
- We heard how there was easy access to GP records through GP records through a computer link.

Safeguarding

- The trust had a safeguarding vulnerable adults and children policy with guidelines readily available to staff on the intranet. We saw information on how to report safeguarding was available on the wards.

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- There were safeguarding leads in the hospital that acted as a resource for staff and linked in with the trust's safeguarding team.
- The trust prepared a safeguarding briefing paper, which identified that they were below the national safeguarding training requirement of 85%. All staff undertook safeguarding level one training at induction and had received appropriate information on identifying safeguarding concerns.
- However not all staff who had regular contact with patients, their families, carers or the public had undertaken level two safeguarding training. To address this the trust introduced a half-day safeguarding course in April 2016. The trust informed us that 54% of 2,309 identified staff had completed the required level two training, which was below the 85% target. The safeguarding training included domestic abuse and Prevent (anti- radicalisation) training.
- All the staff we spoke with confirmed they had received level one safeguarding training as part of annual mandatory training. They were aware of the safeguarding policy and how to access it. They told us they would report their concerns to the nurse in charge and contact the safeguarding lead if needed.

Mandatory training

- The trust had a mandatory training programme in place, which covered health and safety, manual handling, infection control, falls preventions, safeguarding children and young people.
 - Staff undertook mandatory training electronically and recorded on an electronic staff record. Managers and staff were able to access the staff records to monitor compliance.
 - All staff including bank staff had access to on-line and face to face mandatory training. Managers could not verify that bank staff had undertaken their mandatory training updates as training records for bank staff were not held by the ward. Staff we spoke with told us that accessing the annual mandatory training was not a problem, although it was difficult to find the time.
 - The integrated performance report stated that 87% of staff had completed their mandatory training by May 2016, which was slightly better than the trust target of 85%.
- We spoke with new staff recently appointed by the trust. They told us they had undertaken induction training appropriate to their role. On Harbledown Ward, staff told us all health care assistants (HCAs) had two weeks induction when coming into post.

Assessing and responding to patient risk

- Staff recorded patient observations electronically. The results informed the deteriorating patient assessment. The hospital used the national early warning scoring system (EWS) to identify patients whose condition was deteriorating. We reviewed a sample of EWS observation charts and saw the charts were routinely used and patients escalated appropriately.
- The trust supported staff to identify deteriorating patients through the deteriorating patient programme. The critical care steering group had oversight of this group and monitored critical care outreach referrals, cardiac arrest data, electronic data recording and the mortality of ward patients admitted to intensive care beds. This information was analysed and had identified areas for improvement. The audits had identified that observations had improved with the electronic monitoring system. Improvement work included patient handover information, raising staff awareness of the acutely ill patients, sepsis and acute kidney injury.
- Staff told us they had good support from the doctors when a patient's deterioration was sudden and resulted in an emergency. They also felt supported by the clinical outreach teams. However, they told us that the doctors were unable to respond so quickly at night because they were so busy.
- There were individual risk assessments in all patient records we reviewed. These included assessing the risks of falling, pressure damage, nutrition and continence. However, not all were fully completed or updated appropriately.
- In order to meet patients' individual needs, each patient should be assessed on admission. Staff should then devise a plan of care to meet the assessed needs. However, we reviewed 13 sets of patient records across Harbledown and Kingston Wards and found that nursing assessments, repositioning charts, food charts and personal care round records were not always completed. For example, we found a patient without a plan of care for an intravenous cannula. This is a small

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tube placed into a vein to allow staff to take blood samples, and to administer fluids, medications, parenteral nutrition, chemotherapy, and blood products. Another patient did not have a plan of care to protect the identified risk to their skin. This was a concern raised at the previous inspection and we noted that there had not been much progress in addressing the problem.

- Venous Thromboembolism (VTE) was recorded as one of the trust's top five risks. VTE is a serious condition where blood clots form in a vein. Every patient should have a documented VTE risk assessment. Data from July 2016 indicated that 85% of patients had a completed VTE risk assessment. This was worse than the national standard of 95%. The trust monitored individual consultant and divisional compliance monthly. The trust had an action plan in place to improve compliance, which included weekly consultant reports, including VTE compliance in consultants' appraisals, ensuring all patients leaving theatre or the clinical decision unit had been risk assessed and developing electronic support to remind practitioners and prompt appropriate actions to prevent VTE.
- There was on site access four level two high dependency beds and four level three intensive care beds. There were physicians available who specialized in the care and treatment of patients in intensive care. Out of hours, there was consultant anaesthetist cover. A critical care outreach team was available between 8am to 6pm, seven days a week who assisted in the management of critically ill patients across the hospital. Critical care outreach nurses also provided cross-site cover across the Trust.

Nursing staffing

- Lack of nurse staffing was a concern raised at the two previous inspections in 2014 and 2015. Staffing concerns across the medical services was included on the divisional risk register. There were actions in place to reduce the risk; however, staffing remained a concern.
- For example we reviewed the staffing rota for Harbledown Ward and noted that they did not use an acuity based staffing tool. The usual staffing for the ward was one nurse in charge, three trained nurses and three HCAs. On the day of our unannounced inspection, the ward was short of one qualified nurse and two HCAs. At

night, the planned staffing was for two qualified nurses and two HCAs. Staff could put in a request for support from patient watch if there were very confused patients admitted who were likely to wander. There was usually no problem in obtaining extra support from Patient Watch if requested. However, the shortage of staff meant there were insufficient staff on duty to care for the acuity of the patients.

- The ward manager told us the ward was actively recruiting for three band five nurses and 24hrs of HCA cover. There were interviews planned and four applicants for the band five posts. Staff had escalated the lack of staff on Harbledown Ward to the matron at the bed meeting. We were shown the reporting form where the lack of staff had been documented.
- We also conducted an unannounced visit to Harbledown Ward, which cares for acute medical patients, frail patients and those living with dementia. We found staff were rushed in their duties and very busy. There were three qualified nurses and one healthcare assistant (HCA) for 24 patients. One of the qualified nurses was the ward sister. There was a member of Patient Watch on the ward supporting the staff in observing the confused patients. The ward manager was on duty but away at a meeting and was due to go home. Three of the patients were confused and needed one to one supervision. This did not meet the Royal College of Nursing guidance: Safe staffing for older people's wards, which stated for 24 older patients the ward should have a minimum of six staff on duty. We found the ward was understaffed for the acuity of the patients.
- However, we found that the staff on Harbledown Ward worked hard so that the lack of staff did not affect the care of patients. The patients we spoke with confirmed this. They told us the level of care was "Good" and the call bells answered quickly. One patient told us "Bells are always answered within five minutes."
- The trust had taken action to address the shortfall in staffing such as recruiting overseas nurses and implementing a retention plan. A recruitment and retention strategy was in place, which addressed the support plans and action plans to address the staffing

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shortfalls. However, we found that although there was an increased headcount at this inspection, there were occasions where the wards were understaffed for the acuity of patients.

- The trust supported overseas nurses until they had adjusted to nursing in England. This included a period of supernumerary nursing, a mentorship programme and competency support. We spoke with overseas nurses who were full of praise for the support they had in learning basic English and adapting to the British nursing model of care.
- The trust did not use a recognised staffing tool to ensure that medical services had appropriate staffing levels for the acuity of patients. A new staffing tool was being trailed at the time of the inspection but the use of the tool was not embedded across the medical services. Instead, senior staff conducted six monthly ward staffing reviews to monitor if the staffing and skill mix supported safe and effective patient care. The May 2016 review of staffing found that the trust was meeting the NHS Quality Board requirements for providing assurance on safe staffing.
- The most recent review in July 2016 reflected that there was a substantial investment in funding the nursing establishment due to escalation wards. The review reported 78% uptake in newly qualified staff and the impact of appointing the overseas nurses.
- The actual staffing versus planned staffing was reported monthly. The trust reported 95% vacancy fill rates and concluded that ward staffing levels were satisfactory overall. However, during the inspection, staff reported that the majority of medical wards were short staffed, carrying vacancies or were covering for sickness. Staff reported that there was no problem in requesting agency or bank nurses when needed however they were not always available.
- We reviewed the planned versus actual staffing numbers taken from rosters between 8th February 2016 to 6th March 2016. The data indicated an average fill rate of between 59 – 119% for registered nurses working day shifts. The best staffed ward was Mount Macmaster in April 2016. The worst was Kingston Ward in February 2016. Managers discussed staffing shortfalls at the daily operational meetings. Staff working on wards with extra capacity were reallocated to other clinical areas to provide support.

- Emerging data from the dementia dashboard indicated there was a year on year increase in the number of patients admitted living with dementia. This was linked to the increasing acuity and dependency on some wards, which the trust explained meant more staff were needed to care for the same number of patients

Medical staffing

- The trust had a lower percentage of consultants and junior grade medical staff (4% lower) and a higher percentage of registrars than the England average. For example, the medical staffing percentage for registrars was 48%, higher than the national average of 36%. Junior doctors made up 16% of medical staff compared to an England average of 21%. This meant the trust's medical workforce was more reliant on registrars and middle grade doctors than the national average.
- Lack of medical cover was included on the divisional risk register. We noted that the medical staffing risks on the division risk register provided for inspection dated back to 2013. Although there were actions in place to reduce the risk such as employing locums, and the trust was actively recruiting medical staff, this remained a concern.
- We spoke with junior medical staff who explained duty rotas and on call systems. They told us that on call specialist registrars worked 12 hours shifts and were always available in the hospital. There was also an additional 'twilight' registrar on duty in the evening. They told us that there were usually 70 admissions in a 24-hour period. A specialist registrar and Foundation Year 1 (FY1) doctor provided out of hours cover for the five medical wards.
- Consultants working at the hospital told us there was limited consultant and registrar cover for the patients in the acute medical unit (AMU) who were not under the care of the on call consultant of the day. This meant that patients may experience a delay in treatment. They told us that in their professional opinion the out of hour's medical cover for the medical wards was within acceptable limits.
- There were two stroke consultants in post with one vacancy following retirement of a third consultant two years ago. It had not been possible to make a

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permanent appointment to this post and the hospital was working with locum consultant cover. The two stroke consultants provided in house on call cover from 9am to 5pm and an overnight rota.

- An acute medicine consultant worked from 9am to 5pm, Monday to Friday and covered the Ambulatory Care Unit. The hospital had only one acute medicine consultant who was on sick leave. Staff told us "There should be four acute medicine consultants." to cover the hospital.
- There was an on call consultant general physician and a care of the elderly (HCOOP) physician every day of the week including Saturdays and Sundays. We were told that ward rounds started at 2pm and the on call consultants remained on site until 8pm and then were on call overnight until after the first ward round at 8am.
- There were also care of the elderly consultant posts being filled by locums. We were told there should be six full-time and one part time care of the elderly consultant. One full time consultant was on maternity leave and there were two vacant posts filled by locums. The trust was conducting impact assessments and exploring options with the clinicians to resolve the issues of providing adequate cover for the hospital until additional consultants could be recruited. The trust's divisional risk register included the concerns providing adequate consultant cover at the hospital.
- Staff recorded lack of medical cover as incidents on the trust's electronic reporting system. For example, in July 2015 a consultant raised the lack of medical cover at night as an incident. The report documented that the lack of medical cover caused a significant amount of stress and potentially compromised effective patients care. This demonstrated that staff reported staffing issues appropriately on the electronic reporting system.

Major incident awareness and training

- The trust had business continuity plans in place, which included major incidents, emergency preparedness, cold and hot weather plans, pandemic influenza plans and the patient flow and escalation policy.
- Staff were made aware of these through both electronic and paper means. The current policy was available on the trust's intranet with hard copies on the wards.

- The high risk of a major incident was included on the divisional risk register. The main risks included the number of high-risk locations such as the Channel Tunnel, docks, nuclear power station, airports and motorway network. The trust had reviewed the major incident plan and identified a number of actions to ensure the safe management of any incident. This included the management of support services such as switchboards and reception.
- The hospital was not a designated trauma centre and did not undertake emergency activity. There was a minor injury unit with GP support on site. This meant that any major incident would not have a direct impact on the day-to-day activities of the hospital. However, medical services would usually be involved in a major incident admitting patients from other areas and specialities to free up trauma beds in other hospitals.
- We found the hospital consistently worked at capacity and bed availability was a constant problem and pressure across the medical services. This may have an adverse impact on the trust's ability to respond in a timely fashion to any major incident.

Are medical care services effective?

Requires improvement 

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

- The hospital performed poorly in the sentinel stroke national audit programme (SSNAP). There was a decline in performance in six of the key indicators. This was because of a lack of speech and language therapists, physiotherapy and occupational therapists.
- Scores in the National Diabetes Inpatient Audit 2015 at the hospital were worse than the England average for 11 of the 17 measures audited. This indicated a decline in the diabetic services undertaken at the hospital.
- The 2015 Lung Cancer Audit report indicated only 25% of patients were seen by a specialist nurse in comparison to the national average of 80%. The audit showed other results were slightly worse than the England average and lack of specialist nurse support was a concern.

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- The trusts audit programme was underdeveloped due to staffing vacancies. Several local audits had not been completed or action plans implemented.
- Pain scores were not always recorded in the care assessment charts. Which meant there was a risk that patients' pain was not always managed and monitored appropriately.
- The hospital was not offering a full seven-day service. Constraints with capacity and staffing had yet to be addressed. Consultants and support services such as therapies operated an on-call system over the weekend and out of hours. This limited the responsiveness and effectiveness of the service the hospital was able to offer.

However;

- We found medical care was evidence based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. The care delivered was routinely measured through the safety thermometer and national audits to improve quality and measure adherence to national guidance and to improve quality and patient outcomes.
- The medical wards had clinical pathways in place for care for a range of medical conditions based on current best practice guidance and legislation.
- Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists. We found staff training was good with ongoing training and development opportunities available.
- There were suitable arrangements in place to ensure that further training and development was available for staff to enable them to improve their skills and develop their competencies. The majority of staff we spoke with told us they felt well supported and encouraged to develop.
- Throughout the medical services, we found effective multidisciplinary working. Medical and nursing staff as well as support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.

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

Evidence-based care and treatment

- The emergency care and long-term conditions division used guidance and policies based on National Institute for Health and Care Excellence (NICE) and the Royal Colleges' best practice guidelines. New and updated guidance was evaluated and shared with staff. The trust had strengthened the methodology and governance surrounding this process following a clinical incident in 2014.
- Staff were able to access national and local guidelines through the trust's intranet. This was readily available to all staff. Staff demonstrated how they could access the system to look for the current trust guidelines. We noted there were appropriate links in place to access national guidelines if needed.
- The standardised care pathways were based on current best practice and NICE guidance. For example, the acute heart failure pathway and stroke pathways incorporated NICE guidance.
- The trust routinely reviewed the effectiveness of care and treatment by using performance dashboards, local and national audits. Although there was a good programme of regular audit meetings, however due to staff shortages in the audit department the audit programme was limited. The Clinical Audit & Effectiveness Committee documented in May 2016 that although national audits had the best completion rates, the overall audit completion rates were low. Management revised the local audit schedule in order that staff concentrated on successfully completing a smaller number of audits.
- The clinical audit summary report for 2015/16 identified that the medical specialties had been over ambitious with the number of audits that they would be able carried out during 2015/16. Action plans were not always submitted in a timely manner and the actions on plans were not always implemented. The neurology specialty had not had an audit lead for the past six months. Staff planned 14 audits for the 2016/17 audit cycle.

