Care Quality Commission

East Kent Hospitals University NHS Foundation Trust

William Harvey Hospital

Quality Report

William Harvey Hospital
Kennington Road
Willesborough
Ashford
Kent TN24 0LZ
Tel:01233 633331
Website:ekhuft.nhs.uk

Date of inspection visit: 5th,6th 7th September 2016
Date of publication: 21/12/2016

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The William Harvey Hospital (WHH) in Ashford, Kent is one of five hospitals that form part of East Kent University Hospitals NHS Foundation Trust (EKUFT).

The William Harvey Hospital (WHH) is an acute 476 bedded hospital providing a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric and neonatal intensive care services. The hospital has a specialist cardiology unit undertaking angiography, angioplasty, an analytical robotics laboratory that reports all East Kent's General Practitioner (GP) activity and a robotic pharmacy facility. A single Head and Neck Unit for East Kent has recently been established and includes centralised maxillofacial services with all specialist head and neck cancer surgery co-located on the site.

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

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

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

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

Overall we rated the William Harvey Hospital as Requires improvement

Safe

We rated The William Harvey Hospital as Requiring improvement for safe because:

- Whilst 86% of patients were triaged within 15 minutes, only 34% had a clinician first assessment within one hour and only 17% a decision to admit within two hours. Attendance by a specialist within 30 minutes following referral was only achieved 35% of the time.
- Ambulance handover figures for WHH showed an average of 168 occasions per month (July – October 2016) when vehicles were delayed beyond 60 minutes. This represented 7.8% of the total number of patient handovers and was worse than the regional average of 3%. During this period, WHH was consistently in the bottom four of 17 hospitals in the region.
- 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.
  - 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.
  - In Maternity, a lack of staffing affected many areas of service planning and the care and treatment of women. This included not meeting national safe staffing guidelines, meaning 1 in 5 women did not receive 1:1 care in labour.
  - We found poor records management in some areas. Staff did not always complete care records according to the best practice guidance.

Summary of findings

- The trust did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance. The trust did not have adequate maintenance arrangements in place for the 483 medical devices used in maternity and gynaecology.

However

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

Effective

We rated The William Harvey Hospital as requiring improvement for effective because:

- Some documents and records supporting the learning needs of staff were not always completed and there were gaps in the records of training achieved.
- Staff annual appraisals rates were worse than last year.
- The trust had not completed its audit programme. This meant the hospital was not robustly monitoring the quality of service provision. The hospital performed poorly in a number of national audits such as diabetes services.
- There was poor compliance in the use of the end of life documentation across the wards we visited which was reflected in the May 2016 documentation audit undertaken by the SPC team.

However

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- We saw good examples of multidisciplinary working between all staff grades and specialities.

Caring

We rated The William Harvey Hospital as Good for care because:

- Staff treated patients with kindness and compassion.
- Staff responded compassionately when women in Maternity and Gynaecology needed help and supported them to meet their basic personal needs as and when required. Privacy and confidentiality was respected at all times.
- Patients and relatives we spoke with were complimentary about the nursing and medical staff.
- Patients were given appropriate information and support regarding their care or treatment and understood the choices available to them.
- **Responsive**

We rated The William Harvey Hospital as requires improvement for responsive because:

- Performance indicators such as patients being seen within four hours in A&E remained below trust target and national averages.
- Delayed discharges remained a concern.
- 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.

Summary of findings

- 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.
- Maternity staff had diverted women to another hospital on 28 times between January 2015 and June 2016 due capacity issues.

However

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

Well Led

We rated The William Harvey Hospital as requires improvement for responsive because:

- No separate risk register was available for palliative /end of life care. A separate risk register would allow the risks to this patient group be discussed regularly at the end of life board, and allow plans to be made to alleviate any identified risks.
- Changes in leadership in end of life care and maternity services had only recently been realised and as a result had yet to fully address the issues relating to these services.
- 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

However

- Overall, the leadership, governance and culture within the ED was good and we saw examples of good practice regarding visibility of supervisors, comfort rounds and communication. Staff were supported by their managers and were actively encouraged to contribute to the development of the services.

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.

Action the hospital MUST take to improve

- Ensure the number of staff appraisals increase to meet the trust target. So that the hospital can assure itself that staff performance and development is being monitored and managed.
- Ensure 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 that the trust audit programme is completed and that following audits action plans are submitted in a timely manner and these are fully implemented. To have assurance that best practice is being followed.
- Have systems established to ensure that there are accurate, complete and contemporaneous records kept and held securely in respect of each patient.
- Ensure there are adequate maintenance arrangements in place for all of the medical devices in clinical use in accordance with MHRA (Medicines & Healthcare products Regulatory Agency) guidance.
- Ensure maternity data is correctly collated and monitored to ensure that the department's governance is robust.

Summary of findings

- Ensure that mental capacity assessments are in place for vulnerable adults who lacked capacity.
- 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.

Action the hospital SHOULD take to improve.

- Ensure there are sufficient numbers of junior grade doctors and consultants across medical services to deliver a safe and effective service particularly out of hours and at night.
- Reduce the number of bed moves for medical patients.
- Ensure the bereavement suite on Folkestone ward meets the Department of Health Standards.
- Review the physical environment within maternity services to ensure it meets the needs of the patients. Specifically temperature control
- Ensure that the fast track discharge process is fully implemented for end of life patients to be discharged to their preferred place of care within a short time frame.

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated the urgent and emergency services provided at William Harvey Hospital as requires improvement because: • Whilst 86% of patients were triaged within 15 minutes, only 34% had a clinician first assessment within 1 hour and only 17% a decision to admit within 2 hours. Attendance by a specialist within 30 minutes following referral was only achieved 35% of the time. • The WHH had an average of 168 60-minute breaches per month from July – October 2016. This represented 7.8% of the total number of patient handovers from ambulance staff and was worse than the regional average of 3%. WHH was consistently in the bottom four of 17 hospitals in the region. • The monitoring and reporting of training and other safety indicators such mortality and morbidity summaries were not always reliable. Adult safeguarding training figures were low across the directorate and children's safeguarding training for doctors in the department was still below trust targets. While mandatory training rates for some staff groups had improved, others in the department remained below trust targets. We acknowledge that major incident training at WHH was better than the other sites we inspected, albeit below target. • Staff appraisal rates were worse than another A&E locations and the trust target. Lower completion rates makes it difficult for the department to assure itself that staff performance and development is being monitored and given sufficient attention. We found gaps in staff appraisals for key supervisors such as band seven nurses. • Auditing had improved since our last visit, although we found that action plans were not always submitted in a timely manner and where there was an action plan, the actions were not

Summary of findings

always fully implemented or communicated widely. This meant the department did not have full assurance that best practice was being followed or that problems were being identified quickly enough.

- Delivery of performance indicators such as patients being seen within four hours remained below trust target and national averages.
- Patients with mental health conditions who presented in the evening still had long waits before being assessed or admitted by the mental health team. However, the department had responded by employing mental health nurses to provide specialist care and support.
- Delayed discharges remained a concern due to the impact on the A&E. However, as part of this response we observed an operational communications meeting, which showed the trust was addressing patient flow through the hospital and monitoring closely for risks that affected beds available for receiving patients from the department.
- A range of positive initiatives have been implemented in this department along with others we observed at similar sites in the trust. Further harmonisation and sharing of best practice between all A&E locations would benefit patients and staff.

However,

- We saw that new and dedicated facilities had been provided for children. Staff establishments for nurses had been increased and more specialist nurses had been recruited. We also saw well equipped and organised resuscitation facilities.
- There were sufficient staff with the right skills to care for patients and staff had been provided with induction and additional training specific for their roles. A consultant had been appointed with sub-specialty in children, which complies with recommendations contained in the Standards for Children and Young People in Emergency Care Settings (Royal College of Paediatrics and Child Health, 2012).

Summary of findings

- Staff followed cleanliness and infection control procedures. Potential infection risks were anticipated and appropriate responses implemented and measured.
- Patients' treatment and care was delivered in accordance with their individual needs. Patients told us they were treated with dignity and respect.
- We saw improvements in the way the department and the wider trust managed incident reporting and complaints. Lessons learned were widely communicated using a number of information systems.
- Medicines were stored safely and checks on emergency resuscitation equipment had improved.
- Overall, the leadership, governance and culture within the departments was good and we saw examples of good practice regarding visibility of supervisors, comfort rounds and communication. Staff were supported by their managers and were actively encouraged to contribute to the development of the services.

On this inspection we have changed the rating to requires improvement from inadequate, 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:

Medical care (including older people's care)

Requires improvement

We found the medical services at the William Harvey Hospital required improvement because;

- There were insufficient numbers of junior grade doctors and consultants across medical services at the William Harvey Hospital. This meant that consultants and junior staff were under pressure to deliver a safe and effective service particularly out of hours and at night.
- We found there were nursing shortages across the medical services. The situation had improved due to the use of agency and bank staff. Although the trust had recruited overseas nurses, there remained staffing shortages on the wards. The trust did not use a recognised acuity

Summary of findings

tool to assess the number of staff needed on a day-to-day basis. This meant, even when there appeared to be sufficient numbers of staff on duty according the rota, the acuity and complexity of the patients meant that nursing staff were under pressure to deliver an acceptable level of care.

- Staff did not always complete care records in accordance with best practice guidance from the Royal Colleges. We found gaps and omissions in the sample of records we reviewed. The trust did not have a robust system in place to audit, monitor and review care records to ensure they always gave a complete picture of the assessments and interventions undertaken.
- The trust did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance.
- The trust had not completed its audit programme. This meant the hospital was not robustly monitoring the quality of service provision. The hospital performed poorly in a number of national audits such as the stroke and diabetes services.
- We found the hospital was not yet offering a full seven-day service. Constraints with capacity and staffing limited the responsiveness and effectiveness of the service the hospital was able to offer.
- Patients' access to prompt care and treatment was worse than the England average for a number of specialities. The trust had not met the 62-day cancer referral to treatment time since December 2014. Referral to treatment within 18 weeks was below the 90% standard as set out in the NHS Constitution and England average for six of the eight specialties from June 2015 to May 2016.
- The hospital had improved the number of bed moves patients had during their stay. However, a fifth of all medical patients moved wards more

Summary of findings

than once during their stay. This meant the hospital transferred some patients several times before they had a bed on the right ward, which put additional pressures on receiving wards.