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- The minutes from various departmental and divisional meetings showed that where audit results had been documented these were discussed and plans developed to address any issues. For example, the minutes from the heart failure meeting in January 2016 documented that staff discussed the recent heart failure audit results. Staff identified that results were better when patients were admitted direct to a specialist ward. There were limited specialist wards in the Kent and Canterbury Hospital. As a result, the medical model across the trust was under revision.

- The trust had participated in 27 of the 35 medical national clinical audit programmes. We reviewed a sample of local audits such as the venous thrombolysis (VTE) and nasogastric tube audits. A nasogastric tube is a fine tube passed into the stomach via the nose. The trust used audits to inform practice and improve the quality of care provided. For example, following the National Falls Audit a board level the trust established a falls steering group with a multidisciplinary working group. All falls that resulted in moderate harm, severe harm or death had a critical incident review undertaken. The board received the results through the quality and risk committees.

Pain relief

- The trust had a pain management policy in place that was available to staff on the trust's intranet.
- Care assessment charts included space for recording patients' perception of pain. Nurses assessed pain during "intentional rounding". This is where staff attended patients at set intervals to check if they were comfortable. However, we did not see pain scores recorded in the sample of care assessment charts we examined.
- The trust told us that pain scores were recorded electronically on a mobile clinical system that monitored and analysed patients' vital signs in order to identify deteriorating conditions and provide risk scores to trigger the need for medical intervention. The trust raised as an issue in the June 2016 Executive Performance review that there was an issue with recording pain due to the incompatibility of the electronic devices used. This was under review at the time of our inspection.

- The trust had a specialist pain team available to support staff and staff knew how to contact them.
- Kingston Ward had pain scale communication aids available to support patients with speech problems.
- The patients we spoke with told us there was no problem with obtaining pain relief.

Nutrition and hydration

- The trust was using a nationally recognised tool to assess patients' nutrition and hydration. We reviewed a sample of risk assessments on each of the wards we visited which included nutritional assessments.
- We found that in general, the nutritional risk assessments were up to date and additional support from the dietician service was available when needed. However, patients were not always weighed which affected the risk assessment score. A patient on Harbledown Ward confirmed this as they had been losing weight, but had not been weighed or seen the dietician. Inaccurate nutrition scores could affect patients care and treatment.
- We spoke with the dietician service. There were three dieticians and two dietician assistants who covered the wards from 9am to 4:30pm Monday to Friday. There was no out of hours cover. Dieticians' received electronic referrals when patients' nutritional risk assessments indicated a problem.
- The sample 13 nutrition and fluid balance sheets we reviewed were incomplete. Staff told us they were too busy. Maintaining accurate fluid and nutritional balance records is important in assessing a patient's hydration and nutritional status. It helps with assessing and evaluating a patient's condition and enables staff to prescribe additional fluids and medication.
- Dieticians monitored patients who received nutrition through a nasogastric or parenteral feeding tube. Parenteral feeding is the process by which a patient receives nutrients intravenously bypassing the usual process of eating and digestion. They reviewed the patients' individual needs and wrote a plan of care. Dieticians reviewed the plan after three days and then weekly. On Kingston Ward, we reviewed the care of a patient receiving their food through a nasogastric tube.

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Staff completed checks to ensure the tubes were in the right place before giving patients their food through the tubes. A flow chart and guidance on doing this correctly was included in the patients notes.

- The 2016 patient-led assessment of the care environment (PLACE) survey showed the hospital scored 80.77%, which was worse than the England average (88%) for the quality of food.
- Staff offered patients three main meals and snacks were available if needed. There was a choice of food available and the hospital was able to cater for specialist diets if required.

Patient outcomes

- Mortality and morbidity trends were monitored monthly through SHIMI (Summary Hospital-level Mortality Indicator). The SHMI showed that the trust had reduced the number of deaths from August 2015 when the SHMI score was 91.14 to a score of 84.36 in March 2016. Over the past year, there had been a month-by-month improvement in the SHMI score. Reviews of mortality and morbidity took place at local, speciality and directorate level within a quality dashboard framework to highlight concerns and actions to resolve issues. The minutes of the mortality and morbidity meetings and the presentations into the investigations showed learning.
- Hospital episode statistics (HES) from September 2014 to August 2015 showed the standardised relative risk of readmission at Kent and Canterbury Hospital for both elective and non-elective procedures were within expectations apart from general medicine, which was better than expected.
- Across the trust, the standardised relative risk of re-admission was the same as England averages for both elective and non-elective patients. Staff we spoke with told us this reflected their experience that there were relatively few emergency readmissions onto the medical wards.
- Kent and Canterbury Hospital scored similar to the England average for elective re-admissions and slightly worse for non-elective readmissions. An outlier was Nephrology, (Kidney disease) which scored worse than the England average for both elective and non-elective readmissions.

- The hospital performed poorly in the sentinel stroke national audit programme (SSNAP) with a level D across all areas. A is the highest and E the lowest level of attainment. Between January and March 2016 there was a decline in performance in four of the patient centred domains and two of the team centred key indicators, all of which dropped to level E.
- Although there was a common stroke care pathway across the trust, differences in SSNAP ratings between the three hospitals occurred because of different levels of therapist input. We noted at Kent and Canterbury Hospital there was a lack of speech and language therapists, physiotherapy and occupational therapists.
- In the 2014/15 Heart failure audit, the hospital performed worse than the England average for the majority of in hospital care measures and slightly better for discharge care measures. We noted some improvement from the previous years submissions.
- The 2014/2015 National Heart failure audit data indicated less input from a consultant cardiologist although more input from other specialists. There was also a slight delay in inpatients receiving an echocardiogram. An echocardiogram is a sound measurement of the heart which produces an image used in diagnostic investigations.
- An angiotensin-converting-enzyme inhibitor (ACE i) is an important medicine used to treat high blood pressure and heart failure. Angiotensin receptor blockers (ARB) are medicines used to treat high blood pressure. The hospital scored better than the England average for discharging patients on ACEi or ARB. Staff referred more patients to a heart failure liaison service than the England average. However, there were fewer patients receiving beta-blockers on discharge, having a discharge plan or a cardiology follow up appointment than the England average.
- Non-ST Segment Elevation Myocardial Infarction (nSTEMI) is one of the three types of Acute Coronary Syndrome, which is considered a medical emergency. The Myocardial Ischaemia National Audit Project (MINAP) 2014/2015 scores for the care of patients with non-ST elevation infarction (nSTEMI) were worse for two of the three measures compared the England average. However, the scores had improved since the 2013/2014

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audit. The data indicated that the non-STEMI angiography rate was low. This indicated that although emergency coronary care was not as good as the England average the scores were improving.

- The hospital scored worse than the England average for 11 out of 17 measures in the National Diabetes Inpatient Audit 2015 and worse for the majority of measures since the 2013 audit. For example, 27% of diabetic patients were visited by the specialist diabetes team compared with 40% in the previous audit and the England average of 36%. Twenty percent of inpatients had a foot assessment during their stay compared with 42% in the previous audit and the England average of 34%. This showed a decline in the diabetic services undertaken at the hospital.
- The 2015 Lung Cancer Audit showed that the trust was below the level expected for three of the four indicators. These were for process, imaging and nursing measures. Of these patients, 89% were reviewed at a multidisciplinary team meeting, which was worse than the national average of 94%. Sixty-two percent had a pathological diagnosis compared with the national average of 69%. The non-small-cell lung carcinoma (NSCLC) not otherwise specified (NOS) rate was 13.9% against the England average of 11%. Of these only 25% of patients were seen by a specialist nurse against the national average of 80%. Although the overall results were only slightly lower than the England average, the lack of specialist nurse support was a concern, as this meant patients would not get the information and support needed to manage their condition.

Competent staff

- The trust had in place recruitment and employment policies and procedures together with job descriptions. Management completed recruitment checks to ensure new staff were appropriately experienced, qualified, competent and suitable for the post.
- On-going checks took place to ensure continuing registration with professional bodies. Registered nurses we spoke with told us the trust supported them in preparing for revalidation. Revalidation is the process that all nurses and midwives need to go through in

order to renew and maintain their registration with the nursing and midwifery council (NMC). Only nurses and midwives who are registered with the NMC may legally practice in the UK.

- All new employees undertook both corporate and local induction with additional support and training when required. Staff we spoke with confirmed they had received an adequate induction.
- Staff had the appropriate skills and training, and their competencies were regularly monitored through clinical supervision and the staff appraisal process. Staff throughout medical services told us of the additional training and development they undertook to improve their skills and develop their competencies. Management recorded all training undertaken on the central electronic training record.
- Staff competencies were kept on file by the ward. However, when we asked to view the competency file for Harbledown Ward, only medical device competencies were held on file. This meant there was not a robust system in place to monitor staff competencies.
- Management used the appraisal process to identify staff learning and development needs. The ward managers on Harbledown and Kingston Wards told us that staff appraisals were almost up to date with one or two exceptions.
- We observed that staff were professional and competent in their interactions with colleagues, patients and their relatives/carers during our inspection.
- A wide range of specialist nurses supported the nurses on the ward. For example, the dementia care team, palliative care team, safeguarding leads, diabetes care team and discharge co-ordinators.
- Most staff we spoke with told us regular team meetings were held and they were supported with their continuous professional development.
- Consultants undertook appraisals and there were systems in place to support their revalidation with the General Medical Council (GMC) registration.

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- Junior doctors told us that although there were teaching opportunities and education events, the pressure of work was such that opportunities were lost. They told us that the “Ward rounds are usually very quick with minimal teaching.”

Multidisciplinary working

- Throughout the medical services, we found effective multidisciplinary working. This included effective working relations with speciality doctors, nurses, therapists, specialist nurses and GPs. Medical and nursing staff and support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- We observed positive and proactive engagement between all members of the multidisciplinary team (MDT). We found the ward rounds were well organised and well attended by all members of the multidisciplinary team.
- Medical, nursing and therapy staff of all grades described the good working relationships between staff and directorates. For example, the staff on Harbledown Ward told us about the excellent support they received from the specialist services such as dementia leads and the end of life team.
- The consultants confirmed there was a daily MDT board round on the stroke unit. This included the available therapists. A weekly MDT meeting was held that included representatives from community services. The consultants praised the excellent teamwork at these meetings and the good community links.
- The wards used integrated patient records, which were shared by doctors, nurses and other healthcare professionals. This improved communication and meant that care was generally well co-ordinated between healthcare professionals.
- The lack of mental healthcare professionals was included on the divisional risk register. Although staff could access mental health support, their response was not timely due to lack of capacity. Mental health services were provided on a Kent wide basis by the local community mental health trust under a service level agreement.

Seven-day services

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

Access to information

- The hospital used mainly paper-based records. This meant there were sometimes delays when sharing information between hospitals and other providers who used electronic records and means of communication.
- Clinical staff told us they had prompt access to diagnostic results such as blood results and imaging. Staff told us there was no delay in retrieving old patient notes from the archives.

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- There were systems in place to ensure the safe transfer of information when a patient moved between wards or hospitals.
- Site managers and senior staff routinely collected site data to inform the management of the hospital and the trust as a whole.
- All the staff we spoke with told us there was good communication and access to information between staff and between medical specialities.
- Management held ward and departmental meetings on a regular basis. The minutes from these meetings confirmed that information was shared including clinical updates and lessons learnt from incidents and complaints.
- We saw that most clinical information and guidance was available on the intranet. Staff also had access to information and guidance from specialist nurses, such as the diabetic, stoma, and tissue viability nurses and the link nurses for dementia care, infection control and safeguarding.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

- Staff demonstrated good understanding of both written and verbal consent and where consent was implied, such as taking of bloods.
- On Harbledown Ward, three patients had current DoLS in place that were appropriately documented.

Are medical care services caring?

Good

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

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

However;

- On Kingston Ward, we observed one interaction between a member of staff and a patient that was not caring and compassionate.
- On Harbledown Ward, patients did not always feel safe because confused patients did not always receive the level of support the required.

Medical care (including older people's care)

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

Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. The average response rate for the Kent and Canterbury Hospital (25%) was similar to the England average (26%) for the most recent data from May 2016.
- Staff displayed Friends and Family information on notice boards around the wards and departments.
- Each ward and department collected the feedback monthly and this was displayed for staff, patients and visitors to view. The overwhelming feedback was positive across all the medical wards. Patients and their relatives praised the staff for their kindness and consideration in looking after them or their relative.
- A score above 50 is considered a positive indication that patients would recommend the hospital to family and friends. Across the medical services the feedback was consistently positive with between 85% and 100% of patients happy to recommend the hospital to their family and friends over the past year to May 2016. The highest scoring wards were Brabourne, Invicta, Marlowe, Mount/Mount McMaster and Treble all scoring 100%. The lowest scoring were the Clinical Decision Unit (89%) and Harbledown Ward (86%).
- All the wards scored well but some wards scored particularly well, for example, Brabourne achieved a score of 100% for nine out of 12 months between June 2015 and May 2016.
- Staff usually treated patients in a sensitive and considerate manner. We observed this during our inspection and patients confirmed that staff were "Lovely" and "Very kind." For example, on Kingston Ward patients who were able to communicate with us told us staff were caring and helpful. However, on the same ward we also observed a confused patient calling out for over 20 minutes. A senior member of staff pulled the curtains around the patient and left the patient still calling out and unattended.
- Staff we observed were consistently respectful towards patients and mindful of their privacy and dignity. They

demonstrated this by knocking on doors, asking before entering behind curtains and obtaining consent from the patients before undertaking any task. Patients on Kingston Ward told us staff always introduced themselves and respected their privacy. They gave examples of closing curtains when patients had family visiting or when doctors were examining them.

- Patients and their relatives all told us their positive experiences. They told us there was no difference in the quality of care received during the day or at night. Patients told us that the staff asked them if they had everything they needed, were comfortable, pain free and had adequate hydration. The majority of patients told us they had a quick response when they pressed the call bell for assistance.

Understanding and involvement of patients and those close to them

- We spoke with patients receiving medical care on most of the wards and units we inspected. They told us that staff explained care and treatment plans and they were provided with clear information. The patients we spoke with told us they were given adequate information about their treatment telling us that the risks, benefits and alternatives were explained to them.
- During the inspection we observed staff members introducing themselves to patients and relatives and explaining any treatment they would be receiving. One patient told us "All staff are very nice and friendly, they introduce themselves and I feel very involved in my care." Another patient told us how the doctor had called their daughter to explain their medical care and the plan of care.
- Each patient should be aware of who is responsible for their care to ensure that there is a clinician and nurse who was able to provide information about their care. Patients we spoke with were not always aware of the name of the staff member looking after them. One patient on Harbledown Ward told us they were not always told at the beginning of a shift who was caring for them. This meant the ward was not following best practice recommendations.
- On Harbledown Ward we spoke with a patient who had noticed an extra water tablet in their morning medications. The nurse had shrugged their shoulders

Medical care (including older people's care)

when questioned about the tablet. The patient did not take the extra tablet and did not tell the nurse, as they did not want to get them into trouble. This indicated that the nurse did not know the reason for the additional tablet or listened to the patients concerns and investigated the discrepancy.

Emotional support

- Emotional support was provided by clinical staff in the first instance. The hospital had arrangements in place to provide emotional support to patients and their families when needed, which included support from clinical nurse specialists, such as the end of life team, diabetes nurses, and dementia specialist nurses.
- Patients also had access to physiotherapists and occupational therapists who provided practical support and encouragement for patients with both acute and long-term conditions. Patients spoke highly of the therapy staff and told us of the help and support they received from them.
- We saw there were many different ways the staff provided emotional support to patients and their relatives throughout the hospital. Patients and their families had written to staff expressing their gratitude of outstanding care and staff had displayed the many thank you notes and cards.
- We spoke with patients and relatives who were receiving medical care at the hospital. On Harbledown Ward, a patient told us that they did not feel safe especially at night when a patient living with dementia was wandering through the ward.
- Another patient told us how good the staff were at keeping their relative informed. They told us that they had telephoned the relatives and knew they would be visiting later in the day as the nurse had told them.
- There was a hospital chaplaincy service, which provided spiritual, pastoral and religious support for patients, relatives, carers and staff. Chaplains were available 24 hours a day throughout the week and were contactable by staff, relatives or carers through the hospital switchboard.

Are medical care services responsive?

Good



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

However;

- The trust had plans in place to ensure that medical services across the county were sustainable and fit for purpose. The trust was engaging with all stakeholders to implement the changes.
- Where delays to the patient pathway were identified, action was taken to address the issues such as rapid access clinics, rapid discharge team and outsourcing diagnostic investigations.
- The average length of stay at the hospital for non-elective stays was better than the England average.
- Elective stays in general medicine and nephrology was better than the England average.
- Non-elective stays in general medicine and geriatric medicine were better than the England average.
- There was good provision for those living with dementia and their different needs had been taken into account. There was a range of activities available for those living with dementia.
- The majority of patients were admitted to the correct bed for their speciality and did not move beds or wards for the entirety of their stay.

However;

- The average length of elective stays at the Kent and Canterbury Hospital was worse than the England average.
- The average length of stay at the hospital for elective neurology stays was worse than the England average.

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

Service planning and delivery to meet the needs of local people

Medical care (including older people's care)

- The East Kent Hospitals University NHS Foundation Trust provides services to the population of Kent. Patients were admitted to the medical wards at the Kent and Canterbury Hospital through direct referral from their GP or through the urgent care centre.
- The trust was in the process of redesigning the clinical strategy for delivering medical care across the trust. This involved reorganising the acute medical model, implementing an acute frailty pathway, improving discharge pathways and reorganising the acute medical units.
- The trust was working with the commissioning bodies, staff and other stakeholders to ensure the new strategy was fit for purpose. The trust acknowledged that staff shortages, bed capacity and an inconsistent discharge process was affecting the patient experience, service planning and delivery.
- The new model of care incorporated emergency ambulatory care and the acute frailty pathways. At the Kent and Canterbury Hospital, the new medical model supported the urgent care centre. Additional consultant and nursing posts had been funded to support the new model with investment in the leadership and management roles. The new model was not embedded at the time of our inspection although we were shown data, which demonstrated an improved patient flow.
- The flow of patients through the hospital and delayed discharges remained a concern. This was a complex issue and reliant on both internal and external factors, including intake through the urgent care centre, GP referrals and lack of suitable beds or funding for support in the community on discharge.
- The trust had established an integrated discharge team. Staff reported this was having a positive impact. The hospital monitored discharge information through the weekly safer dashboard and the daily board rounds. Various initiatives to support safer discharges were in place and supported both internally and externally for example 'Discharge to Assess' and the implementation of 'Home First'. The trust was working with consultants, commissioners, community staff and the voluntary sector to improve discharge procedures across the trust.
- Consultants at the hospital praised the transient ischaemic attack (TIA) service and the Integrated Discharge Team (IDT). The IDT team included a

physiotherapist and an occupational therapist. The TIA Service is a rapid access service for patients who have experienced a TIA or "Mini-stroke". New patients were usually seen on the day of referral. We heard how the stroke consultants ran daily TIA clinics, Monday to Friday on all three sites across the trust and on one site at weekends. Consultants told us these services provided an excellent effective service to patients.

Access and flow

- From March 2015 to February 2016, the trust had over 80,000 admissions to medical services. This was higher than the majority of trusts in England. The Kent and Canterbury Hospital had 32,987 admissions. Over half of the admissions were general medicine with gerontology, dermatology and other specialities making up the remainder.
- There are two main types of hospital admissions, emergency and elective. Emergency usually happen when a patient seen in the emergency department is subsequently admitted to the hospital. Elective hospital admissions occur when a doctor requests a bed for a patient on a specific day. The average length of stay at the hospital for all elective stays was 7.1 days, which was worse than the England average of 3.9 days. The average length of stay at the hospital for non-elective stays was 5.1 days, which was better than the England average of 6.7 days.
- Elective stays in general medicine (2.6 days) was better than the England average of 4.0 days. The elective stay in nephrology (3.7 days) was better than the England average of 8.0 days. The average length of stay for neurology (11.9 days) was significantly worse than the England average of 5.8 days. The consultant cover at the hospital was reflected in the results and impacted on the patient experience.
- Non-elective stays in general medicine (2.3 days) was better than the England average of 6.2 days. Non-elective stays in geriatric medicine (4.8 days) was better than the England average of 9.8 days. Non-elective stays in nephrology (7.0 days) was similar to the England average of 7.6 days.

Medical care (including older people's care)

- Referral to treatment within 18 weeks was below the 90% standard and England average for six of the eight specialties from June 2015 to May 2016. Cardiology scored well at 97% and rheumatology at 96.6% was only slightly below the England average at 97.2%.
- The trust acknowledged they were unable to achieve 92% compliance with the gastroenterology services due to capacity, workforce and the heavy reliance on locum staff. Although performance was improving, the referral to treatment times for gastroenterology services was 84%.
- The senior management team told us the trust looked at addressing some of the issues causing delays such as outsourcing electrocardiogram (ECG) reporting as there were six weeks delays.
- The trust identified the key areas for delays were endoscopy, hysteroscopy and failure of the MRI scanner, which affected the urology prostate pathway. Patients waiting over 100 days were reported through the electronic incident reporting system and were reviewed weekly. Managers shared the incident reports at the patient safety board and discussed the reports at the cancer board meetings.
- In February 2016, the trust conducted an investigation into the number of incidents where there was a failure to act or delay in treatment. Forty-two incidents were identified over a two year period to February 2016. As part of the investigation, the trust was working to develop an alert system to flag those patients on a cancer pathway to ensure they received prompt investigations.
- Dedicated rapid access clinics were in place to provide additional capacity. The clinics were consultant led, supported by clinical nurse specialists. General managers reviewed the patient target lists weekly. The results and actions were reviewed at the monthly cancer board meetings.
- The rapid discharge team had an arrangement with a voluntary organisation to provide a service called 'Home and Settle', which was available from 10am to 10pm. The service provided minimal support such as help with shopping and ensuring the patient was comfortable and safe at home.
- The hospital held operational bed management meetings twice a day. Ward staff reported on the number of empty beds on their wards, expected admissions and discharges. The information then fed into the trust wide video conferences that were held three times a day to monitor bed capacity, discuss staffing, risks and escalation.
- Staff told us that across the medical services, that patients were sometimes admitted to inappropriate beds because of the pressures on bed capacity. This meant that outlier patients transferred several times before they had a bed on the right ward. Outliers are patients admitted to wards outside of their speciality. This was a risk as the general environment was not always appropriate and staff did not always have the experience and expertise to manage the patients' conditions. For elderly patients it was confusing to change beds and wards during their stay and there may not be rapid access to the specialty doctors in an emergency. On the day of our inspection there were eight outlier patients receiving care in areas outside of their speciality.
- The data on bed moves indicated that the majority of patients (88%) were treated in the correct speciality bed for the entirety of their stay. This was a slight improvement on 2014/2015 when 87% of patients did not move wards. During the period June 2015 to May 2016, 9,027 patients out of 74,016 patients experienced one ward move or more. 6,796 (9%) patients were moved once; 1,405 (2%) patients were moved twice; 535 (1%) were moved three times and 291 (0%) were moved four or more times.
- The hospital had recently designated a ward area to be a discharge lounge. The discharge lounge was open 8:30am to 7pm Monday to Friday. Between 11 to 20 patients used the discharge lounge each day and waited between half an hour to five hours for their transport home. Food and drinks were available to patients waiting in the discharge lounge. Staff and patients we spoke with in the discharge lounge were pleased that the space was available, but told us that being on the first floor meant patients had to go further into the hospital before being discharged home. We were told

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that some patients found this confusing and thought there was a mistake in where they had been placed. The Discharge Lounge was south facing and became very hot when the sun was shining.

- We noted that staff recorded the anticipated discharge dates on the wards main communication whiteboard. This meant that all staff could work towards the planned discharge.
- The hospital admitted new patients to the ambulatory care unit (AMU) by referral either from their GP or through a 999 call. They were then seen by the emergency on call team and reviewed by the on call consultant on the post take ward round. The two AMU senior house officers (SHO) looked after all other patients in AMU, including those who were still in AMU having been admitted earlier. All patients had an allocated named consultant who was responsible with his team for the patient's care. However the medical registrar in the Emergency Ambulatory Care (EAC) unit provided cover to the patients in the AMU if an urgent review was needed. The doctors told us that although the relevant registrar could be contacted by bleep, "It is sometimes difficult to get the team to see their patients if they have been in hospital for a few days." Staff gave recent examples of sick patients being seen by the on call medical registrar, as there was no one available from the patient's specialist team.
- The CT scanner was situated next door to the AMU, which enabled scans to be done quickly if needed. Patients told us they had had their tests and investigations undertaken in a timely manner and had received the results.

Meeting people's individual needs

- The wards used a system of "intentional rounding" to ensure that patients' basic needs were met. Nursing staff usually carried out the rounds at set times through the days .
- The trust employed specialist nurses to support the ward staff. This included dementia nurses and learning difficulty link nurses who provided support, training and had developed resource files for staff to reference. Wards also had 'champions' who acted as additional resources to promote best practice. On Harbledown

Ward, the general environment had been improved to provide a therapeutic environment for patients living with dementia. This included reminiscence activities and a dementia café.

The trust met the national target of screening over 90% of all patients aged over 75 years for dementia within 72 hours of admission.

- There were pictorial aides and communication tools available for use with people with communication difficulties. However, we only saw these in use on the stroke ward, which meant that patients with confusion or living with dementia may not have the tools available to communicate their needs.
- The general environment had been modified to provide assistance for those with limited mobility. This included ramps, assisted bathrooms and lavatories, mobility aids and manual handling equipment. Staff told us that specialist equipment such as bariatric equipment or specialist pressure relieving mattresses were available on request. This meant that the hospital was able to care for patients with mobility difficulties.
- In May 2016, the trust reported to the Quality Surveillance Group that the hospital had a mixed sex accommodation policy that was being adhered to. The report identified that at the Kent and Canterbury Hospital, mixed sex breaches occurred on the medical wards in the coronary care unit, ambulatory Care Unit and Treble Ward. The report identified the issues and the actions needed to ensure compliance. We noted that where building work was required, the trust had plans in place to address the issues. For example, on Treble Ward, an additional shower was required. This action was completed. Other areas such as the ambulatory care unit had no viable estates solution and the department was reviewing how it operated, in order to improve compliance.
- Although each bed had a call bell in place, on Harbledown Ward we noted that seven out of eight patients did not have easy access to their call bells. We found the call bells wrapped around the patients' lamps out of reach. This meant that patients could not use call bells to ask for help but had to call out to attract the attention of staff.
- We spoke with patients about the catering service. They told us that food was always served hot and there was a

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good selection available, although the quality of the food could be improved. Hot drinks and snacks were served throughout the day and the nurses always served patients a hot drink before bedtime.

- Red trays were used on the wards to identify those patients who needed assistance with feeding. We noted that eating and drinking requirements were noted above patients' beds on a white board. We saw instructions such as "thickened fluids only", "nil by mouth" and "Red tray" to remind nursing and catering staff of the patients individual needs.
- Across the hospital, we saw that there were leaflets and useful information available to help patients and their relatives understand their conditions and the treatment options available. These were easily accessible and prominently displayed on most of the wards we inspected. The printed information was only available in the English language. Staff told us that an interpreter service was available for those patients whose first language was not English.

Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas. Staff could also access the complaints policy on the trust's intranet.
- We saw information on raising complaints readily available on all the wards and departments we inspected with access to the Patient Advice and Liaison Service (PALS). Patients had access to the Patient Liaison and Advice service (PALs), who supported patients with concerns and complaints and provided information about NHS services.
- Senior nursing staff and managers told us that complaints were discussed at clinical governance meetings and information disseminated to staff through team meetings, briefings and the governance feedback bulletin 'Risky Business'. We reviewed a sample of governance meeting minutes and noted that complaints were discussed and monitored.
- Staff were aware of the complaints process and knew how to direct patients to make a complaint. They told us that they usually received feedback from any complaint they had been involved in. Junior doctors told us they usually received feedback from any complaints. On

Harbledown Ward, staff told us the complaints were kept in a folder, which were discussed at ward meetings. They told us that staff had to sign to confirm they had read the complaints and the actions needed.

- Patients told us they would raise any issues or concerns with the ward staff in the first instance, but they were aware of the formal complaints process.
- The management of complaints was included on the corporate risk register. Issues included an increase in the number of complaints, delays in response time, poor written responses and poor communication. The trust was investigating a web based complaints system to improve response times and communication between divisions and departments.
- Each speciality reviewed complaints in depth on a quarterly basis. Clinical governance minutes demonstrated that senior managers reported, investigated and learned from complaints at trust, division and speciality levels. The top three themes for complaints received were for delays, concerns about clinical management and problems with communication.
- A trust wide complaints newsletter was produced for disseminating the learning from complaints to staff in the trust. The first issue was sent out in June 2015 and was also attached to the trust newsletter. The newsletter contained the complaints and compliments data for the quarter for each division and includes case studies identifying service improvements within the trust as a result of complaints.

Are medical care services well-led?

Good



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

- The trust had a clear corporate vision and strategy, which engaged staff. Staff engagement was reflected in the developing strategy for medical services where clinicians, staff and stakeholders' opinions were taken into consideration.

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

However

- Although there were measures in place to promote positive behaviour and eliminate bullying, staff still reported incidents of poor behaviour from colleagues. This affected medical staff retention.

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

Vision and strategy for this service

- The hospital had well-documented and publicised vision and values. These were readily available for staff, patients and the public on the trust's internet pages, posters around the hospitals and on the trust's internal intranet.
- The hospital's vision was to provide 'Great healthcare from great people', with the mission statement 'together we care: Improving health and lives'.
- Senior managers at the trust told us of the trust's "Improvement journey". All the staff we spoke with from those on the wards to directors knew and understood the terminology "Improvement journey". They all described an improving safety culture, better clinical leadership and governance. However, there remained challenges with bed capacity, patient flow and developing a sustainable clinical strategy.
- We inspected the trust in 2014 and 2015 and found that medical care services at the hospital required improvement. This is because we identified concerns

with the environment, medical staffing and nursing staffing, support for patients with a deteriorating condition, the storage and management of medicines, record management, and infection control procedures.