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.
- The trust prioritised staff training, which meant staff had access to training in order to provide safe care and treatment for patients.
- 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.
- Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- Staff treated patients with kindness and compassion.
- The trusts average length of stay for both elective and non-elective stays were better than the England average for the majority of medical specialities.
- There was good provision of care for those living with dementia and learning difficulties. There were support mechanisms and information available to take individual patients needs into account.
- The trust had clear corporate vision and strategy. The trust reflected the opinions of clinicians, staff and stakeholders' when developing the strategy for medical services. Staff felt engaged with the direction of the trust and took pride in the progress they had made to date.

Summary of findings

- 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.

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

Requires improvement

We rated this service as requires improvement because:

- Lack of staffing affected many areas of service planning and the care and treatment of women including; not meeting national safe staffing guidelines, therefore 1 in 5 women did not receive 1:1 care in labour; staff did not have the time to attend risk meetings or complete incident forms.
- The physical environment was not conducive to the safe care and treatment of women. The bereavement suite on Folkestone ward did not meet department of health standards. Some areas of the department were intolerably hot, although there had been some improvements on the delivery suite since our last inspection.
- Hospital management did not ensure robust governance, for example, hospital data of the number of surgical abortions was incorrect as figures included women who had miscarried and had a surgical evacuation.
- On our previous inspection, we found there was an ingrained bullying culture within women's services. This had since improved, however the culture of the service needed more input to support the improvement journey. For example, innovation hubs had increased in popularity, however there was still a lot of disengagement amongst staff and at the time of inspection there was no audit of the hubs to monitor benefits.

However;

Summary of findings

- Staff were supportive of one another and worked well as a multidisciplinary team. Staff provided a caring, empathetic environment for women during their pregnancy and labour.
- Care and treatment was evidence based and patient outcomes were in line with other trusts in England.

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

End of life care

Requires improvement

We rated this 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. These concerns had not changed since the last inspection.
- We found an array of service improvement initiates had been introduced across the trust since the last inspection. This included end of life care plan documentation, the appointment of an end of life facilitator, identification of end of life care link nurses, a decision making end of life board with a membership of healthcare professionals from a variety of specialties within the trust and external stake holders. A slot 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.

Summary of findings

- 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 to access if patients were being reviewed regularly. There were no mental capacity assessments in place for vulnerable adults who lacked capacity. DNA CPR orders were being countersigned by Registered Nurses (RN) without support being put in place around training and where a patient was identified as dying it was often confusing for staff as in many cases interventions were still being delivered.
- End of life training was not part of the mandatory training programme. We found some nursing staff on the wards had received training whilst others had not .A RN in Accident & Emergency commented end of life care was poor on the unit, however, the SPC Nurse was able to tell us where end of life care was good across the hospital. 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. By November 2016, training of the link nurses was expected to be complete. However, more time was required for the link nurses to settle into their new roles, to support their colleagues, and improve quality. We found the end of life resources folders were generally available on the wards. These folders contained the necessary documentation for staff, which was an improvement since the last inspection.
- The trust had access to the Medical Interoperability Gateway (MiG) system that

Summary of findings

enabled the trust to view, with consent, patients' GP records meant that this information was available 24/7.However, this system did not allow the trust to update records or input care plans. No electronic palliative care record system was in place where providers shared information. Staff in Accident and Emergency told us communication between the hospital, community, and GP's needed to improve to prevent inappropriate admissions to hospital

- 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.

William Harvey Hospital

Detailed findings

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

Detailed findings

Contents

Background to William Harvey Hospital

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

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

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

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

with care or patient experience).

How

Detailed findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• is it caring?

• is it responsive to people's needs?

• Is it well led?

Prior to inspection we risk assessed all services provided by the trust using national and local data and intelligence we received from a number of sources. That assessment has led us to include four services (emergency care,medical services, maternity and gynaecology and end of life care) in this inspection. The remaining services were not inspected as they had indicated strong improvement at our last inspection and our information review indicated that the level of service seen at our last inspection had been sustained. Before our inspection, we reviewed a range of

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

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

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

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

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

Facts and data about William Harvey 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	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

The urgent and long-term conditions directorate is responsible to the East Kent University Hospitals NHS Foundation Trust (EKHUFT) for the management of a range of urgent and emergency services in five hospitals. William Harvey Hospital (WHH) in Ashford offers full 24-hour accident and emergency (A&E) facilities for adults and children of all ages. WHH is an acute hospital with 452 beds providing a range of emergency and elective surgery as well as maternity, trauma, orthopaedic, paediatric and neonatal intensive care services.

About 225 people attend A&E at WHH each day. Attendances across all sites totalled 205,673 from April 2015 to March 2016, putting the trust into the top 25 of 154 acute NHS trusts. This compares with 204,685 the year before.

We found rated A&E services at WHH as inadequate after our last inspection. We had concerns about serious overcrowding and escalation protocols used to arrange extra support during exceptionally busy periods. Incident reporting was poor and we found a communications log used as an incident reporting tool. We found faults with cleanliness, infection control and hygiene procedures. We were concerned about shared consultant cover with QEQM. We found a lack of monitoring or reviewing of complaints and found little evidence of lessons learned. Across the directorate, we found a number of clinical guidelines and policies out of date and decisions taken at a senior level didn't relate to the experience of frontline staff.

Since then, the directorate has received support from NHS Improvement through the emergency care improvement programme (ECIP) and a new chief executive has been appointed. The trust focussed on five identified risks, which were emergency care, staffing, clinical governance, planned care and finances.

We conducted this inspection to follow up on progress against the action plans that were in place. The inspection took place over three days, 5 – 7 September, when we visited the three main A&E sites. We spent one day in the department at WHH. We reviewed documentary information supplied prior to our visit and provided on request during the inspection. We took into account feedback from staff focus groups and written communications from stakeholders. We made observations of activity levels, clinical rounds and staff interaction with people using the service and made checks on the environment and equipment used by patients. We also spoke with seven patients, two ambulance crews and 16 members of staff, including doctors and nurses at varying levels of seniority, allied healthcare professionals, managers, health care assistants and administrative staff.

Urgent and emergency services

Summary of findings

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

- Whilst 86% of patients were triaged within 15 minutes, only 34% had a clinician first assessment within 1 hour and only 17% a decision to admit within 2 hours. Attendance by a specialist within 30 minutes following referral was only achieved 35% of the time.
- The WHH had an average of 168 60-minute breaches per month from July – October 2016. This represented 7.8% of the total number of patient handovers from ambulance staff and was worse than the regional average of 3%. WHH was consistently in the bottom four of 17 hospitals in the region.
- The monitoring and reporting of training and other safety indicators such mortality and morbidity summaries were not always reliable. Adult safeguarding training figures were low across the directorate and children's safeguarding training for doctors in the department was still below trust targets. While mandatory training rates for some staff groups had improved, others in the department remained below trust targets. We acknowledge that major incident training at WHH was better than the other sites we inspected, albeit below target.
- Staff appraisal rates were worse than another A&E locations and the trust target. Lower completion rates makes it difficult for the department to assure itself that staff performance and development is being monitored and given sufficient attention. We found gaps in staff appraisals for key supervisors such as band seven nurses.
- Auditing had improved since our last visit, although we found that action plans were not always submitted in a timely manner and where there was an action plan, the actions were not always fully implemented or communicated widely. This meant the department did not have full assurance that best practice was being followed or that problems were being identified quickly enough.
- Delivery of performance indicators such as patients being seen within four hours remained below trust target and national averages.
- Patients with mental health conditions who presented in the evening still had long waits before being assessed or admitted by the mental health team. However, the department had responded by employing mental health nurses to provide specialist care and support.
- Delayed discharges remained a concern due to the impact on the A&E. However, as part of this response we observed an operational communications meeting, which showed the trust was addressing patient flow through the hospital and monitoring closely for risks that affected beds available for receiving patients from the department.
- A range of positive initiatives have been implemented in this department along with others we observed at similar sites in the trust. Further harmonisation and sharing of best practice between all A&E locations would benefit patients and staff.

However,

- We saw that new and dedicated facilities had been provided for children. Staff establishments for nurses had been increased and more specialist nurses had been recruited. We also saw well equipped and organised resuscitation facilities.
- There were sufficient staff with the right skills to care for patients and staff had been provided with induction and additional training specific for their roles. A consultant had been appointed with sub-specialty in children, which complies with recommendations contained in the Standards for Children and Young People in Emergency Care Settings (Royal College of Paediatrics and Child Health, 2012).
- Staff followed cleanliness and infection control procedures. Potential infection risks were anticipated and appropriate responses implemented and measured.
- Patients' treatment and care was delivered in accordance with their individual needs. Patients told us they were treated with dignity and respect.
- We saw improvements in the way the department and the wider trust managed incident reporting and complaints. Lessons learned were widely communicated using a number of information systems.

Urgent and emergency services

- Medicines were stored safely and checks on emergency resuscitation equipment had improved.
- Overall, the leadership, governance and culture within the departments was good and we saw examples of good practice regarding visibility of supervisors, comfort rounds and communication. Staff were supported by their managers and were actively encouraged to contribute to the development of the services.

On this inspection we have changed the rating to requires improvement from inadequate, 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:

Are urgent and emergency services safe?

Requires improvement

We have rated WHH as requires improvement for safe, because:

- Whilst 86% of patients were triaged within 15 minutes, only 34% had a clinician first assessment within one hour and only 17% a decision to admit within two hours. Attendance by a specialist within 30 minutes following referral was only achieved 35% of the time.
- Ambulance handover figures for WHH showed an average of 168 occasions per month (July – October 2016) when vehicles were delayed beyond 60 minutes. This represented 7.8% of the total number of patient handovers and was worse than the regional average of 3%. During this period, WHH was consistently in the bottom four of 17 hospitals in the region.
- The monitoring and reporting of training and other safety indicators such mortality and morbidity summaries were not always reliable. This meant departmental leaders could not be fully assured that safety concerns had been consistently identified or addressed.
- Adult safeguarding training figures were low across the directorate and children's safeguarding training for doctors in the department was still below trust targets.
- While some staff groups had improved, aspects of mandatory training for medical staff were also below trust targets.
- Although lower than target, major incident training at WHH was better than the other sites we inspected and above the trust average.