- The hospital's improvement plan identified 30 actions. Stakeholders received monthly reports on the hospital's progress against the action plan. Although there had been much reported progress, the trust acknowledged staffing remained a concern, which in turn affected day-to-day activities and patient experience.
- We spoke with the Division of Medicine Directorate Management Team divisional leads. They told us of the new ideas and structural framework for the division. We were told that staff had been involved in the design of the new structure, which was now "Bottom up rather than top down" as was the case previously. The strategic direction and strategy for the medical services across the trust was under review. Senior managers were working with the commissioning bodies, consultants and staff in order to develop a sustainable service for the future.
- The senior management team told us that the main challenges to the trust were working within the constraints of the environment and the impact of staff shortages. For example, staff shortages in the Audit Department affected the trust's ability to carry out clinical audit.
- The management team acknowledged the pressures of medical staff shortages. There were plans in place to address this through centralising some of the specialties. The trust was addressing the nurse staffing issues through an overseas recruitment drive and a recruitment and retention strategy overseen by the strategic workforce committee. Over the next year, the trust had offered positions to over 100 overseas nurses. There had been three nurse consultants recently been appointed in Acute Medicine.

Governance, risk management and quality measurement

- The trust operated a divisional governance model. There were four divisions, which included surgery, urgent and long-term conditions, clinical support services and specialist services. The majority of medical services were included in the urgent and long-term conditions division.

Medical care (including older people's care)

- Over the past year, 'Triumvirate working' had been introduced. This was a structure, which ensured that both clinicians and managers were involved in the management and planning of hospital activities at every level. The Triumvirate model usually consisted of a lead clinician, a senior nurse and a manager. Each of the triumvirate leadership teams had responsibility for designated wards and departments.
- The trust identified that the divisional structure had to work across all locations and specialities taking into consideration the unique factors of the individual hospitals but ensuring consistency across the trust. There were monthly trust wide clinical and quality assurance meetings together with a risk group to look at emerging issues.
- Ward and department governance meetings fed in to the divisions' safety and quality meetings. The divisional governance meetings reported to the executive safety and quality committee. We saw minutes of meetings where quality issues such as complaints, incidents, risks and audits were discussed.
- The Executive Team (ET) was the main committee for approval of trust policy and procedure and for discussing and agreeing major strategic and policy decisions prior to approval by the Board of Directors.
- A number of external reviews had been commissioned to assess the trusts progress and the effectiveness of the changes put in place. A report from July 2016 found there was increased visibility of the senior managers and board; there was improved site management and safety, better staff engagement, stable divisional structures and strengthened leadership across the trust.
- The top five risks to the trust identified as were emergency care, staffing, clinical governance, planned care and finances. There were action plans in place to address the areas of concern and reduce the risks to patients and staff.
- We found there were corporate and divisional risk registers in place. Managers we spoke with were aware of the risk registers and knew the main risks and the actions needed to reduce the risks. The lack of medical trainees and consultants at the hospital meant there

was a risk that the Kent and Canterbury Hospital would not be able to offer an acute medicine service. The risks associated with this were included on the corporate risk register.

- We reviewed the minutes of meetings, which demonstrated that regular team and management meetings took place. The minutes documented how information on incidents and complaints were investigated and any learning shared and good practice promoted.

Leadership of service

- Across the hospital, staff spoke of the visibility of the senior management team. They told us that the chief executive and chief nurse visited front line services on a daily basis. They told us they felt free to raise any issues with them direct or through their line manager.
- Across the medical services, local ward and department leadership was generally good. Staff told us they felt well supported, valued and that their opinions counted. All ward managers we spoke with knew what their wards were doing well and could clearly articulate the challenges and risks their ward faced in delivering good care.
- The managers we spoke with were aware of the hospital's improvement plan and their role in implementing it. There was a structure of daily site meetings, which occurred twice a day at the hospital. These fed into the trust wide meetings, which occurred three times a day and were held by video or conference call. Managers took issues that required escalating to the board through the various governance routes and then communicated the outcome back to teams.
- There were educational programmes to educate, support and develop new leaders in the organisation. These included the Clinical Leadership Programme, the Aspiring Consultant Programme and the Medical Clinical Leadership Programme.

Culture within the service

- Following the last inspection the trust had initiated the "great place to work" initiative. The actions from this included the executive development programme, which was to start in October 2016, targeted interventions for

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the “respecting each other” campaign, the health and wellbeing group, embedding values based appraisals and medical engagement. The trust was auditing the engagement of clinicians during the inspection.

- We heard from all staff groups throughout the hospital that the trust was “On a journey”. Staff were positive about working for the hospital, and spoke with pride about how far they had come in such a short time. They told us they now felt valued and that their opinion mattered. Although they acknowledged there was still a lot of work to do, they felt part of the plan to put things right. For example, staff remained under pressure to deliver high quality care with an increasing workload and low staffing levels. The change in culture meant they now felt able to escalate the staffing issues and senior managers worked together to find solutions.
- The trust monitored workforce performance indicators in order to plan recruitment and monitor trends. The June 2016 staffing data indicated 11% vacancy rate, 10% turnover rate, 68% appraisal rate, sickness absence of 4% and mandatory training at 87%. This was similar to other NHS trusts. The staff survey action plan for the urgent care and long-term conditions division was working towards reducing sickness absence to 3.5%, improving the vacancy rate to 10%, the mandatory training and appraisal rates to 95%. The action plan gave a target date of September 2016.
- Staff told us that the culture in the hospital was generally inclusive and supportive. They told us that following the trust’s “Respecting each other” campaign, there had been less incidents of bullying reported. However, we received comments that there were still pockets of a bullying culture operating within some staff groups.
- The June 2016 Family and Friends Test indicated that 80% of staff had never experienced bullying or harassment and the majority of staff would feel confident in reporting such issues. Ninety six percent of staff were aware of the trust’s anti bullying initiatives.
- Staff said that there was still a bullying culture. They told us that a number of consultants had moved elsewhere because they were unhappy. One staff member told us “the bullying culture has not improved, we are not valued”.

Public engagement

- The trust’s website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and the public a wide range of information about the safety and governance of the hospital.
- The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch, feedback from the Friends and Family Test, inpatient surveys, complaints and the ‘How Are We Doing?’ initiative.
- Stroke services organised ward based patient groups run in conjunction with charitable organisations. Patients and their families were given access to support groups and information resources to help them understand and adjust to stroke and traumatic brain injuries.
- The “hello my name is ...” initiative was widely practiced by staff and during our visit and we heard examples of staff using this when talking with patients. The initiative is aimed at raising awareness for staff to always introduce themselves to patients. Patients confirmed that staff always introduced themselves before any treatment or therapy.

Staff engagement

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


Medical care (including older people's care)

- The trust recorded a positive staff friends and family test result with 57% of staff recommending the trust as a good place to work (up 8%) and 78% recommending the trust as a good place to receive treatment (up 4%).
- Staff we spoke with assured us they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested that the trust had an 'open culture' in which staff could raise concerns without fear.
- The trust's Improvement and Innovation Hubs were now an established forum to give staff the opportunity to learn about and to contribute to the trust's improvement journey. The hubs were run by staff and provided topics of interest suggested by staff that could be accessed at any time the hub was open. The Kent and Canterbury Hub was open every Wednesday between 10am to 2pm.
- We saw the programme of events developed by staff to educate and support each other on the improvement journey. These included dementia, sepsis, and staff wellbeing. A fortnightly newsletter was developed to spread information resulting from the hubs activities. Staff spoke highly of the value of this means of communication, stating the only drawback was there were sometimes insufficient resources on the ward to release staff to attend.

Innovation, improvement and sustainability

- Across the medical directorate senior managers, directorate leads and front line staff told us that the trust had another two years of hard work ahead to improve the quality of care. All staff were aware of the term 'Improvement journey' and told us that there was little risk of slipping back because of the changes at both senior management and ward level.

Maternity and gynaecology

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

Information about the service

Summary of findings

We have also included our findings of the services at Kent and Canterbury Hospital in the William Harvey Hospital location report due to the limited number of maternity services at this location. Births do not take place at Kent and Canterbury Hospital with mothers going to either the William Harvey Hospital in Ashford, or the Queen Elizabeth the Queen Mother Hospital in Margate. Kent and Canterbury Hospital has a midwife led unit providing pre and postnatal services including education classes and breast feeding support. Gynaecology services are provided at the day surgery unit, which also offers pre and post-operative advice.

Maternity and gynaecology

Are maternity and gynaecology services safe?







Are maternity and gynaecology services responsive?

Are maternity and gynaecology services effective?

Are maternity and gynaecology services well-led?

Are maternity and gynaecology services caring?

End of life care

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

Information about the service

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

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

A medical palliative care consultant from the Pilgrim's Hospice supported the SPC team.

The chaplaincy team provided multi-faith support.

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

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

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

During the inspection, we visited a variety of wards across the hospital including Marlow, Taylor, Invicta, Mount McMaster/Mount, Brabourne, and Treble ward. We also visited the relative support offices and the porters lodge.

We reviewed the medical records of nine patients receiving end of life care. We spoke with 15 members of staff that included junior ward doctors, clinical nurse specialists, registered nurses, end of life facilitator, a relative support officer, ward matrons, heads of nursing and porters to assess how end of life care was delivered.

We reviewed documents relating to end of life care provided by the trust and observed care on the wards provided by medical and nursing staff. We spoke with two patients receiving end of life care and one family members. We received comments from people who contacted us individually to tell us about their experiences.

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

The delivery of safe care was not always possible due to the lack of staff training when new equipment arrived. We found out of date medicine charts in use and where new policies had been introduced; frontline staff were unaware of the new policies and were not implementing them into clinical practice. Staff delivered good care, however, no extra staff were placed on wards when nursing end of life care patients which meant patients and their loved ones did not always get the support they required.

We found the effectiveness of the service to be 'inadequate'. Identification of patients who were approaching the end of their life's was poor which meant

End of life care

clinical interventions were not removed and comfort care put in place. We found no individualised care plans. Care delivered did not reflect patient's wishes and preferences and did not reflect national guidance. Attendances at end of life training sessions were poor for both medical and nursing staff with more buy in needed from consultant colleagues.

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

Summary of findings

We rated the trusts end of life service as requires improvement because:

- The trust's SPC team demonstrate a high level of specialist knowledge. A strong senior management team who were visible and approachable led them. The SPC team provided individualised advice and support for patients with complex symptoms and supported staff on the wards across the hospital. However, the SPC team were small and there were concerns regarding the sustainability of the service. We noted the planned improvements and the implementation of the end of life strategy would be difficult to apply due to the current available resources.
- We found an array of service improvement initiatives had been introduced across the trust since the last inspection. This included end of life care plan documentation, the appointment of an end of life facilitator, identification of end of life care link nurses, and a decision making end of life board. We saw the SPC team had a stall at the Quality, Innovation, and Improvement hub to spread the word and raise the profile of end of life care.
- All service improvements were based on national guidance. However, we found changes were recently implemented and more time was required to embed the changes into clinical practice, upskill staff and provide a robust training and education programme to ensure end of life care was delivered following national recommendations.
- Since the last inspection, we found the training of junior and speciality doctors had improved with the SPC team invited to divisional meetings to present and raise the profile of the importance of good end of life care conversations and symptom control. We saw Clinical leads were championing end of life care however, further work was required to strengthen collaborate working with consultants.
- Staff told us that since the last inspection end of life care had a much higher profile across the trust. However, we found on the wards that ceiling of treatments were not generally documented, poor completion of nursing notes which made it difficult

End of life care

to assess if patients were being reviewed regularly. There were no mental capacity assessments completed for vulnerable adults who lacked capacity.

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

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

Are end of life care services safe?

Requires improvement 

We have given Safe a rating of Requires Improvement because:

- Staff understood their responsibilities to raise and report concerns, incidents and near misses. They were clear about how to report incidents and we saw evidence that learning was shared across the teams. However, the IT system was slow with some staff suggesting not all incidents were reported because of this. This has not improved since the last inspection.
- Generally, we found out of date syringe driver prescription charts were no longer in use.
- A greater proportion of patients were identified as dying however; we found the decision often left staff confused as active treatments were still being delivered. Experienced staff were able to question clinical practice however, more junior staff would not.
- End of life training of the generalist staff was patchy, and many had received no training around the use of end of life care documentation. There was a gap in the skills set of the generalist staff delivering end of life care. This gap will continue to exist until the link nurse are fully training and performing their new support roles. Staff still found accessing the training modules difficult.
- No 7 day face to face access to the SPC team was available which meant that processes out of hours was often difficult, and time consuming which could delay treatment times for patients.
- Nursing records were poorly completed which meant it was unclear if patients were being reviewed regularly in line with national guidance.

However :

- We found portering training had improved since the last inspection. Porter's received training around new trust policies.
- We were able to view the training records on the wards of the syringe driver's competency programme. This programme had been introduced since the last inspection.

End of life care

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

Incidents

- All the staff we spoke with told us they were encouraged to report incidents using the electronic reporting system. During the last inspection staff told us the reporting system was slow. Staff confirmed during the inspection there had been no change in the workings of the reporting system.
- The trusts incident reports for July 2015 to July 2016 consisted of 53 incidents relating to end of life care, 10 of which related to Kent and Canterbury Hospital (K&C). The data indicated that no incidents had resulted in serious harm. Staff gave examples of incidents that had been reported and the feedback they had received. One incident involved inappropriate communication between a doctor and a patient. This resulted in more training for staff in communication skills which was undertaken by the SPC CNS.
- Lessons learnt from these events were regularly communicated through handovers and staff meetings. On Marlow ward, the ward manager monitored their incidents and identified themes. The ward was undertaking a pilot study which had resulted in fewer incidents.
- The mortuary provided data about incidents across all 3 sites from July 2015 to June 2016. Forty eight incidents had been reported in the past year with 3 of the incidents having taken place at the Kent and Canterbury site. These were around failures in identifying deceased patients and infection control issues. We reviewed that end of life board minutes and saw that these incidents had been highlighted and extra training was going to be introduced as part of the 'back to basics' nursing programme.
- During the last inspection it was highlighted that the last offices policy had not been embedded across the trust. This had resulted in mortuary staff participating in a 'task and finish group' for last offices procedure which led to the redesign of the '10 steps form' which was used by the nursing staff on the wards and a communication campaign at the Quality, Improvement and Innovation hub. (QII) Mortuary staff told us deceased patients arrive in the mortuary in a respectful and dignified manner since the '10 steps form' has been updated.

- The lead mortuary technician at the QEQM (Queen Elizabeth Queen Mother) manages overall incidences and shared learning across the three sites. For each incident, feedback was provided to wards and portering managers.
- A portering manager described one incident involving a deceased patient at William Harvey Hospital.(WHH). This was recorded on the portering company and trust reporting system. The porters involved in the incident had received further training around the placement of deceased patients into the mortuary fridges. Two porters who were not directly involved in the incident at K&C were able to describe this, as the learning was shared across the three sites with all porters.
- Staff were able to describe the new duty of candour regulation. This regulation requires the trust to be open and transparent with a patient when things go wrong. Staff we spoke to were able to articulate the need to be open and honest.

Cleanliness, infection control and hygiene

- The wards, we visited were clean, bright, and well maintained. In all clinical areas, the surfaces and floors were covered in easy-to-clean materials allowing hygiene to be maintained throughout the working day.
- On the wards we visited we saw clear signs reminding staff and visitors to follow the infection control guidance. We saw that staff observed appropriate precautions when attending to patients and between patient contacts. There were hand hygiene dispensers in place and written reminders for visitors to clean their hands.
- Ward and departmental staff wore clean uniforms and observed the trust's 'bare below the elbows' policy. Personal protective equipment (PPE) was available for use by staff in all clinical areas. Porters told us they use gloves and gowns when transferring a deceased person from the bed to the trolley in the wards. PPE was removed during the transfer and was worn again on arrival at the mortuary.
- Guidance was available for staff to follow to reduce the risk of spreading an infection when providing care for people after death in the trust's 'Last offices policy'. The policy included the wearing of gloves, aprons and the use of body bags. Adequate supplies of body bags were available. However, we noted in the mortuary incidents, mortuary staff did not always learn on time that a deceased patient had had an infection.

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Environment and equipment

- Staff told us they had access to equipment needed for caring for patients at the end of their lives including syringe drivers, pressure relieving air mattresses, and air cushions. These were readily available through the equipment library. Staff on the wards told us that there were no issues securing equipment in and out of hours to support patients.
- The trust used syringe drivers to deliver consistent infusions of medication to support end of life patients with complex symptoms. Patients discharged were discharged with the syringe driver in place. This did raise issues as the syringe drivers were not being returned to the hospital after use. However by discharging a patient home with a syringe driver in place meant that patient's symptoms were kept under control during the transfer to their preferred place of care.
- We reviewed documentation for the syringe drivers and saw planned preventative maintenance (PPM) was 89% completed (108 of 122). A business case (to be approved) to improve medical devices maintenance for all of the medical devices in clinical use was currently achieving 75% across the trust, recommendations were made to increase this to 95%.
- On Invicta ward, the ward manager described the checks undertaken prior to attaching a syringe driver. The checks included flow rate, the battery life, the amount of medication to be infused and checking the infusion site. Two Registered Nurses (RN) would undertake the checks.

Medicines

- Patients receiving end of life care were prescribed anticipatory medicines to enable prompt symptom relief at whatever time the patient develops distressing symptoms. The SPC team had introduced 'guidance for patients in the last hours or days of life', which set out the management of patients who had been recognised as dying. The guidelines gave easy to follow instructions on the drug management of symptoms in the dying patient. We saw the guidance was available in the ward resource folder and on the end of life care web page. On the wards we visited, we saw end of life patients had been prescribed anticipatory medications.
- On Marlow ward, we reviewed the patient's medical notes of a patient discharged to the hospice. We saw the

appropriate end of life drugs were prescribed however, there was no evidence on the electronic discharge of the medication prescribed which introduces a level of risk during the transfer to the PPC.

- A ward manager we spoke to told us that when prescribing end of life medication they would generally start on the lowest dose for analgesia and work up the dose. If several PRN (as needed) medication was required over a 24 hour period the medication would be reviewed by the medical team or SPC team and a syringe driver would be prescribed to manage symptoms. PRN stands for 'pro re nata' and refers to medication that should be taken only as needed. We saw this practice had been followed on Invicta ward where a patient required too many PRN's in 24 hours to control pain. The patient was reviewed and doctors prescribed the medication through a syringe driver at 13.30 pm and by 15.30 pm, the syringe driver was attached.
- Medical teams could contact the SPC team if patient symptoms persisted, or the patient had a complex medical condition. We saw medication guidance had been developed to support patients with a variety of conditions including end stage renal failure and heart failure. On Mount McMasters Ward, the foundation year 2 (FY2) doctor told us that they were happy to prescribe end of life anticipatory drugs, as the guidance was very clear.
- We were told by staff on the wards we visited that medication for end of life care was available on the ward and was easily accessible. We observed locks were installed on all store rooms, cupboards, and fridges containing medicines and intravenous fluids. Medicine cupboard keys were held by the nursing staff.
- We found that controlled drugs (CD) were handled appropriately and stored securely. This demonstrated compliance with relevant legislation. Controlled drugs were regularly checked by staff working on the wards we visited. We checked the contents of the CD cupboard against the controlled drug register on two wards and found they were correct.
- During the last inspection, it was found that out of date syringe driver prescribing and record of administration forms. These referred to two types of syringe drivers no longer used in the trust. In the prescription charts we reviewed during this inspection we found that, a sticker had been introduced referring to the correct syringe driver.

End of life care

Records

- We reviewed the paper medical records of nine patients receiving end of life care. These demonstrated the SPC team had supported and provided evidence-based advice, for example, on complex symptom control and support for the patients and families as they pass along the care pathway. This specialist input by the SPCT ensured that a high level of expertise was used to ensure the best possible care was delivered to end of life care patients.
- The 'record of the end of life conversation' documentation was not in use at the time of the last inspection but was introduced across the trust in December 2015. This had been developed by the SPC team to support full discussions with patients and their families on their diagnosis, prognosis, and options and had to be completed by the consultant or registrar caring for the patient. We found that in the nine patient's records we reviewed, we found that only four had this documentation completed. The SPC team told us that due to poor compliance of the completion of this documentation senior nurses could now complete the documentation.
- In the 'record of end of life conversation' documentation it states that when completed a copy be faxed to the general practitioner (G.P) and the SPC team. We found no evidence in the patients' medical notes that copies had been faxed to the GP or the SPC team.
- The critical care unit had developed a 'ceiling of treatment form' which was completed for all patients. The document included information such as the rationale for making decisions regarding the use of ventilation and hemofiltration, and whether medication was required for comfort and symptom control. Having clear guidance on the ceiling of treatment supports staff to deliver individualised care to fit the needs of the patient.
- The SPC team told us the record of end of life conversation (RELC) form, when completed, was the ceiling of care. However with poor compliance in completing the RELC form meant that many end of life patients had no ceiling of care documented.
- In one set of nursing notes we reviewed on the unannounced inspection, we found that the completion of nursing records were poor. We found that the rounding, skin integrity checklists, and repositioning charts were not completed daily and during a day, the number of checks varied considerably. We also saw the end of care record was only completed once a day and not four hourly. Nursing care records need to be completed to identify that good regular care is being delivered.
- On reviewing patients, medical records we saw that patients were being regularly assessed by the physiotherapist to ensure all efforts were being made to ensure the patients were comfortable. We saw referrals were made to speech and language therapists to ensure end of life patients received adequate nutrition and hydration. Comprehensive assessments were documented in the patients' medical records by the therapists.
- In January 2016 the SPC team introduced the 'end of life care record' which covered the '5 priorities of care' and was being implemented for patients in receipt of end of life care. The care record guided staff through symptom control, comfort measures, and psychological, spiritual, and social needs. On 4 wards we visited we found that the end of care record was not being used by the ward staff so more work is required to embed this care record into clinical practice.
- In nine patients' medical records we found Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) orders at the front of the medical records allowing easy access in an emergency.
- Records were stored securely and patient confidentiality was maintained. The SPC team audited a sample of patients' medical notes for end of life documentation on a three monthly basis and provided feedback to the wards.
- There were clear recording systems in the mortuary for the admission and storage of deceased patients and their discharge to the care of funeral services.

Safeguarding

- Staff explained to us that they undertook safeguarding training. Safeguarding training was a mandatory subject. Staff who spoke with us were able to demonstrate their knowledge and understanding of safeguarding vulnerable individuals, including signs and symptoms and the action to be taken.

Mandatory training

- All SPC team and mortuary staff were up-to-date with their mandatory training. The majority of the mandatory training was e-learning with some face-to-face training.

End of life care

- End of life training was not mandatory across the trust .However, the SPC senior management team were working with an outside provider to develop end of life care mandatory e-learning modules. The priority at present was to train all palliative care/end of life care link nurses who would support the training of frontline staff on the wards. At the time of the inspection records confirmed that 54 end of life care link nurses had attended the initial training day in July 2016.
- During the last inspection staff told us that there was significant reliance on e-learning to ensure staff were updated regularly. However, staff told us the trust IT systems were not fast or reliable enough to support this training. They described difficulties accessing the courses; the slowness of the system and the completed training was not always saved and recorded by the system. We found during this inspection the same issues still existed.

Assessing and responding to patient risk

- The trust used a mobile clinical system that monitors and analyses patients' vital signs providing clinicians with accurate, real-time information. The system monitors all admitted patients and can alert staff of deterioration in their condition .For the patients receiving end of life care the system recognised patients were on this pathway and the need for monitoring was reduced to a minimum. On one of the wards we visited staff were able to demonstrate the system; we saw one patient receiving end of life care had monitoring reduced to a minimum.
- For patients, where the progression of their illness was clear, care was based on ensuring the person remained as comfortable as possible, at all times. However, we saw often the decision whether the patient was at the end of their life changed several times as the patient was prescribed treatments. On reviewing a patient's medical notes on Mount McMasters ward there was confusion around whether the patient was to receive end of life care as active treatments were commenced after the decision to place on the end of life pathway was made. This left staff confused. However, when patients were finally identified as at the end of their lives, monitoring was modified to ensure an emphasis on comfort. Staff told us that any changes to the frequency of monitoring was discussed with patients and their families to ensure they understood the plan of care.

- We reviewed a set of patient's records and found that a 'rounding checklist' was in place. This included checks for pain, comfort, food or drink , and whether mouth care was required. However, we found there was poor completion of the rounding checklist. Over a 2 week period, we found that completion of the records varied from one check a day to 12 checks a day. This suggests more time was required to complete the nursing records to reflect the care being delivered.

Nursing staffing

- The clinical nursing staff levels of the SPC team had not changed since the last inspection with a trust-wide nurse consultant and two CNS is covering the Kent and Canterbury site. No cover was available for annual leave or sickness for the nurse consultant role. The nurse consultant covered holiday periods for the clinical nurse specialists.
- The SPC team were unable to provide out of hours cover. Telephone advice out of hours was provided by the hospice.
- The SPC nurses provided advice and support to patients, relatives, and staff on all aspects of end of life care. This included complex symptom control, patient involvement in decision-making and the delivery of education and training to staff across the hospital.
- End of life care 'link' nurses were available on individual wards. We were told that 100 link nurses had agreed to take on the role during the inspection.
- An end of life facilitator had been recently appointed to the team. This role would spend one day each week on each site and any extra time would be spent where support was needed. This role was not a clinical post but supported the training and education needs of all staff across the trust.
- We were informed that two cancer charities funded nursing posts had been put on hold by the trust. Discussions were still taking place to decide the best role to support the SPC service across the 3 sites.
- Nursing staff told us that there were insufficient numbers of staff to ensure that needs of patients were met. Staff told us that no extra staff were allocated when end of life patients were being nursed on the wards.
- There had been no increase in the salaried chaplains since the last inspection across the trust. A good network of volunteers and seven sessional chaplains were available

End of life care

- A counsellor and social worker were part of the SPC Team. They worked across the 3 sites.
- The porters told us they feel they did not have enough staff at weekends at KCH (three to four porters)

Medical staffing

- There was 0.2 WTE palliative care consultant visiting K&C from the hospice. Two ward rounds each week were undertaken, along with attending the SPC multi-disciplinary team meeting and the local site meetings.
- There was no medical palliative care consultant cover in the hospital out of hours but advice was available via the hospice. This had not changed since the last inspection.
- During the last inspection, we were told that there had never been any service level agreement (SLA) regarding medical time between the trust and the hospice. Following the inspection discussions took place between the trust and the hospice. The first draft of the 'service level agreement' was with the procurement team and the second draft had just arrived. The trust will use this SLA as a baseline and then work out the gaps in the service. The SLA will not address medical cover outside normal working hours.

Major incident awareness and training

- The trust had a business continuity management plan in place with a framework for dealing with the disruption of services. This covered major incidents such as winter pressures, severe loss of staff, loss of electricity or water. We saw that major incident training was now part of the mandatory training programme and staff were being encouraged to view a video and sign onto the training day.
- The Mortuary technician lead was currently developing a trust wide policy specific to mortuary. This was due to be ratified by the end of life board in October 2016. This would link to the trust's overall major incident plan. Mortuary staff were aware of the major incident awareness plan.
- Mortuary staff told us that if demand was high across the trust 24 extra spaces were provided at William Harvey Hospital mortuary. If all fridge spaces were occupied, mortuary staff would work with funeral directors who would accommodate up to six patients per site within the hour throughout the week.

Are end of life care services effective?

Requires improvement



We have rated effective as requires improvement because:

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

However

- Since the last inspection, 100 link nurses had been identified through the appraisal process to support good end of life care across the wards. Their role through training and education will be to cascade the latest end of life care information to all staff groups. The

End of life care

training of these link nurses has commenced however time will be required to embed these roles into clinical practice and support the service development work of the SPC team.

- Pain medication was reviewed daily by the renal consultants and registrars due to the specific needs of patients in renal failure. Out of hours, support was available from the renal registrar up to 10pm each night with consultants on call from home if any complex issues develop.
- Staff described how supportive and responsive the SPC team were which was reflected in the data we reviewed. The SPC team aimed to respond to requests to review patients with complex symptoms within 24 hours. In 2015/16 the SPC team received 1,471 referrals and reviewed 1,420 patients within 24 hours. This is a compliance rate of 96.5%
- Since the last inspection, the trust took part in the National Care of the dying Audit Hospital (NCDAH) round 5: 2015. A NCDAH action plan was developed to address the key findings. We saw evidence during the inspection that improvements were in the process of being actioned.

At our last inspection, we rated effective as inadequate. On this inspection we have changed the rating to requires improvement because: link nurses have been appointed and new SPC nurses are in post.

Evidence-based care and treatment

- East Kent hospitals University Foundation Trust (EKHUFT) had responded to the National Recommendations of the Liverpool Care Pathway (LCP) review, 'More Care, Less Pathway' (2013) by removing the LCP from the trust in July 2013. During this inspection ward staff confirmed the trust were no longer using the LCP and it had been removed some time ago. This showed that the trust had responded to concerns regarding the LCP and informed staff of its removal. However, during the last inspection we found no guidance had been given to staff after its removal apart from staff continuously assessed the needs of all patients and clearly identifying patients who appeared to be dying.
- Since the last inspection the SPC team had introduced end of life care documentation to give generalist staff

more guidance on delivering care around the '5 priorities of care' and with the introduction of an end of life facilitator bring together the trusts education programme around end of life care.