However,

- While we acknowledge a number of non-compliances in the last infection control audit and note the latest report for the department (June 2016) has yet to be finalised, we found cleanliness had improved and our findings were supported by other indicators such as environmental audits and the annual PLACE assessment.

- We saw new and dedicated facilities that had been provided for children. Staff establishments for nurses had been increased and more specialist nurses had been recruited. We also saw well-equipped and organised resuscitation facilities.
- We found robust safeguarding systems in place for children, including improved training figures for most staff groups.
- A consultant had been appointed with sub-specialty in children, which complied with recommendations contained in the Standards for Children and Young People in Emergency Care Settings (Royal College of Paediatrics and Child Health, 2012).

At our last inspection, we rated the service as inadequate for safety. On this inspection, we have changed the rating to requires improvement because we have seen significant changes in key areas such as staffing levels, new facilities and the way incidents and safeguarding concerns were monitored.

Incidents

- Staff reported incidents on an electronic reporting system, which they confirmed they had received training on. These were shared and discussed during departmental meetings and we saw minutes confirming this. This indicated that the department was learning lessons from incidents that occurred.
- We also saw an example of the trust's clinical safety newsletter called 'Risk Wise' (Summer 2016) which comprised of case studies and lessons learned along with advice and guidance. This included a link for staff to automatically receive email safety alerts to their own smartphones.
- There have been no never events and 10 serious incidents (SI) reported across the directorate between July 2015 and June 2016. 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.
- Nearly all of the SIs related to treatment delays. One was a reported delay in diagnosis, another an allegation of abuse by staff and one a pressure ulcer meeting the SI criteria. Location data was provided by the trust but was limited to all SIs for the division.
- 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 we spoke to knew about the DoC legislation and we saw that the electronic incident reporting system included DoC prompts that had to be completed as part of the investigation process.
- The trust provided copies of the A&E 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 January to May minutes. The status of mandatory training for doctors and nurses was not included in these reports. This meant the clinical governance committee could not be assured that safety concerns had been consistently identified or addressed.

Cleanliness, infection control and hygiene

- There were no reported cases of MRSA, Clostridium difficile (C. diff) or Escherichia coli (E. coli) in the period April 2015 –March 2016. These serious infections have the potential to cause harm.
- The last infection control audit for A&E scored 11 non-compliances and 29 compliant standards. This was worse than the trust average of 87%. Some of the non-compliances arose from the condition of fixtures and fittings while others related the cleanliness of portable equipment and trolleys. From our observations of equipment and clinical storage areas, we judged that cleanliness had improved. When we asked, we were told the latest report for the department (June 2016) had yet to be finalised.
- Our findings were supported by department's Patient Led Assessment of the Care Environment (PLACE) audit for 2016, which showed A&E scored 98.6% for cleanliness. This was an improvement over the 2015 results and was similar to the England average of 98%. PLACE assessment teams are made up of patient and staff representatives and national guidelines set out the environments to be reviewed each year. EKHUFT were required to review A&E departments, 10 wards, three outpatient areas, food preparation areas, car parks, grounds and gardens as well as key public locations such as lifts, stairwells and corridors.
- Disposable curtains were used throughout the department and each had a label showing the curtain

had been recently changed. This complied with Health Building Note (HBN) 00-09 and helped to reduce the chances of germs passing from one person or object to another.

- The most recent audits for hand hygiene and staff 'bare below the elbows' showed 100% compliance by all levels of staff. This was an improvement on our last inspection and during our observation we saw that all staff followed these practices correctly. Handwash basins were installed in all clinical areas and complied with HBN (00-10 (2013): Part C – Sanitary assemblies). We saw wall mounted dispensers for aprons and gloves as well as wall-mounted hand-sanitising gel at strategic points throughout the department. Posters were displayed which explained hand washing technique in line with World Health Organisation guidance.
- Single-use consumable items we checked were in date. Correct storage and stock rotation ensured that the sterility of items was maintained and risks of bacterial contamination reduced. We saw these items being used once and disposed afterwards.
- We saw that waste was separated into different coloured bags to signify the different categories of waste. This was in accordance with the Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health (COSHH) and health and safety at work regulations. All waste was kept in appropriate bins that were locked within a secure compound where they were accessed by the waste disposal contractor.
- We saw sharps bins available in treatment areas and correctly used in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The bins were secure containers, clearly marked and placed close to work areas where medical sharps were used. The bin labels included clear instructions for staff on safe disposal.
- We reviewed the department's decontamination of toys checklist on display in the new paediatric area and we saw that staff had cleaned toys daily. We saw that portable items of equipment displayed 'I am clean' stickers. This showed that staff had cleaned these items ready for the next patient.

Environment and equipment

- The department comprised of 14 cubicles designated as a 'majors' area, a resuscitation area of four bays, an ophthalmic room and eight observation beds. Bays and cubicles were free from clutter and had partitions or curtains to help preserve patient privacy.
- All doors leading from reception had functioning security locks, which helped prevent unauthorised access to other areas of the department.
- Construction of a new paediatric A&E unit had just been completed and the rooms opened two weeks before our inspection. The facility appeared to be well designed and functional with a high standard of age-appropriate décor and finishing.
- The 2016 PLACE assessment results showed a significant improvement over the previous results. A&E scored 95% for 'condition, appearance and maintenance', compared to 88% in 2015 and better than the England average of 93%.
- We saw trust environmental audit results for A&E (February 2016) that showed 85% compliance. These results were an improvement compared to 75% scored in the previous year.
- Flooring throughout A&E 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).
- Patient trolleys, furniture and equipment were labelled with asset numbers and service or calibration dates. This helped to provide assurance that items were maintained in accordance with manufacturer recommendations.
- We checked several portable electrical devices selected at random as we inspected the department. These devices were labelled with the dates of the most recent electrical testing, which provided a visual check that they had been examined to ensure they were safe to use.
- Staff were aware of the process for reporting faulty equipment. None of the staff we spoke with had concerns about equipment availability and if anything required repair it was fixed.
- We saw a resuscitation trolley in the 'majors' area and the paediatric section. Both trolleys were locked. Records showed the trolleys were checked daily, except for two days in the last month in the majors' area. All drawers contained consumables and medicines in accordance with the checklist. We saw that

consumables were in date and trolleys were clean and dust free. The automatic electrical defibrillator and suction equipment were in working order. This meant all items were ready for immediate use should an emergency occur.

Medicines

- The department had safe systems for ordering, storage and administration of medicines. Local and trust-wide audits were completed which demonstrated that the department complied with trust policy. We observed appropriate storage and record keeping of controlled drugs consistent with the Misuse of Drugs Regulations, 2001. There was a clear process for the department to order controlled drugs.
- The CD register was completed in accordance with the legal and regulatory standards including Nursing and Midwifery Council (NMC) Standards for Medicines Management.
- Staff were familiar with policies regarding the destruction of controlled drugs and we saw daily controlled drugs stock checks in the department's controlled drug register.
- Medicines that had to be stored in a temperature-controlled environment were secured in designated drug fridges. The fridges had digital thermometer displays that allowed temperatures to be monitored. Staff undertook fridge temperature checks daily and recorded on a standardised form. Staff explained the process of dealing with 'out of range' temperatures, which included reporting it as an incident on the electronic reporting system.

Records

- We reviewed five patient medical records. These were generally tidy with no loose filing, they were legible, dated and signed. Each patient had the appropriate care pathway documented.
- Similarly to the other A&E locations, we saw a combination of electronic records and paper files in use. We saw patient personal information and medical records managed safely and securely, in line with the Data Protection Act.
- When not in use, patients' notes were kept in a locked records cabinet.
- We saw local auditing processes in place that helped department managers obtain assurance that patient records were up to date and accurately completed. Examples included weekly reviews of notes by a safeguarding group and recorded checks made by the matron or deputy during 'rounds' of the department.

Safeguarding

- No adult safeguarding allegations had been made against the A&E department last year.
- Staff used a screening management and reporting tool (SMART Plus) to identify high-risk vulnerable adults. This had been rolled out by the trust in conjunction with a revised policy (December 2015). We saw a copy of the flow chart on display and staff stated that they had access to flow charts, forms and advice on the 'Staff Zone' hospital intranet.
- According to a trust report, the learning and development tracking system had become inoperable. After a delay of over a year, figures obtained in May showed all areas were below the target of 85%. The urgent and long-term conditions directorate achieved 61% for level 1 training and 56% for level 2, compared to the trust average of 47%.
- The figures were better for children's safeguarding training. A&E nurses at WHH had achieved 98.8%, the best of the three sites we inspected. Doctors had achieved 74%, which was less than QEQM (94%) and below the trust target of 85%
- We found that staff had safeguarding training at the appropriate levels for their roles and all we spoke with were alert to any potential issues with adults or children.
- Staff we spoke to could identify the safeguarding lead for the departments and the trust, which was an improvement on out last inspection.
- We saw safeguarding pathways for adults and children displayed on notice boards and noted that attendance cards for children were marked with an orange strip for easier identification.
- We observed a safeguarding meeting held in A&E. This weekly review was chaired by the clinical lead and attended by the safeguarding liaison and the lead nurses from both adult and paediatric areas. We saw the group review A&E and safeguarding records of recent paediatric attendances. Medical records for each case were scrutinised to ensure appropriate care had been delivered. These review meetings started in April and according to the staff involved, were a positive

development. There was a "great improvement" in the way the A&E department coordinated with social services in the locality and other resources such as the child, adolescent and mental health service (CAMHS).

Mandatory training

- While some courses such as safeguarding were classroom-led, the majority of mandatory training was completed by staff on-line 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.
- On our last inspection, we found the completion figures for medical staff was worse than other staff grades. These had marginally improved, although all remained below the trust target of 85% and compared poorly with the results from QEQM. The figures for medical staff at WHH were:
  - Fire training - 72%
  - Moving and handling training - 72%
  - Health and Safety training - 68%
  - Infection control prevention - 72%
  - Equality and Diversity - 68%
  - Safeguarding Children and Young People - 77%
  - Information governance - 68.2%
- The figures achieved for other staff groups at WHH had also improved and apart from adult safeguarding and information governance, were close to or above the trust target of 85%:
  - Equality and Diversity - 84.1%
  - Fire Safety - 87.8%
  - Health and Safety Awareness - 97.6%
  - Infection Prevention and Control - 92.7%
  - Information Governance - 81.7%
  - Moving and Handling - 95.1%
  - Safeguarding Children and Young People - 98.8%
  - Paediatric nurses at band 6 and 7 levels were trained in advanced life support for children (APLS).

Assessing and responding to patient risk

- Walk in patients arriving at reception were immediately seen by a Band 5 nurse, who assessed their condition using the emergency severity index (ESI). The ESI is a five-level emergency department triage algorithm that helps staff sort patients into one of five categories of urgency, based on established clinical criteria. Once screened by the nurse, the patient was sent to book in at reception and then directed to the appropriate section of the department. Children arriving at the hospital were directed to the adjoining paediatric area, which had been opened two weeks before our inspection.
- Patients arriving by ambulance were taken through a separate entrance into the handover area, which was in the corridor between the nurses' station and the resuscitation area. We observed this corridor becoming congested with trolleys and staff as the day progressed and the department became busier.
- Whilst 86% of patients were triaged within 15 minutes, only 34% had a clinician first assessment within 1 hour and only 17% a decision to admit within 2 hours. Attendance by specialist doctor within 30 minutes following referral was only achieved 35% of the time.
- We noted an improved layout of the central observation area in the department, which included observation bays that could be screened off when needed and fitted with equipment and call bells.
- The hospital used the National Early Warning Score (NEWS), a scoring system for physiological measurements, for patient monitoring. We saw records that showed NEWS scores were correctly calculated at the required frequency.
- We saw that paediatric early warning scores (PEWS) were used when needed. This meant that children attending the department were being assessed using a national warning score tool so that any deterioration in their condition would be rapidly detected.
- The hospital used the SMART Plus tool to risk assess patients with mental health conditions. The tool helped staff grade the risk as red, amber, yellow or green, which then stipulated what actions should be taken next. 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.
- We observed a 'board round' at 10am conducted at the medical/nursing station. The lead doctor and nurse briefly reviewed the status of each patient in the department, following key topics contained on a laminated prompt card. Conducted every two hours, this process helped ensure the progress of patients were the effectively monitored and managed.

- We saw team leaders presenting 'situation updates' to the lead nurse, using a prompt and record sheet called "UPDATED". The prompt reminded leaders of the need to audit pain scores, documentation, assessments, treatments, escalation and offer diet and fluids. Instructions on how to use the record sheets and the purpose of the form were displayed on a wall close to the main desk. This was an initiative developed by one of the band 7 nurses and helped to improve situation reports in a structure red and meaningful way.

Nursing staffing

- A&E at WHH had an establishment for nurses of 80.12 whole time equivalent (WTE). This was a larger establishment than in 2015 (49.61 WTE) and managers explained that across the whole directorate, new nurses amounting to 24 WTE had just joined but were awaiting Nursing and Midwifery Council personal registration numbers. In the interim, they worked as health care assistants. Another 18.6 WTE (Band 5 nurses) were progressing through pre-employment checks before joining the trust.
- The paediatric area was staffed by one children's nurse at band 7 level, two at band 6 and five at band 5. Staff stated that with annual leave and sickness cover, one children's nurse present on each shift. We saw the last month's roster, which confirmed this. We were told that recruitment for children's nurses was ongoing.
- In addition, a health care assistant was on each shift who was trained to cannulate and perform vital signs monitoring.
- We saw trust reports showing that staff turnover for the department directorate was 13%. Sickness absence had increased to 4.07%, although this was lower than other parts of the trust. An average of 21% agency staff were used to cover shortfalls at WHH A&E over the last year, which was similar to the other locations.
- The directorate had undertaken staffing reviews using the RCN BEST model and NICE guidance along with "professional judgement" by managers. In principle, the department rostered staff based on two registered nurses to one patient in cases of major trauma or cardiac arrest and one registered nurse to four cubicles in either 'majors' or 'minors'.
- It was acknowledged that demand in the department can change rapidly and that reviews of activity had shown that more staff were needed in the evenings. The use of minimum ratios meant that managers could calculate what services could be made available at any time and prioritise these to meet the demand and patient safety. In this regard, patient acuity (the severity of their illness and care needs) was assessed using NEWS scores.
- We saw trust data from the last four months that showed actual staffing hours matched planned hours at rates of between 87% and 26% over requirement. At the time of our inspection, we saw sufficient staff in both areas and on reviewing rosters noted that planned staffing levels matched the trust figures. Bank and agency staff were employed to make up any shortfall in numbers.
- The trust was taking positive action to recruit and retain staff. The recruitment strategy included investment in advertising, social media and recruitment agencies both here and in Europe.

Medical staffing

- The A&E department had consultant cover from an emergency medicine physician (ED consultant) seven days per week. Managers confirmed that from September, two new consultants would join the five staff already in post at WHH.
- Consultant cover was provided from 8.00 am to 22.00 pm Monday to Friday, along with eight hours of consultant cover on weekend days. On call cover was arranged outside these hours. The weekend on call roster was based on a 1:7 rotation with the five existing consultants sharing the two vacant weekends on a locum basis. This arrangement would revert to a full rotation once the new consultants started work.
- A&E at WHH had an establishment of 25.50 WTE for doctors. The clinical lead stated that 24 junior and specialist grade doctors were in post. Locum cover for WHH averaged 36% over the last year, which was higher than UCC (31%) but lower than QEQM (42%).
- The medical staffing skill mix showed the trust has a higher percentage of junior grade staff when compared to the England average, but the percentage of consultants is lower. Across the trust, 20% of medical staff were consultants compared to the England average of 26%, 17% were 'middle career' compared to 15% in England and 63% were registrar or below compared to 41% in the rest of the country.
- No doctor was allocated to the paediatric area. The children's nurses called an A&E doctor to attend as

required and stated that this happened promptly. In addition, we were told that good support was also provided by the paediatricians working in the hospital's paediatric assessment unit (PAU).

- According to the Standards for Children and Young People in Emergency Care Settings (Royal College of Paediatrics and Child Health, 2012), all paediatric departments supporting an on-site emergency care setting seeing more than 16,000 children per year should aim to appoint a consultant with sub-specialty in children. Since our last inspection, managers told us that a consultant had just been recruited with the appropriate speciality.

Major incident awareness and training

- A new Emergency Planning Policy was introduced in January 2016, which included an online training package as part of annual mandatory training. Resources, policy and information had also been made available on the staff intranet, which meant that improved frameworks existed that supported preparedness for major incident or events disrupting the work of the hospital.
- Major incident raining figures for WHH (May 2016) were good. 79% of 'target staff' had received either DVD-based awareness training or completed the classroom-based course. This was better than QEQM (44%), UCC (56%) and the trust average of 62%, although worse than the trust target of 100%.
- Staff described participating in scenario-based training events, including 'table top exercises', which had been commenced along with a requirement for selected staff to attend annual training updates. Training was provided and monitored by the emergency planning team. This indicated the trust had improved support and preparedness for any business-disrupting event or major incident.
- Within the A&E department, clinical scenarios including resuscitation were conducted to help ensure staff responded appropriately to emergencies.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated the A&E at WHH as requires improvement for effective, because:

- Some 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 were low across the directorate.
- Annual appraisals rates were worse than last year and are yet to be completed for some key staff.
- Auditing had improved since our last visit, although we found that action plans were not always submitted in a timely manner and where there was an action plan the actions were not always fully implemented or communicated 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 quickly enough.
- RCEM audit data for WHH had shown mixed results compared to our last inspection. Areas of improvement were supported by other benchmark indictors such as the national trauma audit and research network.

However,

- We saw evidence of comfort rounds performed and audited. These confirmed pain assessments had been performed at initial triage, analgesia administered and comments on the effectiveness of the medication documented.
- We saw good examples of multidisciplinary working between all staff grades and specialities as well as colleagues from the other emergency departments.
- We saw waiting times displayed in the reception area so patients knew how long they might have to wait. This information was replicated on the trusts website, which meant people with access to the internet at home or work could quickly obtain information on service status.

Urgent and emergency services

At our last inspection, we rated the service as inadequate for effective. On this inspection, we have changed this to requires improvement, as we have seen improvements in key areas such as advanced resuscitation training, pain management and seven-day services.

Evidence-based care and treatment

- We saw a range of care pathways provided on the intranet. These complied with the national institute for health and care excellence (NICE) and royal college of emergency medicine (RCEM) clinical standards.
- Care pathways we viewed were up to date and referenced, which indicated that the guidance followed best practice.
- The trust also provided staff with a range of easy to use guides and documents for recording information, such as the SMART Plus tool used to assess the health of patients being treated in the department.

Pain relief

- Patient group directives for pain relief medication were available and processes in place for early administration.
- We saw comfort rounds undertaken by nurses and augmented by 'tea rounds' performed by senior nurses on duty, including the matron. This meant that managers had assurance that pain assessments had been completed and analgesia administered as required.
- In the last CQC A&E survey, 77% of patients agreed that "staff did everything they could to help control your pain" 77% and 55% were satisfied with the time taken to receive pain medication after requesting it. These results were about the same as other hospitals in England.

Nutrition and hydration

- In response to the question "Were you able to get suitable food or drinks when you were in the A&E Department", 65% of patients said yes, which was scored about the same as other NHS hospitals in England.
- We were shown evidence of a range of food items available to patients, including options suitable for people requiring gluten free diets or special preparations based on cultural or religious preferences.
- We saw a water dispenser in the waiting area as well as a tea trolley 'round' to offer patients food and drinks if necessary.
- Nurses and support staff we spoke to understood the needs of patients they were caring for and the importance of ensuring they had adequate food and drink. Elderly or frail patients underwent risk assessments which included an assessment using the malnutrition universal screening tool (MUST), which helped staff identify patients at risk of poor nutrition, dehydration and swallowing difficulties. We saw nutrition and hydration assessments being reported and monitored using the locally developed "UPDATED" situation report. Copies of completed updates were recorded and kept for auditing by senior nurses, along with records of the patient rounds conducted by the matron.