- There had been 2,608 deaths across the trust during the period April 2015 to March 2016. We reviewed the SPC team data and saw that 1,625 patients referred to the SPC team during this period, which was a 14% increase on the previous year where 1,393 patients were reviewed.
- The SPC team aimed to respond to requests to review patients with complex symptoms within 24 hours. In 2015/16 the SPC team received 1,471 referrals and reviewed 1,420 patients within 24 hours. This is a compliance rate of 96.5%. Urgent advice was available from the SPC CNS's via the telephone prior to reviewing the patient. Staff on the wards we visited told us how very responsive the SPC team were and how they would always be available to give telephone advice
- The trust followed the manual for cancer services (2004) guidance which reflects the National Institute of Health and Care Excellence (NICE) guidance for improving supportive and palliative care for adults (Quality Standard (QS) 13) and the '5 Priorities of care' recommended by the Leadership Alliance. We saw guidelines had been developed for the medication necessary to support the management of the five symptoms experienced by patients at end of life. Symptom control algorithms had been agreed and implemented to support the management of dying patients. We were shown these were available on end of life care web page and symptom control booklet.
- The nurse consultant was part of the end of life pathway/integrated group working alongside four Clinical Commissioning Groups. The aim of the group was to improve end of life care across the county. The work was based on national guidance. The group had recently introduced patient and carer information packs which we were able to review. However on the wards we visited staff were not using the information packs as no training had been received by the nursing staff around the use of the documentation.
- The choice of medications at the end of life had been aligned to local community guidelines to support safe and consistent practice between care providers. Medical consultants from the SPC team worked across the trust and hospice, which improved the continuity of care for patients.

End of life care

- By the trust having a SPC team, patients were able to benefit from the specialist knowledge of the SPC team, who worked alongside other specialist nurses in providing evidence based care and treatment. We reviewed the medical records of nine patients on Marlow, Mount McMaster and Invicta wards receiving end of life care; these demonstrated the SPC team had supported and provided evidence-based advice for example, on complex symptom control and support for the patients and families. This specialist input ensured a high level of expertise was used to ensure the best possible care was delivered to end of life care patients.
- The trust took part in the National Care of the dying Audit Hospital (NCDHA) round 5: 2015. The audit highlighted the trust performed below the national average in all five clinical audit indicators performing poorly around audit indicator three which was 'patient was given an opportunity to have concerns listened to' and audit indicator four, which was evidence that the 'needs of person important to the patient were explored.' Of the eight organisational audit indicators, the trust achieved six of these. Of the two they did not achieve we saw that one had been achieved with the appointment of an end of life facilitator in May 2016.
- In order to address the organisational audit indicators not achieved and to improve compliance in the clinical audit indicators, a NCDHA action plan was developed to address the key findings. We saw evidence during the inspection that improvements were in the process of being actioned.
- To maintain standards and ensure consistent care for patients approaching the end of their life, staff were asked to continue to regularly assess the needs of all patients. The decision to place patients on end of life care was a multi-professional one led by the medical consultant or a senior nurse after discussions with the patient and family. To support the ongoing care, documentation called the 'end of life care record' was introduced in January 2016. This was based on the 5 priorities of care and was a guide/prompt for care only. A new care record would be completed each day. However, in the notes we reviewed on Mount McMaster and Treble ward we found the documentation was not being used.
- The SPC team had developed the 'multidisciplinary prompts for the care of patients at end of life' and incorporated national guidance. The prompt flowchart

was a checklist, which aimed to support staff as an aide memoire when caring for end of life patients. On reviewing nine sets of patient records, we only found the 'prompt' in one set of patient records.

- On Treble ward we reviewed the medical records of one end of life patient and found the RELC was completed by a doctor who confirmed their PPD, DNA CPR in place, all unnecessary medicines were stopped, and anticipatory medicines were prescribed.

Pain relief

- Effective pain control was an integral part of the delivery of effective end of life care. On Mount McMaster Ward, a senior nurse told us that patient pain levels would be reviewed four hourly. If the ward team was unable to manage pain effectively, the SPC team would be called to review the medication prescribed. In the recent end of life survey report, April 2016, relatives were asked if they felt 'that pain was controlled in the last days of life. Relatives responded by saying that 40% of patients received excellent pain control however 14% received fair to poor pain control. This suggested that more work was required to improve pain management in the last days of life.
- As part of the end of life care record, pain was assessed four hourly. On the wards we visited staff told us for end of life patients they would assess pain more often if patients were suffering as well as on the medication rounds. On Invicta ward, we saw one patients pain control was assessed more regularly due to fracture.
- The SPC CNS's were nurse prescribers and were involved in advising and reviewing the medication of patients approaching the end of life. The SPC CNS's were able to give advice on the medication required to manage pain effectively as well as advising the medical and nursing teams around the medication that the patient no longer required. We were told by staff on the wards we visited all patients who needed a continuous subcutaneous infusion of opioid analgesia or sedation received one promptly. On Mount McMaster ward, we reviewed a prescription chart and saw that the syringe driver was attached within two hours of being prescribed.
- We found no information for patients and relatives on end of life medication however; we found information

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for patients and carers that the SPC team had developed on the syringe drivers used across the trust. However, on Treble, Taylor and Mount McMaster wards staff had not seen the booklet and were not using it.

- On Marlow ward, the ward manager told us that patients' pain medication was reviewed daily by the renal consultants and registrars due to the specific needs of patients in renal failure. Out of hours, support was available by the renal registrar up to 10pm each night with consultants on call from home if any complex issues develop. The ward manager felt pain was well managed on the ward. A RN and Health care assistant are allocated to each nursing bay. Comfort rounds take place hourly and pain can be assessed to ensure patients are as comfortable as possible and not in pain.
- On Mount McMaster ward we saw patients living with dementia or had a learning disability, the house communications book which contained smiley faces was used to evaluate any pain patients may be experiencing. This was used in conjunction with clinical observations including facial, vocal, behavioural, and physical signs.

Nutrition and hydration

- In the 'Multi-disciplinary prompts for the care of patients at end of life' multi-professional teams were encouraged to involve the patient's in all decisions regarding their care, which covered nutritional and fluid requirements. The 'prompt' asks that patients and family wishes and preferences around nutrition and hydration. It was recognised as good practice to discuss the role of nutrition and hydration with relatives of dying patients, as a perceived lack of adequate food and fluid intake can be a source of distress for relatives of a dying patient.
- In the 2016 RELC audit undertaken by the SPC team, discussions around nutrition and hydration were discussed in 13 out of 15 cases (87%) of cases which is an increase from 8 out of 13(67%) in the previous year, showing that raising awareness of the importance in discussing nutrition and hydration has improved compliance.
- On Mc Master Ward, the ward manager told us on admission, patients underwent risk assessments that included a Malnutrition Universal Screening Tool (MUST) assessment; this identified patients at risk of poor nutrition, dehydration, and swallowing difficulties. We reviewed patients' medical records and saw the MUST

assessment was being undertaken weekly. However, the ward manager told us if the patient deteriorated the risk assessment would be conducted more often. We saw the electronic monitoring system alerted staff when a MUST re assessment needed to take place.

- On Invicta ward, we spoke to a registered nurse (RN) who told us they would check if patients were alert to receive fluid. 'Comfort' foods would be provided to patients such as ice cream and yoghurt. Nurse assessments were recorded in the nursing notes. If the patient developed swallowing issues, a swallow assessment was performed and the patient would be referred to the speech and language therapist, who would undertake a review to give guidance around the foods and drinks the patient would best tolerate.
- On Marlow ward mouth care takes place every 4 hours. However families are shown how to do this and can therefore help. If the family do not want to be involved the nursing staff can do mouth care during the rounds or when a family raises concerns.

Patient outcomes

- The trust had an end of life care audit programme in the place for 2016/17. End of life care documentation was being reviewed three-monthly, looking at 90 sets of notes across the Trust. The objectives were to identify if end of life care plan documentation (MDM Prompt sheet, End of life care record, Communication diary) was being used to facilitate end of life care; to measure the completeness of the end of life care plan documentation and to monitor the quality of documentation. The audit found that only 13% compliance around the use of the documentation suggesting that further work was required to embed into clinical practice.
- Other audits related to end of life care included an Audit of Fast Track Supported Discharges April 2016, Audit of Rapid Discharge Home for end of life care July 2016 and the NCDHA 2015.
- An audit was undertaken by a palliative care consultant at the Pilgrims hospice in April 2016 to assess the quality of discharges home for end of life care from both East Kent Hospitals and Pilgrims Hospice sites. The aim of the audit was to identify areas of good and potentially substandard practice and offer an opportunity to make recommendations to improve future practice. Dying in

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the place of ones choosing is considered one of the many facets of a good death. Of the patients discharged from a hospital setting, the specialist palliative care nurses were involved in the discharge process in 71% of cases.

- The 'record of end of life conversation'(RELC) form was introduced in 2015 in response to national guidance, which identified that senior clinicians did not communicate or document well, end of life care conversations or decisions made with patients and their families, as end of life approaches. Reviewing the June 2016 audit undertaken by the SPC care team there was poor compliance of the use of this documentation with only 2 out of 30 sets of patient records having a completed end of life conversation record. This is a compliance rate of seven percent. During the inspection, we reviewed nine sets of patient records and found improved compliance with six out of nine sets having completed the RELC form. However compliance rates suggest that further work was required to embed the 'conversation' documentation into clinical practice.
- Where the RELC form has been used, completion has improved particularly around areas such as discussions of preferred place of care, nutrition and fluids, DNACPR and documentation of patient and family concerns.
- To try to improve compliance further the end of life board agreed to certain recommendations including senior nurses can now complete the RELC form, disseminate audit results via link nurses meeting and educational days and include in the induction for new medical staff.
- The RELC audit looked at the time interval between from completing the form to the patient's death. 92% of RELC forms were completed within 4 days prior to death. This may suggest staff often do not recognise that patients are approaching the end of their life in a timely manner and does not allow the wishes of the patient to be achieved.
- The portering service audit the time taken from a call received from the wards to the completion of the transfer of a deceased patient in the mortuary. We were unable to review the records during the inspection.
- The relative support officer (RSO) told us they had started a database recording patient's details, including the date and time of death, division, hospital site, ward,

consultant, referral to coroner and reason, date and time doctor was bleeped and date and time of M CCD issued. By auditing this process, the trust was able to use the information collected to improve the service.

- No advanced care planning took place on the wards we visited.

Competent staff

- Across the hospital, end of life care/palliative care (PC) link nurses were being identified on the wards we visited. We were told that 100 link nurses had been identified through the appraisal process. Their role through training and education was to cascade the latest information through to all staff groups within the wards to support the delivery of good end of life care. The SPC team had developed a 'cancer/palliative care/end of life care link nurse programme for 2016/17'. This set out the expectations of the link nurse and their duties within this role.
- Training days have been introduced by the end of life facilitator to support the development of these roles. 68 link nurses have signed contracts showing commitment to the role; with agreement from their line managers. 38 link nurses have completed their e-Learning module in relation to "Dying in the Acute Hospital." The trust expected that all link workers will have completed their e-learning by the end of September 2016 and that by the next link worker day in November 2016.
- The CNS's from the SPC team were highly qualified in palliative care with several of the team having achieved their masters in palliative care or associated subjects. One SPC CNS we spoke to told us that as a medicine prescriber they attended two study days per year and attended a prescribing forum three times a year to keep their knowledge and competencies up to date.
- The SPC team were involved in education meetings where they would discuss case studies, medicine prescribing, and what went right discussions. Twice a week the SPC CNS's would have peer review sessions with the palliative care medical consultants. This ensured the knowledge and skills of the SPC team were kept up to date and high quality care was delivered to those receiving end of life care.
- On Braebourne ward, the SPC CNS had undertaken communication skills training with the staff on the ward along with training around the use of the end of life care documentation.

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- The SPC senior management team were able to tell us end of life training for medical staff was high on the training agenda with a training programme in place for the new junior doctors. Training covered areas such as breaking bad news, case study reviews and symptom control. The training sessions were being led by the SPC CNS's and were due to start in October 2016. A video around end of life care has been developed for the junior doctors and was available on the trust web page. Medical division training and mortality and morbidity meetings have end of life care as a standing item with the SPC nurses being invited.
- A recent geriatric training day included training from the SPC CNS's where case studies were used to get doctors talking about death and dying. Orthopaedic surgeons attended an end of life training session and now want a rolling programme to cover identifying the dying patient and end of life conversations. However, it is recognised that more work was required to involve consultants in the education programme so a working group has been set up to address this.
- The Chaplaincy undertaken open meetings at each site around the role of the chaplaincy service in end of life care. They have conducted two meetings at each site with attendances running into the thirties at each meeting.
- The Chaplaincy volunteers went through an induction programme which included an interview, a 12 week course, disclosure and barring check (DBS), and a six month probationary period. Two training sessions take place annually for the team and site team meetings to create a sense of team.
- Mortuary training of porters has improved since the last inspection. Training was developed and provided by the trust mortuary, moving, and handling teams, which was based on the last offices procedure/policy. A 'train the trainer' scheme takes place where the portering managers are trained to cascade training to porters. Mortuary training records provided by the portering manager show 100% compliance. Training is provided at induction and annually.
- Areas of concern raised by the porters at the last inspection included Infection control training (IPC), the use of hoists and green sheets. Since the last inspection, we were told that IPC training was now provided in conjunction by the trust therefore was consistent with

the hospital staff training. Compliance on training in the use of hoists had improved with over 95% of staff has received training. The remaining are new staff that will be trained at induction.

- We reviewed training records provided by the portering company for all sites. Porters say they feel confident using the hoists. Staff reported the compliance on the use of green sheets has improved. These are accessible from the mortuary on each site which meant there was always a supply of these when required.
- In house syringe drivers training was available to give staff the opportunity to refresh their knowledge with regard to setting up the syringe driver ready for use and to maintain their competencies. We reviewed training records on three wards and saw that 27 RN had completed their competencies.

Multidisciplinary working

- A weekly multi-disciplinary meeting between the three acute hospitals was held via video link. Consultants, SPC team, counsellor, and social worker attend. Each hospital brings patients for discussion regarding their care and treatment.
- The SPC teams worked closely with the local hospices to discharge patients who wished to die in their own homes. We were told of very good working relationships with the hospices.
- The end of life board had a multi-disciplinary membership, which meant end of life care was everyone's responsibility. Information discussed at the end of life board would be cascaded from the board members to the teams across the hospital through a variety of directorate meetings. The surgical matron was a member of the end of life board and was able to tell us end of life care was presented to the last surgical audit meeting where all surgical specialities were in attendance.
- The SPC team had introduced end of life care plan documentation to support the care of patients approaching the end of their life's. However, we saw poor uptake of the documentation across the wards visited. This meant the care delivered to the patients could not be easily reviewed. It was unclear for these patients if the recommendations set out in national guidance were being delivered.
- We saw evidence across the wards of MDT meetings taking place throughout the week to review patient's management plans. On Marlow ward, the ward manager

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told us that MDT meetings took place every Wednesday and involved multi-disciplinary professionals including nursing and medical staff. The ward manager told us following the renal MDT a discussion would take place at the next ward round with the patient to keep the patient informed of their plan of care.

- Mortality and morbidity meetings take place in renal services with the matron and ward manager in attendance. Deaths that occur on the ward and in ITU, in the last three months are discussed along with any harm that may have occurred. Feedback is given to staff at the next staff meeting.
- The SPC senior nurse told us that close working relationships were in place with other CNS's across the hospital including cancer and non-cancer specialists. They were able to describe joint work undertaken with CNS's to support the complex symptom management at end of life,
- Porters (employed by a contracted company), mortuary, patient experience staff and ward staff all described good working relationships. The SPC senior management team told us the head of nursing for support services regularly feedback to support staff and gave guidance on new policies and procedures. Task and finish groups were set up when new guidance was being developed. All relevant staff groups were invited to contribute.
- There was no electronic palliative care system to share information across providers

Seven-day services

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

- The Chaplaincy service was available 9am to 5pm Monday to Friday with an on-call service from 6pm to 6am for emergencies only. There were two Chaplains on-call at the weekends for the three acute hospital sites.