Patient outcomes

- According to the trust, 24 audits were progressed in the directorate during the 2015/16 Audit Programme. Audit managers reported that specialties had been "over ambitious" with topic selection and that action plans were not always being submitted in a timely manner. Where there was an action plan, the actions were not always implemented and communications was seen as an issue to be improved.
- The department audited clinical practice against the standards set by the royal college of emergency medicine (RCEM). We saw data from (RCEM) audits on initial management of the Fitting Child, mental health in the ED and assessing for cognitive impairment in older people.
- According to RCEM data for WHH, the department scored 100% for the initial management of the fitting child (between the upper and lower England quartiles); 84% for management of mental health in ED (between the upper and lower quartiles) and 92% for assessing the cognitive impairment in older people (between the upper and lower quartiles). These figures had improved since our last inspection.
- We also saw data showing the trust participated in the national trauma audit and research network (TARN) annual audit and is part of the South East London, Kent and Medway regional grouping. TARN provides important information about the rates of survival for patients who have been injured and treated at different hospitals across England and Wales. It also provides

information about the benefits of certain kinds of treatment. Audit results for April – December 2015 showed that WHH scored 98% data completeness in key aspects of trauma care, based on 331 submissions.

- This score matched QEQM and had improved from a score of 97% the year before. Accreditation scores for WHH were better than other facilities seeing comparable numbers of trauma victims in the region. This meant that senior clinicians and managers were able to benchmark results between seven regional NHS trusts and more easily determine areas of clinical practice requiring improvement.
- There had been a significant improvement in sepsis (infection of the blood that causes damage to the body) care and management of deteriorating patients since our last inspection. We saw examples of the "Emergency Department Observations Chart" introduced for use in A&E. The observation document was for all adult patients included a colour-coded observation record combined with NEWS scores and a tick-box Sepsis flow chart, in addition a "critically ill patient flow chart" printed on the reverse. Staff completing the document were given clear instruction on sepsis "red flags", which mean that all those delivering care had robust instruction on when blood tests were required and reporting concerns to the responsible doctor. We saw and heard evidence that observation charts were being completed by staff; blood tests were taken and the process audited on an ongoing basis during check rounds made by the matron on duty. These controls were augmented by the two-hourly "board round" review of all patients in the department along with the "UPDATED" situation reporting mentioned earlier in this report.
- Further enhancements were in prospect. The identification and management of sepsis had been placed on the directorate's risk register and plans were in place to improve processes. Following a study undertaken at the hospital in 2015, the report "Just say Sepsis" was presented on a study day held at the hospital in July 2016. Senior A&E staff participated in the event which included the audit results of the use of a NEWS "Track and Trigger" system. This electronic system automatically recorded patient observations and used the data to assist clinical staff manage deteriorating patients. We learned that the system was being used in all clinical areas apart from A&E and that colleagues in A&E QEQM were due to trial the system prior to rollout to the emergency departments later this year.
- Nurse practitioners working in the area undertook audits of their own practice and clinical decision-making. These were shared 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.

Competent staff

- Recruitment checks were made by the trust to ensure all new staff were appropriately experienced, qualified and suitable for the post. On-going checks took place to ensure continuing registration with professional bodies and divisional managers assisted by human resources monitored this process.
- We found that some appraisals had not been completed and this was confirmed by a band 7 nurse, who stated "none had received appraisals" this year. Trust data shows an average of 55% appraisals completed for WHH A&E nursing, clinical and administrative staff groups (April 2015 to March 2016). According to the data, this figure is worse than for the same period the year before and indicated that staff performance was not always monitored or development needs identified.
- All registered nurses we spoke with told us they felt supported when preparing for their revalidation and most staff we spoke with told us they had regular team meetings and were supported with their continuous professional development.
- There was a local induction process in place for agency staff and we were told the department tried to use regular agency staff that were familiar with the department.
- Sixteen consultants and regular locums at WHH A&E completed advanced trauma life support training (ATLS) last year. Five consultants completed advanced paediatric life support (APLS) and eight completed advanced life support training (ALS). In addition, three nurses completed the ALS qualification. This indicated the department had considered and addressed the need for advanced resuscitation training and trauma management.

Multidisciplinary working

Urgent and emergency services

- We saw good examples of multidisciplinary working in the department. Medical and nursing supervisors were visibly conferring and we saw frequent interactions between staff from specialist areas and visitors from other parts of the hospital.
- We also saw A&E staff working closely with ambulance crews and support staff as well as external visitors such as a safeguarding team.
- Staff stated they had good links with colleagues locally and the other emergency departments. We saw this when we observed a status meeting at the operational communications centre and it was further supported by comments from external visitors such as ambulance crews and a security officer.

Seven-day services

- We found that consultant cover was provided on a seven-day basis, with 16 hours daily during the week and eight hours a day on weekend. There were robust on-call arrangements out of these hours.
- In addition, the trust had responded to increasing numbers attending the department by the introduction of referrals made to a contracted GP service located that operated 24 hours a day.
- Weekend and on-call cover was also provided for pharmacy, pathology, imaging and maintenance services. There was full 24-hour access to diagnostic and screening tests.
- Agency mental health nursing cover was also provided to the department and we saw physiotherapists in the department assisting a patient to mobilise. They were available from 9.00 am to 5.00 pm during the week and on call outside these hours.

Access to information

- Clinical guidelines and policies were available via the trust intranet.
- The Hospital used a combination of computer software and paper notes to document care, treatment and observations. We learned that other parts of the trust used an electronic system that monitored and analysed patients' vital signs to identify deteriorating conditions and provide risk scores to trigger the need for further care.
- Managers stated that this system was due to be trialled by colleagues in QEQM and would be introduced to all the emergency departments.
- We saw waiting times displayed in the reception area so patients knew how long they might have to wait. This information was replicated on the trusts website, which meant people with access to the internet at home or work could quickly obtain information on service status.

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 of the Mental Capacity Act 2005 (MCA) guidance and treatment checklists. There were no patients requiring this at the time of our inspection.
- Training on consent and the Mental Capacity Act 2005 was available online, although the figures for the directorate was low. According to data we saw, only 26% of band 6 and 7 nurses has completed the training. The trust reported that implementing revised DoLS training in the light of a recent Supreme Court ruling (2015) and its implications for the acute sector had proved challenging. The trust had adopted a package of tools developed by the association of directors of adult social services in England (ADASS) to assist the effective prioritisation of DoLS assessments and the trust continues to work to raise awareness about clinical restraint. In addition, the trust used a contracted service that provided specialist staff to support patients with challenging behaviours.
- Staff were aware of their responsibilities under the Mental Capacity Act 2005 and DoLS and were able to describe the arrangements in place should the legislation need to be applied. We saw a new web page that 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:

Urgent and emergency services

- Patients and their relatives gave positive feedback about the care provided by staff.
- Patients understood the care and treatment choices available to them and were given appropriate information and support during this process. We saw a variety of support services available to assist patients and their families and these were well publicised in the department.
- The department had provided enhanced facilities to assist staff maintain patient privacy and dignity, including appropriate use of curtains in the central observation area (overflow bays) and cubicles.
- 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.

At our last inspection, we rated the service as requires improvement for care. On this inspection, we have changed this to good, as we have seen improvements in key areas related to overcrowding and lack of dignity. Since then, nurse establishments have been increased and better facilities provided to help manage overflow of patients at peak periods.

Compassionate care

- The trust was rated as "about the same as other trusts" for all questions in the ED survey 2014.
- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. The latest results available for the A&E Friends and Family test showed the trust scored below the England average (June 2015 – May 2016). This information was displayed on notice boards in the department and visible to visitors and patients.
- Patients and relatives were complimentary about the nurses, nursing practitioners and medical staff. We saw care given that was considerate and kind. Staff introduced themselves and wore name badges that helped patients and visitors identify their roles.
- In the paediatric unit, we observed kind, reassuring and family-cantered care from the nurses and paediatrician.
- In the main unit area, we saw that curtained bays had been fitted for use when the department was busy. The curtains helped staff to maintain patient dignity. We saw one person being cared for in a bay during our inspection and noted the curtains were used by staff.

Understanding and involvement of patients and those close to them

- Patients we spoke with said they felt involved in their care and participated in the decisions regarding their treatment.
- We an example of good staff interaction with the mother of an ill child, who was fully involved in the assessment of her child.
- We observed another instance in the paediatric unit where staff kept a child and their family informed of why the doctors had left the department to attend to an emergency elsewhere in the hospital.

Emotional support

- We saw posters displayed showing details of support groups or services such as domestic violence support, mental health support and community social support for elderly people.
- The hospital offered a 'take home and settle service', where patients were escorted home and helped to settle in. The service ensured that patients had a support network in place, a supply of everyday items such as milk and bread and that the home was suitable.
- We saw a 'quiet room' where relatives could be seen away from the main floor of the department. Staff gave a good account 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 'Staff confirmed they had access to the end of life team and previous referrals had been acted upon promptly.
- We saw that a multi-faith hospital chaplaincy service was provided and could be contacted via the main hospital switchboard.

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

Urgent and emergency services

Requires improvement

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

- Delivery of performance indicators such as patients being seen within four hours remained below the trust target and national averages.
- Patients with mental health conditions who presented after 8.00 pm still had long waits before being assessed or admitted by the mental health team. However, the department had responded by employing mental health nurses to provide specialist care and support.
- Delayed discharges remained a concern due to the impact on A&E. However, as part of this response we observed an operational communications meeting, which showed the trust was addressing patient flow through the hospital and monitoring closely for risks that affected beds available for receiving patients.

However,

- The department was actively testing and trialling new ways of collaborative working to speed patient flow and take advantage of electronic technology. Early results were positive.
- We saw good examples of the department responding to patient's needs such as people with dementia.

At our last inspection, we rated the service as requires improvement for responsiveness. On this inspection, we have retained the same rating, although we acknowledge improvement in areas such as the way patients are screened and processed and complaints are reported, lessons learned and changes made when needed.

Service planning and delivery to meet the needs of local people

- Department managers participated in resilience groups designed to address business continuity and they told us they had been fully engaged in the emergency care recovery plan. A&E staff worked within the trust's governance structure in support of the department's "journey to improvement". For example, an urgent care board had been established to plan and manage actions for change and staff we spoke with were positive about the way the hospital had progressed in meeting the needs of its patients.
- According to trust reports, delayed discharges remained a concern due to the impact on A&E. For example, bed occupancy in the trust over the last quarter was as high as 93%. As part of the response to this, we observed a situation update meeting at the operational control centre. As centre had been established at each hospital and meant A&E had access to enhanced planning and management of patient flow. The centre meetings included video-conferencing sessions with the other hospital sites at set times each day. Data displayed on screens provided "real-time" situation and risk assessment information for use in bed management meetings and predicting demand.
- In addition, we learned that the trust had also established integrated discharge teams to help speed the process. Other initiatives to support safer discharges had also been implemented, such as the 'Home First' scheme. Staff said these had a positive impact.
- The new A&E waiting room and paediatric facilities were positively viewed by managers and staff, who felt they helped to enhance the services that were delivered.
- There was a helipad outside the department with step free access directly to the ambulance entrance.
- The department offered free Wi-Fi access to patients and visitors, which meant people could use their smartphones and other portable digital devices. We saw a poster advertising the feature and advising users to ask a member of staff for the password. Staff told us this was an increasingly popular feature.

Meeting people's individual needs

- We observed a good example of the department adapting to the needs of patients, when a patient was identified on admission and linked to another patient already in the resuscitation area. We saw that staff discreetly and rapidly modified their processes to provide continued care for both individuals in separate areas of the department.
- We observed 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.

- An electronic flagging system alerted the learning disabilities link nurse whenever a patient with learning disability was referred through the department for admission.
- We saw the 'This is me' dementia awareness scheme operated in the department, which included a named 'dementia champion' who helped the trust disseminate information to staff and improve awareness.
- Staff had access to a mental health liaison team to provide input to any patients who required mental health assessments.

Access and flow

- The trust as a whole failed to meet the emergency department four hour access target between June 2015 and May 2016.
- The trust has developed business intelligence to support the implementation of its urgent care improvement plan. This data is site specific and provides a detailed breakdown of key performance indicators for access and flow. The trust provided data covering the period March – June 2016.
- For WHH, the average performance against the four-hour target was 76% for that time period. Whilst performance for patients seen in 'minors' was 91% (still below target), only 68% of patients seen in the majors area were treated within four hours.
- However, across the trust the percentage of emergency admissions waiting 4 -12 hours from the decision to admit until being admitted was consistently lower (better) than the England average. The data reflects the continued issues the hospital faced relating to patient flow through the emergency pathway.
- The percentage of unplanned re-attendances averaged 7.2% over the same period. Lower percentages for unplanned attendances suggest that the care and treatment received is appropriate and effective for the patient's condition.
- Across the trust, the percentage of patients leaving before being seen was worse than the England average (March 2015 to March 2016), as was the total time spent in A&E. In the last CQC A&E survey, the trust was rated about the same at other English hospitals for questions such as how long patients waited with the ambulance crew prior to being seen; or waiting to see a doctor or nurse.

Learning from complaints and concerns

- Complaints received by the patient experience team (PET) were allocated to a case manager who acknowledged the complaint within three working days and remained as the single point of contact for the patient and the department lead. Using an electronic system, the complaint was investigated by the matron or another designated clinical lead, who drafted a response which was then reviewed by the PET and sent to the chief executive for sign-off.
- We saw information leaflets on display in the department and were shown the trust website which contained contact details as well as an 'on line' complaint form that could be completed and submitted directly to the PET.
- Senior staff such as the matron or a designated clinical lead investigated, depending on the complaint topic. 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 department received 110 formal complaints. This totalled 40% of all complaints received by the directorate and according to managers, was a similar figure to last year. The majority of complaints were about clinical treatment and admissions, discharge and transfer arrangements.
- 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.
- ED 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 for disseminating the learning from complaints to staff in the Trust. The first issue was sent out in June 2015 and was also attached to the trust newsletter. The newsletter contained the complaints and compliments data for the quarter for each division and includes case studies identifying service improvements within the trust as a result.

Urgent and emergency services

Are urgent and emergency services well-led?

Requires improvement

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

- Despite improvements, there were still gaps in key areas of mandatory training. Lower achievement levels in topics such as MCA and adult safeguarding remain a concern.
- Difficulties with one learning and development recording system appears to have delayed the response of managers to addressing low training levels in adult safeguarding, consent and the Mental Capacity Act. MCA figures across the directorate were low.
- Staff appraisal rates were worse than the trust target and for key groups such as band seven nurses. Low completion rates make it difficult for departmental leaders to assure themselves that staff performance and development is being monitored and managed.

However,

- We found the department had a strong philosophy of care which was displayed by staff at all levels.
- Managers and staff were candid about the "improvement journey" and were engaged with the trust's vision and strategy for improvement. This was reflected in the staff survey results and the people we spoke to expressed pride in the progress the department had made so far.
- The trust had improved and implemented clearly defined governance systems. There was a well-established governance structure, with cross-directorate working, developing standard practices and promoting effective leadership.
- Local supervision and leadership was effective and visible. We saw a range of positive initiatives have been implemented in this department.

At our last inspection, we rated the service as inadequate for well-led. On this inspection, we have changed this to requires improvement, as we have seen significant improvements in key areas relating to local and trust-wide leadership, governance and staff engagement.

Vision and strategy for this service

- Staff at all levels were candid but positive about the "improvement journey". Leaders were fully engaged with planning and resilience and benefited from access to better and stronger data.
- The vison across A&E was stated as the provision of safe, effective and timely emergency care to meet the needs of the local population. Managers translated this into goals that included achieving the 4-hour emergency access standard, stronger partnership working and integration between the "emergency floor" which incorporated A&E and acute medical services, better site management linked to business continuity and emergency planning along with improved access to mental health services.
- We saw good evidence of improved local organisation and decision making. Reporting risks and escalation triggers in the department was significantly stronger. For example, we saw minutes of meetings and risk register for the directorate, which included links to the corporate risk register. This indicated that local governance structures were in place that fed into the higher levels of the trust management. Dated actions indicated regular review and reporting, which was supported by comments in the 'emergency department' governance board meeting notes.
- Staff confirmed that morale had improved and people had responded to the more inclusive and visible approach of senior management.
- We saw the trust had well-documented and publicised vision and values. These were readily available for staff, patients and the public on the trust's internet pages, posters around the department and on the trust's internal intranet.
- 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. We saw examples of improvement plan spreadsheet for the department along with minutes referring to the plans.

Governance, risk management and quality measurement

- The trust had introduced a divisional governance model, which meant governance activities were divided into four divisions (surgery, urgent and long-term conditions, clinical support services and specialist

services). Directorate leaders had identified a number of risks to A&E, which it was addressing through the trust improvement program. These included overcrowding, which delayed patient care, inconsistent departmental and care process, poor leadership, workforce challenges and the built environment at WHH.

- We found that governance had improved in A&E since our last inspection. Staff described a clearer line of accountability that now existed up to board level. Department leaders worked through monthly "ED Department" meetings along with a Band 7 nursing forum. Both groups reported to the ED Business and Governance group which then reported to the trust wide UCLTC Quality and Management Board. This group worked with project teams responsible for initiatives such as the acute medical project at WHH and QEQM and UCC Project at Kent and Canterbury and reported to the Urgent Care Programme Board, which was a sub-group of the trust management board and chaired by the Chief Operating Officer.
- We saw meeting minutes that showed A&E department governance meetings fed into divisional safety and quality meetings, which then reported to the executive safety and quality committee.
- The trust had commissioned external reviews to assess progress and the effectiveness of the changes put in place. Reviewers concluded that there was increased visibility of the senior managers and board; improved site management and safety, better staff engagement, stable divisional structures and strengthened leadership across the trust.

Leadership of service

- The trust had introduced 'Triumvirate working' into the department, which was a management structure that helped to ensure both clinicians and operational managers were involved. In A&E, the triumvirate model consisted of a lead clinician, a senior matron and a manager. We found a cohesive local management team that was clear on the direction of travel for the department and the challenges involved. The clinical lead told us that the trust was seeking to create more site-based responsibility whilst maintaining the overall structure and identity
- We saw good examples of local leadership during our inspection. We observed the lead nurse and doctor keeping the department under constant review and acting to making referrals and other tasks to speed the flow of patients through the department. Both wore reflective armbands that were clearly marked as 'doctor in charge' and 'nurse in charge'. This meant that patients, staff and visitors could rapidly identify supervisors on duty, which improved communications and provided visible assurance that control was effective during busy periods. This was also apparent during trauma calls in the resuscitation area, where team staff wore tabards that clearly identified their roles.
- In other examples of local leadership, we saw the senior matron conducting a 'tea round' and using the interaction as an opportunity to monitor and assess the effectiveness of the care being delivered.
- Staff said that the chief executive and chief nurse visited front line services on a daily basis. They felt free to raise any issues with them directly or through their line manager and nurses told us about monthly open forums led by the Chief Nurse where issues could be discussed.
- We spoke to a band 7 nurse who stated that annual appraisals had not been completed. When we checked none of the department staff had at this level. We saw other completed appraisals for band 6 staff.