Access to information

- Staff had access to the information they required to provide good patient care.
- Each ward had been provided with an end of life care resource folder, which contained current information and trust documentation. Ward staff were able to show us the folders on the wards we visited. We reviewed the folders and saw that all the relevant information had been included in the folders including end of life conversation and care records, the multi-disciplinary prompt for the care of patients at end of life and medication guidance. Staff were also able to show us that they could access documentation on the trusts intranet end of life care page.
- The trust had access, with patient consent, to GP records through the Medical Interoperability Gateway (MiG) system. This meant that when a patient arrived in A&E the system automatically flagged up if they were at end of life. The palliative care team monitored the system and the local hospice was informed if the patient was known to them. However, the SPC senior management team told us that the MiG system was read only and therefore they cannot edit information, attach care plans, or place discharge summaries onto the system. We were told this issue was being picked up by the divisional lead.
- We saw that the Trust had guidance on 'Religions, beliefs and practices - Guidance for the care of the dying/deceased patient. This guidance gave information around beliefs, eating and drinking, key issues and death and dying and covered a variety of religions including Buddhism, Hari Krishna, Hinduism, and Islam. However on two wards we visited staff were unaware of any guidance that supported different belief and cultures when caring for dying patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During our visits to the wards, we saw and heard several occasions when staff sought the consent of patients before an intervention. On reviewing patient medical records, we observed that allied health professionals

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including physiotherapists and speech therapists clearly documented that consent had been gained before proceeding with an examination. We observed that staff of all disciplines communicated sensitively with patients at level based on their communication need.

- Assessing capacity specifically for resuscitation decisions did not appear to be documented on a routine basis. On reviewing the of the eight patients we found patients described as lacking capacity to make decisions and did not have the necessary Mental Capacity Act assessments(MCA) in place. We saw all orders were signed and countersigned by the consultant.
- The DNA CPR orders have only a top and bottom copy. This meant when the patient was discharged the top copy would go with the patient, the 2nd copy would be sent to the General Practitioner which meant that no copy of the order was kept in the clinical notes as a record.
- On Mount McMaster ward we found two patients with DNA CPR's in place. The two orders were signed and countersigned however we found no evidence in one patient's records of discussions with the family whereas the second order had the discussion in place. One patient lacked capacity. There was no MCA in place.
- On Marlow ward we reviewed one DNA CPR order and found discussions had taken place with the patient. We saw the orders were signed appropriately.
- On Treble ward we reviewed four DNA CPR's and found no real discussions around advanced care planning and patient wishes were documented. Where patients lacked capacity to make decisions, two patients had no mental capacity assessments in place to support the decision however the third patient had a lasting power of attorney in place.
- On Taylor ward we reviewed one DNA CPR order; we found no discussions in place with family. The order was completed correctly. In looking at whether patients and their relatives were involved in discussions, we found variations in the completeness of the forms across the hospital.

Are end of life care services caring?

Good



We rated caring as good because:

- Staff at K&C provided compassionate end of life care to patients. The SPC CNS performed patient reviews in a sensitive, caring, and professional manner, engaging well with the patient. The patient's complex symptom control needs were being met and the supportive needs of both the patient and relative were being addressed.
- In the trust's April 2016 bereavement survey, 81% of the bereaved relatives reported that the overall quality of care delivered was good to excellent with 85% of relatives reporting family members were kept informed of their loved ones condition as well as receiving information that was easy to understand. The Critical Care team routinely wrote to bereaved relatives 4-6 weeks following a death to give relatives the opportunity to visit the unit and discuss any outstanding issues with the staff involved in caring for their relative.
- We found ward staff to be caring, compassionate, and respectful when describing how they cared for patients as they approached the end of their lives. Staff ensured as best they could that relatives were supported, involved, and treated with compassion. This was confirmed by a relative who told us 'care had been wonderful.
- Spiritual and religious support was available through the chaplaincy. The chapel was open at all times of the day and night for patients and families to visit. Facilities for other religions and cultures were available including an area and mats for Muslim prayers. This summary should act as the explanation of what the evidence below adds up to and support the rating.

At our last inspection, we rated caring as good and on this inspection we have maintained a rating of good

Compassionate care

- We observed that staff demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how the SPC teams work impacted on the overall service. On Invicta ward, a RN told us that the ward was 'open and

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honest' and was committed to providing good patient care. On Invicta ward, 97% of patients who completed the inpatient survey said they received the care that mattered to them.

- We observed the interaction between a member of staff and a patient on Braebourne ward. The staff member was very supportive and spent time talking to patients by their bedside.
- We spoke to a patient and their relative on the Taylor ward who told us it was a 'fabulous ward' and they were 'very well cared for'. On Treble ward we spoke to a patient who told us they were very happy with the care they had received on the ward.
- The SPC team developed a carers bereavement survey to gather the views of bereaved family members with a report of the findings being published in April 2016. The response rate of the survey was low at 24% however it gave the SPC team valuable insight into the experience of dying patients and their families.
- The survey asked bereaved relatives a variety of questions to gain an understanding of the care delivered across the trust. The areas covered included the overall quality of care, communication, dignity and respect, emotional care, spiritual care and symptom control. From the survey, 81% of the bereaved relatives reported the overall quality of care delivered was good to excellent with only 5% reporting care was poor.
- With regard to communication, 85% of bereaved relatives reported family members were kept informed of their loved ones condition as well as receiving information that was easy to understand. This indicates that staff were mindful of the delicate situation families members found themselves in and ensured communication channels were open at all times.
- 57% of bereaved relatives reported emotional support was excellent to fair. However, 15% of bereaved relatives reported they were offered no support at the actual time of death. On the wards we visited, we asked staff how they supported families after a death, staff were caring, and compassionate, which does not reflect the survey's findings.
- Porters ensure curtains are drawn when transferring the deceased on the wards and used a single sheet to cover the deceased in addition to the shroud.
- Deceased patients were transferred by hospital porters to the mortuary in a discreet and respectful manner. The mortuary staff ensured they were aware, from the documentation, that any particular religious or cultural

wishes were respected. Mortuary and nursing staff said the porters treated the deceased patients with respect and were sensitive to the feelings of other patients on the wards.

Understanding and involvement of patients and those close to them

- We reviewed nine patient medical records and saw that patients referred to the SPC team were kept actively involved in their own care and relatives were kept involved in the management of the patient with patient consent.
- The ward manager on Mount McMaster ward told us that they like to include families as much as possible in caring for their relative but only as much as they wanted to be involved. Areas where relatives supported their relatives included mouth care and making sure the patient was supported to lie comfortably. Relatives could be asked to support relatives at meal times.
- On two wards, we visited the ward managers told us that some families wished to be involved in care after death however no families recently had engaged in providing after-care for their relative. Both ward managers told us that families could stay on the ward as long as they wished after death to give them time with their deceased relative.

Emotional support

- The SPC team members had completed the advanced communications skills course and several of the team were trained to psycho-oncology level 2 skills that supported several NICE Guidelines in Oncology. This highlights that the provider supported staff to gain the knowledge and skills required to meet the needs of patients requiring palliative and end of life care.
- The trust counsellor and social worker linked closely with the local hospices. This enabled them to signpost patients towards community support after leaving the hospital. These included bereavement counselling and support groups as well as local site specific tumour groups.
- On braebourne ward, staff told us that counselling or complimentary therapies were not available for patients and relatives.

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

Are end of life care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- In the wards we visited staff would nurse patients approaching the end of their life in a side room if one was available to ensure patients dignity and privacy was maintained at all times. During the inspection, the majority of patients receiving end of life care were being nursed in bays, as single rooms were not available. This meant there was little privacy from surrounding patients, relatives, and the workings of the bay for patients as they approach the end of their life.
- After a patient's death families would be asked to contact the relatives support officers to arrange an appointment to collect their relative's belongings and the medical certificate of cause of death (MCCD) which enables the deceased's family to register the death. The trust set a target of 3 days to release a MCCD. The data we reviewed confirmed a small number of certificates were still taking between 3-7 days. We did see however an increase in the number of certificates meeting the target through service improvement initiatives.
- During the last inspection, it was highlighted that there were delays in discharging patients to their preferred place of care (PPC) or preferred place of death (PPD) through the fast track process. Staff confirmed the

process had not improved with the majority of patients taking weeks rather than hours to be discharged to their PPC or PPD. Since the last inspection, installing equipment at home had improved and care packages could be requested in four hours. However if patients PPC was a nursing home or hospice, delays were introduced whilst a bed became available.

- The trust did not audit the percentage of patients that achieve their PPC or PPD.

However:

- We were able to review SPC data from April 2015 and March 2016. This showed the SPC team reviewed 56% of patients with a cancer diagnosis and 44% of patients with a non-cancer diagnosis. The SPC team were supporting a high percentage of patients with a non-cancer diagnosis, which was well above the national average of 28%.
- The SPC nurse consultant sat on the group that developed the interagency policy. By being part of this policy group the trust would ensure their services were developed to meet the needs of the local community and help more people at the end of their life to be cared for and die in the place of their choice.

At our last inspection, we rated the service as requires improvement. On this inspection we have maintained a rating of requires improvement however good progress had been made.

Service planning and delivery to meet the needs of local people

- The four East Kent Clinical Commissioning Groups (CCGs) had an end of life

work stream group and was setting the EOLC strategy for End of life care across all the service providers in the area. The SPC Consultant Nurse attended the East Kent CCG work stream in order to feed back into the EOLC Board at the Trust. The trust had developed their strategy in line with the CCG strategy in order to deliver a service that meets the needs of the patients that are admitted to hospital.

- An interagency policy was in place across all the providers in East Kent. This policy ensured that services were developed to meet the needs of the local community.

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- When possible, patients approaching the end of their life were given the opportunity to be nursed in a side room if one was available. However, patients that had infections took priority over an end of life patient. On the wards we visited, we found the majority of end of life patients were being nursed in bays.
- If a patient was nursed in a bay, privacy was maintained by keeping the curtains drawn, if requested by the patient or family. The ward manager on Invicta ward told us that there were only four side rooms available to support end of life patients and it was, therefore, not always possible to nurse end of life patients in a side room. On one ward we visited, we saw an end of life care patient situated in a four bed bay. We observed there was little privacy from surrounding patients and relatives.
- On Taylor ward only one single room was available which meant the majority of end of life patients were nursed in a ward bay. On treble ward two side rooms were available but these were used for telemetry. We observed an End of life patients being nursed in a bay.
- The trust had opened a suite on all three sites specifically for relatives of patients receiving end of life care. They consisted of sitting rooms, a shower, and a kitchen with access to a garden. These had been agreed by the clinical management board. They provided a place of quiet and peace for relatives to rest and make themselves drinks. Staff on the various wards we spoke to were able to tell us they signposted relatives to the suite. On Invicta ward, the ward manager told us they had a key for the suite and would signpost relatives to the suite.
- We found little evidence of family rooms on the wards. However, staff would use the day room or nursing/ doctor's room to provide a quiet place for relatives. These rooms did not always provide the appropriate surrounding and privacy the families required at such a time.
- Mortuary staff provided the required information to the William Harvey Hospital mortuary staff who undertook a daily track of the mortuary spaces available for the three hospitals.
- Although there was no electronic system that alerted the SPC team if a palliative care or end of life patient was admitted, the ward staff would make the necessary electronic referral to the SPC team if their support was required.
- All patients with complex symptoms within the trust who required end of life care had access to the SPC team. On Marlow ward, the ward manager told us that two patients were receiving end of life care on the ward. Of the two patients, both patients required input from the SPC team who provided advice and support on complex symptoms.
- Once a patient was referred to the SPC team, treatment and care took account of the patient's individual needs. This could be working in conjunction with other specialist nurses to support patients with complex symptoms as well as those with complex needs being cared for by generalist teams. On Invicta ward, the ward manager told us when an oncology patient was admitted the acute oncology matron would review the patient and if necessary, after discussion with the medical teams and the patient, all unnecessary interventions will be stopped and a referral would be made to the SPC team.
- The SPC team and other nursing staff we spoke with told us that all communication would include the patient and those people who were important to them. During the unannounced inspection, we reviewed three patients' medical records. They contained evidence that regular conversations were taking place and being documented between the medical staff and the patients next of kins .On Mount McMaster ward we saw that regular discussions took place with relatives and in one patients records we saw three discussions took place and were documented over a four day period.
- On two wards we visited, we were told that any patient with dementia or a learning disability would have their care reviewed by the dementia care nurse. Staff had received training around caring for dementia patients and felt they had received the necessary training to care for these patients.
- On all the wards we visited, staff spoke of the need for opening visiting hours for families whose relatives were receiving end of life care. On Invicta and Mount McMasters wards, staff confirmed that open visiting hours were in place. During both the announced and unannounced inspection, we observed patients with their family members visiting throughout the day.

Meeting people's individual needs

- There was no dedicated specialist palliative care ward. People reaching the end of their life were nursed on the main wards in the hospital.

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- The SPC team have introduced communications diaries to allow relatives to write any questions they have down. We only saw these in use on Treble ward. On Marlow and Invicta wards the communication diaries are not in use at present. Staff felt they know their patients well and communicate a lot.
- Chaplaincy volunteers are allocated to a ward and work approximately three hours a week. The volunteers record outcome data, visits, and interventions. A sticker system is available and they give this to the ward clerk to put in the patients' medical records. Salaried chaplains record in patient records any interventions.
- On the wards we visited, after a death has occurred, relatives were given a bereavement leaflet called, 'Help the bereaved, A practical guide for families and friends' and the number of the nurse in charge as they left the hospital. The families would be asked to contact the relatives support officers (RSO) who will confirm details and arrange an appointment to collect their relative's belongings and the MCCD.
- On the wards we visited staff told us relatives could stay on the ward after a patient died to help with the after care of the deceased patient. However, we were told that this rarely happened.
- A porter told us that two porters would transfer a deceased person to the mortuary out of hours. This was confirmed in hospital policy. For access to mortuaries, the porters were provided with a key fob or pin codes.
- The Relative Support Office (RSO) was open from 10am to 4pm Monday to Friday. The RSO booked all appointments for families following a death, liaised with funeral directors and ensured that the medical records and all documentation was in place for the doctors to complete the medical certificate of cause of death (MCCD) which enables the deceased's family to register the death. They also saw anyone who had a query or a concern.
- We were told that the MCCD was available for relatives ideally within three days, or slightly longer if the death happened at the weekend. However, we were told this did not always happen and there had been delays in releasing the MCCD. We reviewed the data and found at K&C for July 2016 and found that of the 73 certificates issued eight certificates took between 2-7 days, 12 took 24 hours and 53 took 6 hours to complete. This has improved since the last inspection however more work is required to further improve the time.
- Families attending for appointments were escorted to a quiet room for discussion, advice, and information. Patient belongings were stored there.
- The Chaplain was available on site from 9am to 5pm Monday to Friday. An on-call service was provided for out of hours.
- During the last inspection, we visited the mortuary and observed the viewing suite where families came to spend time with their relatives after their death. The viewing suite was decorated in neutral colours, with no religious symbols in place, however, staff were able to show us symbols of different cultures and religions that they had if required.