Culture within the service

- We learned that after our last visit the trust had started a "great place to work" initiative. Actions in the program include an executive development programme, a "respecting each other" campaign and health and wellbeing group.
- The "Respecting each other" campaign included a confidential report line and managers and staff we spoke to viewed the project positively.
- The trust used workforce data to plan recruitment and monitor trends. Data from June 2016 indicated 11% vacancy rate, 10% turnover rate, sickness absence of 4% and mandatory training at 87%. This was similar to other NHS trusts. The staff survey action plan for the directorate was reducing sickness absence to 3.5%, improving the vacancy rate to 10% and mandatory training and appraisal rates to 95%.
- According to A&E staff, the culture in the hospital was now more inclusive and supportive. The last Family and Friends Test (June 2016) indicated that 80% of staff had

never experienced bullying or harassment and the majority of staff would feel confident in reporting such issues. 96% of staff were aware of the trust's anti-bullying initiatives.
- Staff at all levels reflected pride in their work and the achievements of the department so far. All felt the trust was ready to come out of special measures and expressed commitment to the direction of travel.

Public engagement

- The trust included 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 such as the Stakeholder Forum, League of Friends and Healthwatch.
- Feedback was also received from the Friends and Family Test, inpatient surveys, complaints and the "How Are We Doing?" initiative. We saw posters and leaflets in the department advertising these forums and inviting interested persons to participate.
- 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.
- We saw the "hello my name is …" initiative being used by staff during our inspection.

Staff engagement

- The trust conducted staff satisfaction surveys in line with national policy. The trust recorded the highest staff engagement score for five years and the results demonstrated an improvement in communication (up 12%), decision making (up 11%) and managers acting on feedback (up 13%).
- This was supported by staff comments made to us. Staff said they felt more engaged and "valued" and that "things had improved". We saw examples of posters and newsletters including 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.
- According to the last friends and family test (FFT) results, 57% of staff recommended the trust as a good place to work, which was up 8% on the previous year. 78% of staff recommended the trust as a good place to receive treatment, which was up 4% on the last FFT.
- Staff understood the trust whistleblowing policy and said they felt comfortable using it if necessary. We also saw information displayed on the 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.

Innovation, improvement and sustainability

- Since our last inspection, the triumvirate has focussed on delivery of local improvement plans in collaboration with the urgent care programme board and resilience or business continuity groups to develop and deliver safe emergency and urgent care pathways. The department has also worked closely with the National Emergency Care Improvement Project (ECIP), who reported "green shoots" in June 2016: a desire from front-line staff to make things better, improved Band 7 leadership and better capability for information provision.
- Other initiatives that contributed to the "green shoots" included the acute medical model development being trialled at QEQM, improved escalation including crowding and handover guidance, better planning of staff resources, improved departmental processes and agreed SOPs such as the emergency severity index triage mentioned earlier in this report.
- Refurbished and better facilities have come on stream and "real-time" review of patient flow and performance is being achieved by the control centres now established on the three main hospital sites.
- We saw examples of improved care processes, assessment and treatment of the deteriorating patient and improved dignity and privacy. We observed the use of tools like UPDATED; comfort rounds and re-focussing on pain scores and timely analgesia. We liked the improved visibility of clinical leaders 'on the floor' and acknowledge the improved staff levels that have been achieved. We were told that funding has been made available for 20 ED Consultants and the senior doctor and specialist rota increased from 10 to 14 posts. A new specialty Doctor training programme had been commenced which included secondments to other specialities. There was more use of ENPs in the department and the directorate has achieved an

increase in nursing establishments of 24.91wte RNs and 9.73wte Band 3 Technicians. Practice Development Nurse had been appointed in both A&Es and paediatric nursing cover was now 24/7 at the two A&E sites. Recruiting also included the provision of 24-hour departmental clerks.

Medical care (including older people's care)

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

Information about the service

The William Harvey Hospital is a location of East Kent University Hospitals NHS Foundation Trust. The hospital is an acute hospital with 166 beds providing a range of medical care services on 12 medical inpatient wards. These include acute medical units, general medical wards, care of older people, endoscopy services, stroke and cardiac services. The hospital provides primary percutaneous coronary angioplasty (urgent treatment for heart attacks) and thrombolysis (urgent treatment for strokes).

Between March 2015 and February 2016, there were 25,505 medical admissions. Of these the majority were emergency (58%) with 7% elective and 35% admitted as day cases. The majority of admissions were for general medicine, with cardiology, geriatric medicine and other specialities accounting for the remainder.

On our previous inspection, we found the medical services at the hospital required improvement because of we identified concerns with medical and nursing staffing, especially at night, the storage and management of medicines, the management of confidential records and shortfalls in infection control procedures.

We conducted this inspection to follow up on these issues and assess the progress of the trust against the action plans that were in place. In order to do this we reviewed information data supplied by the trust, visited the Ambulatory Care Unit, the Clinical Decision Unit, the Coronary Care Unit, Cambridge L, Cambridge J, Cambridge K, Cambridge M1, Cambridge M2, the Cardiac Catheter Laboratory, Celia Blakey Centre, Endoscopy, Oxford Ward, Renal Dialysis Unit and the Richard Steven's Unit.

We spoke with staff and observed staff delivering care. We spoke with over 32 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 held focus groups where staff could talk to inspectors and share their experiences of working at the hospital. We spoke with patients and their relatives. We reviewed 15 sets of patients' records, as well as other documentation. We also received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection.

Medical care (including older people's care)

Summary of findings

We found the medical services at the William Harvey Hospital required improvement because;

- There were insufficient numbers of junior grade doctors and consultants across medical services at the William Harvey Hospital. This meant that consultants and junior staff were under pressure to deliver a safe and effective service particularly out of hours and at night.
- We found there were nursing shortages across the medical services. The situation had improved due to the use of agency and bank staff. Although the trust had recruited overseas nurses, there remained staffing shortages on the wards. The trust did not use a recognised acuity tool to assess the number of staff needed on a day-to-day basis. This meant, even when there appeared to be sufficient numbers of staff on duty according the rota, the acuity and complexity of the patients meant that nursing staff were under pressure to deliver an acceptable level of care.
- Staff did not always complete care records in accordance with best practice guidance from the Royal Colleges. We found gaps and omissions in the sample of records we reviewed. The trust did not have a robust system in place to audit, monitor and review care records to ensure they always gave a complete picture of the assessments and interventions undertaken.
- The trust did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance.
- The trust had not completed its audit programme. This meant the hospital was not robustly monitoring the quality of service provision. The hospital performed poorly in a number of national audits such as the stroke and diabetes services.
- We found the hospital was not yet offering a full seven-day service. Constraints with capacity and staffing limited the responsiveness and effectiveness of the service the hospital was able to offer.
- Patients' access to prompt care and treatment was worse than the England average for a number of specialities. The trust had not met the 62-day cancer referral to treatment time since December 2014. Referral to treatment within 18 weeks was below the 90% standard as set out in the NHS Constitution and England average for six of the eight specialties from June 2015 to May 2016.
- The hospital had improved the number of bed moves patients had during their stay. However, a fifth of all medical patients moved wards more than once during their stay. This meant the hospital transferred some patients several times before they had a bed on the right ward, which put additional pressures on receiving wards.

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.
- The trust prioritised staff training, which meant staff had access to training in order to provide safe care and treatment for patients.
- 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.
- Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- Staff treated patients with kindness and compassion.

Medical care (including older people's care)

- The trusts average length of stay for both elective and non-elective stays were better than the England average for the majority of medical specialities.
- There was good provision of care for those living with dementia and learning difficulties. There were support mechanisms and information available to take individual patients needs into account.
- The trust had clear corporate vision and strategy. The trust reflected the opinions of clinicians, staff and stakeholders' when developing the strategy for medical services. Staff felt engaged with the direction of the trust and took pride in the progress they had made to date.
- The trust had clearly defined local and trust wide governance systems. There was well-established ward to board governance, with cross directorate working, developing standard practices and promoting effective leadership. The trust acknowledged they were on an improvement journey and involved all staff in moving the action plan forward.

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;

- The trust acknowledged there was a shortage of junior grade doctors and consultants across the medical services at the William Harvey Hospital. This meant that consultants and junior staff were under pressure to deliver a safe and effective service particularly out of hours and at night.
- The trust had attempted to address staff shortages through the recruitment of overseas nurses, there remained staffing shortages on the wards covered by agency and bank staff. 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. Staff did not always complete care records according to the 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 the assessments and interventions undertaken.
- The trust did not have adequate maintenance arrangements in place for all of the medical devices in clinical use. This was a risk to patient safety and did not meet MHRA (Medicines & Healthcare products Regulatory Agency) guidance.

However;

- The trust had a robust system for managing untoward incidents. The trust's reporting performance between May 2015 and April 2016 was better than the national average. Staff were encouraged to report incidents and there were processes in place to investigate and learn from an adverse event such as the one never event that occurred in the medical services.
- The hospital measured and monitored incidents and avoidable patient harm through the National Safety

Thermometer scheme. This is a national improvement tool for monitoring the patients harm. Staff used information gathered from the scheme to inform priorities and develop strategies for reducing harm.

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

Incidents

- The trust reports all patient safety incidents through the National Reporting and Learning System (NRLS). When an incident is assessed as a serious incident, or a never event it is reported through the Strategic Executive Information System (StEIS). NHS England describes a never event as "Serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers."
- The trust reported 13,137 incidents between May 2015 and April 2016. This was better (7 per 100 admissions) than the national average (8.6 per 100 admissions). The trust rated 98% of incidents reported to NRLS as low or no harm. This indicated a good reporting culture as staff reported any incident no matter the impact.
- Between July 2015 and June 2016, the trust reported 75 serious incidents of which 13 related to medical services. Four of these were slips, trips or falls, which met the serious incident criteria; three were delayed treatment. The remaining six had various causes where the trust could not identify any patterns.
- The trust reported seven never events between January 2015 and January 2016, of which one related to the medical departments. 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. 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 the amended policy for the management of responding to patient safety-related alerts and noted the additional lines of communication, escalation process and enhanced systems for agreeing and monitoring action plans received via the Central Alerting System (CAS).
- Weekly quality meetings took place on the ward where all available staff met and discussed learning from incidents, complaints and quality issues. Staff not on duty could access copies of the minutes of the meetings. Staff on the Richard Stevens Stroke Unit described how they now undertook daily VTE rounds. This was now embedded practice following an investigation into an incident.
- There was an incident reporting policy and procedure in place that was readily available to 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.
- 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.
- The majority of staff we spoke with had good awareness of the duty of candour and their responsibilities under it. The staff gave examples of supporting patients and relatives in accordance with the trust's duty of candour. However, the trust had identified through reviewing the incident reporting system that staff did not always consider the duty of candour when investigating moderate or severe incidences. The trust had provided additional training and support to improve the rate of reporting under the duty of candour.