Access and flow

- During the last inspection, it was highlighted that there were delays in discharging patients to their preferred place of care (PPC) or preferred place of death (PPD) through the fast track process. The purpose of the Fast Track Pathway Tool was to ensure that individuals with a rapidly deteriorating condition, which may be entering a terminal phase, are supported in their PPC as quickly as possible. Work was planned to improve this pathway however, we found that the process was still a problem.
- On the wards we visited, we found the Fast Track Pathway Tool for NHS Continuing Healthcare November 2012 (Revised) was in place to facilitate the fast-track discharge of patients to their PPC or PPD. However staff told us the discharge process was anything but fast with many patients not achieving their PPC due to the length of time the process took to facilitate the discharge.
- On braebourne ward a patient has been waiting 3 weeks on the fast track discharge due to a delay in the care package. In contrast on Marlow ward a patient was discharged to the hospice in two days.
- The discharge process was a multi-professional approach, which included doctors, nurses, physiotherapists, and occupational therapists working together to ensure that patients had all the necessary support and equipment in place for the patients discharge. However, staff told us that they encountered issues around the process. Issues included slow hospital processes such as getting the doctors to fill the necessary documentation, the stopping and starting of

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the process and external delays with funding and care packages. All these issues led to a long and cumbersome process, which could result in the patient not receiving their PPC.

- The trust did not audit the percentage of patients that achieve their PPC or PPD although this information regarding the patient's preference was expected to be collected at the time of the end of life conversation. During the 2016 audit of the end of life record of conversation documentation it was found the PPC was discussed in nine out of the fifteen forms completed, this was a 60% compliance rate. This has increased from the 2015 audit where there was only 33% compliance. Discussions about PPC are vital if the wishes of patients and their families are to be fulfilled.
- Patients were discharged to their home, hospice, or nursing home. We were told the majority of the patients were local, but within the renal services, which are a specialist county led service, having to liaise with a variety of clinical commissioning groups could delay the process. We were told by staff on one ward that a patient had been waiting three weeks due to a delay with the care package.
- Of the patients reviewed by the SPC team 56% of patients had a cancer diagnosis and 44% of patients had a non-cancer diagnosis between April 2015 and March 2016. The SPC team were supporting a high percentage of patients with a non-cancer diagnosis that was well above the national average of 28% that highlights the SPC team commitment to supporting all patients with complex symptoms approaching the end of their life no matter the diagnosis.
- At the last inspection the SPC team told us patients with the most complex needs were referred to the SPC team, this had not changed in the last year, as there was no increase in staffing. The SPC team acknowledged that they did not have sufficient resources to support generalist staff to have the skills and confidence to care for patients at the end of life with less complex needs.
- The SPCT CNS reviewed patients depending on their needs, offering them support and reviewing their care needs. Patient contacts ranged from 15 to 60 minutes depending on the need of the patient and their families, with many end of life patients requiring more than one contact in a day. Palliative care medicine consultants reviewed complex cases and spoke to medical teams and carers.

- The portering company records the time of each patient when removed from the ward to the transfer being completed. For deceased, this can take from 30 minutes to an hour for all 3 sites. We were unable to view the records during the inspection.

Learning from complaints and concerns

- The end of life care and palliative care service did not receive a high number of complaints. We were provided with the complaints log for the period June 2016 where a total of two complaints were received both of which did not take place at the Kent and Canterbury hospital. We saw that no complaints had been made against the SPC team in the last year.
- Any complaints around the delivery of end of life care were reviewed by the End of Life Board. The process undertaken when the complaint was made demonstrated that systems were in place to respond to complaints in a timely manner. We saw a good governance structure and learning from complaints.

Are end of life care services well-led?

Requires improvement 

We have rated well led as requires improvement because :

- The end of life strategy for East Kent was a working document. However the majority of the agenda was due to be implemented by the SPC team. With a small SPC team and their commitment to support patients with complex symptoms it was difficult to understand if this would be possible. The trust had been in negotiations with a cancer charity and had secured funding for two further nursing posts. A decision on the how these roles will support the service needed to be made.
- Since the last inspection, a clear governance structure was in place to support end of life care. The end of life care board was well represented by a multi-disciplinary membership which covered a variety of specialities across the trust as well as with outside stakeholders. The terms of reference for the end of life care board had recently been changed and it was now a decision making board.

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- However, we did not see that end of life care incidents from across the trust were discussed meaning the board did not have a comprehensive overview of the service and an awareness of the wards that were providing the best or worse care.
- No separate risk register was available for palliative /end of life care. A separate risk register would allow the risks to be discussed, regularly at the end of life board and allow plans to be made to alleviate the risks.
- The service level agreement between EKHUFT and the hospice was still not finalised. This needs to be in place as soon as possible. The signing of the contract will allow the trust to establish the gaps in their service provision.

However

- We found the leadership of the SPC team to be strong and forward thinking. Staff told us they were approachable and visible. Staff in the SPC team new their reporting responsibilities and took ownership in their areas of influence. The SPC team were on the right trajectory and had achieved a lot of good work since the last inspection.
- The SPC team had undertaken a bereaved relatives and staff survey since the last inspection to gather views and use the outcomes to initiate change.

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

Vision and strategy for this service

- End of life care sits in the Specialist Service Division and there was a Trust-wide End of Life Care Board that met bi-monthly. The head of nursing and consultant nurse for palliative care attended this board. The four East Kent Clinical Commissioning Groups (CCGs) had an end of life work stream group and was setting the end of life strategy for East Kent in which the Consultant Nurse for Palliative Care attended so feedback was given to the end of life Board at the Trust. The trust had an improvement plan in place to implement the strategy.
- The East Kent End of life strategy has been ratified and was available to review on the EKHUFT web site. The strategy stated a commitment to improving the end of life experience for patients and their relatives and involved all parties working closely together. It

considered an expected increase in demand for both cancer and non-cancer end of life care in the region. This was reflected in the referrals to the SPC team, which have increased, by 16% in the last year.

Governance, risk management and quality measurement

- There had been considerable work done to improve communication between the board and the wards by having a wide range of health care professionals from various specialities attending the board. We saw representation from critical care, surgery, renal, oncology, urgent care and the chaplaincy. Stakeholders from outside the trust including members of Healthwatch and the CCG also attend.
- The end of life Board minutes fed into the Patient Safety Board and into the Specialist Palliative Care meetings for decision making and implementation. The terms of reference for the end of life care board had recently been changed and it was now a decision making board.
- The Head of Nursing for the Specialist Service Division was able to tell us that there was not a specific risk register for end of life care. No high risks had been identified for the service at the last governance board.
- We reviewed the minutes from the end of life board and from the beginning of 2016. However, we did not see that end of life care incidents from across the trust were discussed meaning the board did not have a comprehensive overview of the service and an awareness of the wards that were providing the best or worse care.
- Since the withdrawal of the LCP from the trust in July 2013 and the introduction of the end of life care plan documentation in January 2016, the SPC team had introduced a three monthly audit programme to monitor the implementation of the documentation across the wards. Results from the audits were discussed at the end of life care board where members would feedback results via there divisional clinical governance meetings. Results were also placed in the quality, Innovation, and improvement hubs for staff to review during visits.
- The last two audits of end of life documentation showed that there was still limited take up of the documentation with variable understanding and knowledge on the

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wards. Improved compliance was expected with the appointment of the end of life facilitator who was engaging with the wards and the end of life link nurses to raise the profile of end of life care across the trust

- We were told that the Specialist Palliative Care Teams oversaw the whole end of life care agenda trust-wide however, with no increase in the medical and nursing establishment this was a tall order for all the staff concerned. The trust had been in negotiations with a cancer charity and had secured funding for two further posts. However, the trust, at the time of the inspection, had put this on hold to evaluate the best way to support end of life services across the trust.
- During the last inspection, we found no contract or service level agreement was in place between the trust and the local hospice. The SPC senior team told us that a second draft had been received by the trust and they expected to sign the contract in the coming months. The signing of the contract will allow the trust to establish the gaps in their service provision.
- There was a trust wide Specialist Palliative Care Team Annual Report for 2015-2016 that described the staffing, role and training provided by the team. With the recent appointment of the end of life facilitator, this role will bring together the education and training of all the staff groups and support the role of the end of life care link nurses to embedded good end of life care across all the hospital sites

Leadership of service

- The Medical Director was the nominated lead for end of life care and was a member of the end of life care board. All actions from the Improvement Plan relating to Specialist Services Division were circulated to the trust board.
- Staff we spoke to across the trust were found to be passionate and committed to delivering quality care to patients and their families at this difficult time. However, this was still frequently managed in an ad hoc and reactive manner as need was recognised. To address this end of life care at ward level was to be led by the end of life link nurses with support from the end of life facilitator and SPC CNS's. Link nurses through signing a contract showed a commitment to support staff to deliver good end of life care and give regular updates on new guidance. At the time of the inspection, 100 link nurses had been identified and training was underway to skill up the staff across the trust.

- We saw strong leadership of the SPC team with the appointment of a new head of nursing for the specialist service division. We observed that the SPCT were visible, responsive and were active in policy and audit. Team working within the palliative care team was of a high standard and this was confirmed by all staff we spoke with who said the SPC team were 'responsive and very supportive'.
- The chaplaincy service was well-led by the hospital chaplains. We observed that the chaplaincy team were visible, responsive and were involved in policy and auditing. The lead chaplain was an integral member of the End of Life board.
- Through the end of life board, formal links were in place with stakeholders from the community, hospice, and CCG's. This meant that stakeholders opinions were included in the decision making process.
- Across the trust 'Schwartz Rounds', had been established for staff to regularly come together to discuss the non-clinical aspect of caring for patients, including: psychological, emotional and social challenges associated with their work and help staff deliver compassionate care. We saw that end of life care was on the agenda of the next Schwartz round.

Culture within the service

- Across the trust, it was being communicated that end of life care was everyone's responsibility. We saw that through a variety of methods including the end of life care board, with its multi-disciplinary membership, the Quality, Improvement, and Innovation Hub, the appointment of end of life care link nurses and a structured education programme, end of life care was not to be delivered in isolation. The SPC team told us they were changing the focus and trying to change the culture and release the burden from the SPC CNS's by empowering the ward teams. We saw that this shift in culture was work in progress.
- Across the wards we visited, we saw that the SPCT was integrated well with nursing and medical staff, there was obvious respect between specialties, and disciplines. SPC team members we spoke with were passionate about supporting both families and staff in end of life care. This was confirmed when we spoke to staff on Invicta Ward. One nurse told us that SPCT staff were excellent in helping with "discharge and complex symptom control", another nurse told us how helpful, and supportive the SPCT CNSs were.

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- All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service.
- All staff we spoke with described an improving culture since the new Chief Executive Officer and other changes in the senior management team had taken place. Staff told us, that the chief executive and Head of Nursing were regularly seen on the wards and felt they could talk honestly to them. Staff felt it was becoming a more open organisation.

Public engagement

- The end of life care service had conducted an end of life survey for a period of three months in January 2016, which sought the experience of bereaved relatives and carers. The trust end of life board and CQC improvement board have actions to monitor the survey and produce an action plan against the key findings. Following this year's survey actions included the SPC CNS's targeting wards to improve end of life care across the trust and robust education programme around the use of the end of life care plans.
- The Trust had completed the End of Life Care Audit – Dying in Hospital: National report 2015. No previous involvement in the audit was available for comparison. However, we did review the Trusts audit programme and found the trust will be participating in the next audit.

Staff engagement

- The end of life care service had undertaken a staff survey in order to obtain the opinions of staff across the trust.
- Staff spoke highly of the Quality Improvement and Innovation Hub. This was an area where staff could come with suggestions for improvement. There was an

end of life care stand. It was manned once a week from 8am to 6pm. Staff we spoke to us that they had attended the stand and thought it was a great way to spread the word and updates on end of life care.

Innovation, improvement and sustainability

- The SPCT submitted data to the National Minimum Data Set, this allowed the team to benchmark their service nationally and could be used as a service improvement tool.
- The SPC Team had introduced the end of life care plan documentation which was based on the '5 priorities of care' to support the delivery of good care by the generic staff on the wards. All the new documents were set out in an easy to follow manner. We saw limited up take on the wards of the documentation. However, this was work in progress.
- The SPCT were actively involved in audits to monitor the quality of end of life care across the trust and used the outcomes to initiate change across the service.
- Both a bereaved relatives and staff survey was undertaken since the last inspection, to gather the views of the end of care delivered across the wards as well as the views of the staff. This meant the SPC Team were using the views of service users and staff to initiate change.
- The trust took part in the National Care of the Dying audit: Hospitals 2015 to gather further views of the care delivered. An action plan was in place to address the issues raised.
- The end of life care agenda was being implemented by the SPC team. With a team that had not increased in size since the last inspection and a large number of deaths that took place across the trust it was questionable as to how the small specialist team could deliver the agenda and delivery high quality care to patients with complex symptoms.

Outstanding practice and areas for improvement

Outstanding practice

The trust's Improvement and Innovation Hubs an established forum to give staff the opportunity to learn

about and to contribute to the trust's improvement journey. The hubs were run by staff and provided topics of interest suggested by staff that could be accessed at any time the hub was open

Areas for improvement

Action the hospital **MUST** take to improve

- The trust must ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times. This includes medical, nursing and therapy staff.
- The trust must ensure there are systems established to ensure there are accurate, complete and contemporaneous records are kept and held securely in respect of each patient.
- The trust must ensure that all staff have attended mandatory training.
- The trust must take steps to ensure the 62-day referral to treatment times for cancer patients is addressed so patients are treated in a timely manner and their outcomes are improved.
- The trust must ensure that patient's dignity, respect and confidentiality are maintained at all times in all areas and wards.

- The trust must ensure there are sufficient staff available to complete its agreed audit programme. Ensure that where audits identify deficiencies, clear action plans are developed that are subsequently managed within the trust governance framework.

Action the hospital **SHOULD** take to improve

- The trust should ensure that it continues with its measures to promote positive behaviour and eliminate bullying,
- The hospital should address the gaps in mandatory and additional training records that made it difficult to determine if training met policy requirements. Additionally, the department should increase the number of staff who had completed training in safeguarding, consent and the Mental Capacity Act to meet trust targets.
- The trust needs to ensure that audit action plans are submitted in a timely manner, communicated to staff and fully implemented.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Ensure that there are sufficient numbers of suitably qualified, skilled, and experienced staff available to deliver safe patient care in a timely manner.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The trust must ensure that all equipment used by the service provider must be properly maintained

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems or process must be established and operated effectively to ensure compliance with requirements of this Part.

Contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The trust must ensure there are sufficient staff available to completed its agreed audit programme. Ensure that where audits identify deficiencies, clear action plans are developed that are subsequently managed within the trust governance framework.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

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

Why there is a need for significant improvements

Where these improvements need to happen

Start here...

Start here...