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

Safety thermometer

- The hospital used the NHS Safety Thermometer. This is a national improvement tool for measuring, monitoring and analysing harm and the proportion of patients that experience 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism.
- The medical wards we inspected displayed their patient safety thermometer results on notice boards in the public areas of the wards. This meant that up to date patient safety information was readily available for patients, visitors and staff.

Reports of pressure damage had remained stable across the trust between June 2015 and June 2016, although a slight increase was recorded trust wide in November 2015. The trust reported 44 pressure damage incidents over the past 12 months. Pressure damage is localised, acute ischaemic damage to any part of the body caused by the application of external force (either shear, compression, or a combination of the two).

- The trust reported 45 falls between June 2015 and June 2016. The rate remained stable with slight increases noted in July and November 2015. Staff confirmed they were supported by the specialist falls prevention nurse who reviewed the falls risk assessments and any falls on the ward.
- There were 15 CUTI's 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. Staff displayed results in an easy to access format. They discussed the results at governance meetings and shared across the trust. This demonstrated that there were systems in place to monitor the incidents of patient harm across the trust. There were methods in place to feedback the findings to staff on a regular basis to inform practice and encourage improvement.
- Staff on Cambridge L Ward were trialling a new hand over system to improve patient safety communication and reduce falls and pressure sore. The ward sister told us it was too soon to see if it had made a difference, but staff were always looking to improve care and the patients' experience.

Cleanliness, infection control and hygiene

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

- The safety thermometer Public Health observatory data for June 2015 to May 2016 reported low numbers (three) of MRSA for the trust compared to the number of MSSA cases (28). There were 29 cases of C. Diff. The number of cases per 10,000 bed days was generally below the England average during this period with no trends identified.
- Infection prevention and control was included in the trust's mandatory training programme. Staff we spoke with all confirmed they had completed this training.
- 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 William Harvey Hospital demonstrated an improvement from the 2015 results. The PLACE team rated cleanliness at William Harvey Hospital at 99.65%, which was better than the national average of 98%. The Patient Experience Committee chaired by the chief nurse and Governors developed an annual action plan based on feedback from the report.
- The majority of areas we inspected where patients had access were visibly clean and tidy to the standard expected in the high-risk category of the National Specifications for Cleanliness in the NHS. However, we noted that areas of Cambridge J Ward smelt musty and offensive.
- We noted there was a lot of moving and handling equipment stored in a doctor's clinical room in the Clinical Decision Unit (CDU). The room used to be a patients bedroom and had a WC and hand basin in. This room would be at risk of legionnaire's disease as it would not be possible to run the taps on a regular basis because of the storage of physiotherapy aids.
- The CDU also had patient showers that were not fit for purpose. The showers required refurbishment, they were leaking and encrusted with lime scale. This meant that it was difficult for patients who wished to have a shower to keep clean.
- On the majority of wards, the linen cupboards were clean and tidy with bed linen managed in accordance with best practices. The sluices were clean, tidy and well-ordered with little clutter. This made it easier for the staff to keep the area clean. Patients told us that cleaners attended the ward twice a day and kept the ward clean and staff changed the bed linen daily.
- We spoke with domestic staff and reviewed their cleaning rotas. The staff completed daily checklists for each ward or area, which their manager then collected for monitoring. English was not the first language of a number of cleaners. In order to reduce the risk of misunderstanding, domestic staff had cleaning instructions translated into their first language. This demonstrated there were systems in place to maintain and monitor the cleanliness of the hospital.
- On all the wards and units we visited, we noted the moving and handling equipment was visibly clean and had "I am clean" labels in place.
- We saw that clinical and domestic waste bins were available and clearly marked for appropriate disposal. Staff managed and disposed of sharps safely.
- We saw that personal protective equipment (PPE) such as disposable gloves and aprons were readily available for staff to use. There were hand-washing sinks with sanitising hand gel available. The majority of staff followed infection control principles as demonstrated in the hospital's hand washing audits. At inspection, we observed staff washing their hands and using hand gel appropriately.
- Staff adhered to the hospital's 'Bare below the elbows' policy. We observed staff wearing PPE and saw they washed their hands in between patient contact. Patients confirmed that staff were always washing their hands or using hand gel.

Environment and equipment

- The 2016 PLACE rated the hospital at 97.8% for the facilities, which was higher than the England average of 90%. This score related to the condition, appearance and maintenance of the hospital including patient environments, décor, tidiness, signage, lighting, linen, access to car parking, waste management and the external appearance of buildings and grounds. The Patient Experience Committee chaired by the chief nurse and Governors developed an annual action plan

based on feedback from the report. In addition, the Patient Experience and Investment Committee included the report findings and feedback into the annual refurbishment and improvement capital plans

- In the cardiac care unit, each bed had piped oxygen and suction with central monitoring at the nurses station. Staff could also relay the electronic observations to the central monitor. This meant that staff could constantly monitor patients' conditions from the central nursing station.
- Space on Cambridge M2 Ward was limited. Patient bays were cramped; staff were required to store equipment in corridors. Each bed station had only two plug sockets, which was not enough for the electrical equipment used in the care of patients. Oxygen and suction were only available to two out of the six beds in each bay.
- Although on the Richard Stevens Unit, moving and handling equipment cluttered the ward. the unit provided a therapeutic environment for the management of stroke patients. There was a therapy gym, dayroom space and a reflection room.
- We found that corporate Control of substances hazardous to health (COSHH) risk assessments were available for 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 reported there were no problems in obtaining stock or equipment. There was an equipment library on site and aids such as air mattresses, pressure relieving boots and air cushions were always readily available.
- We found there was adequate resuscitation equipment on each ward and unit. We saw the documentary checks on each ward confirmed that staff checked the resuscitation equipment daily. However, we found on Cambridge M2 the daily checks were not always documented in the log book.

Medicines

- The hospital had medicines management policies together with protocols for high-risk procedures involving medicines such as the intravenous administration of antibiotics. These were readily available for staff to access. Staff had access to relevant resources on medicines management such an electronic copy of the British National Formulary.
- We found that the wards and units we visited handled medicines appropriately according to hospital policies and best practice guidance. This included patients own drugs, medicines requiring refrigeration and controlled drugs.
- The majority of patients had their medication stored in locked drug cupboards beside their beds. This reduced risk of drug errors rather than staff administering medication remotely. Staff locked medication trolleys when not in use and secured them against the wall.
- We reviewed the untoward incidents recorded over the past year and noted that staff in general reported medicine related incidents. Staff we spoke with understood how to recognise and report medicines related incidents.
- Each ward had an allocated pharmacist, however, the support available varied. The pharmacists' role included undertaking regular audits and checking drug charts. On Cambridge M2 Ward, staff told us that poor recruitment, retention together with funding issues had led to an "Erratic" pharmacy service. Staff there told us "A technician visits two or three times a week for 20 minutes. There's a stock check on Fridays".
- We undertook random medicine checks on the wards and units and found that in general medicine management met current best practice guidance. For example, on the cardiac care unit, staff ensured medicine cupboards were locked and regularly checked controlled drugs.
- We found that none of the medical wards routinely measured the ambient temperature of rooms where the medications were stored. The majority of medicines

have a maximum and minimum temperature, which they should be stored at otherwise; they may deteriorate more quickly or become ineffective. The treatment room in the Clinical Decision Unit was particularly hot. There was no room thermometer present.

Records

- The standard of record keeping was poor and did not always meet the best practice guidelines from the Royal Colleges. Staff had not always completed the nursing records appropriately. We found that although staff had dated, timed and signed the entries, they had not added their designation. The paper-based records were not always in chronological order, which meant it was not always easy to find the most current entry. Staff had photocopied some forms so many times it was difficult to make out the original content and layout.
- On Cambridge L Ward, we found patients living with dementia had not always had the "This is me" information-sharing document completed. Staff had not always documented conversations with relatives about the patients' medical condition or discussions about ceilings of care or resuscitation expectations.
- The majority of records we reviewed had risk assessments such as falls, skin bundles and moving and handling in place but staff had not completed the majority of them appropriately. For example, on Cambridge J Ward, a patient with a pressure ulcer did not have a wound chart and staff had not completed their skin assessment on admission. Several patients had not had their fluid charts completed or other risk assessments updated. On Cambridge L Ward a patients with an identified need for daily pressure ulcer assessments had not had them completed for 13 days.
- Medical notes were legible and well completed in accordance with the General Medical Council guidance 'Keeping Records'. However, we found gaps in most of the records we examined. For example there were instances 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.
- We noted that staff had recorded allergies on medication records, but not always the patient's weight. This had implications for the amount of medication staff would administer.
- We noted that the therapy notes were included in the doctor's medical notes. The therapy documentation provided a clear assessment, plan of care and regularly updates.
- 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 patients care and treatment.
- Managers told us that regular nursing records audits took place. However, on further investigation we found staff checked only a small sample of records four times a year.
- At the last inspection, we found records were not always stored securely. At this inspection, we noted an improvement in records management as staff kept record at the nurses' station. However, they remained unsecure.
- We heard how there was easy access to 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. Information on how to report safeguarding was available on the wards. The trust's safeguarding policy was consistent with the local authority multiagency policy.
- 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 in April 2016, the trust had introduced a half-day safeguarding course. This included the Mental Capacity Act, Deprivation of Liberty Safeguards, domestic abuse and Prevent (anti- radicalisation) training.

- The trust informed us that 54% of 2,309 identified staff had completed the required level two training, which meant they were below the national safeguarding training requirement of 85%. There was an action plan in place to improve this, with a completion date of November 2016 to reach 85%. The Quality and Improvement Hubs had delivered MCA and DoLS training and awareness. The trust was assessing staff understanding and awareness using an "Ask 5 questions" audit.
- All staff we spoke with confirmed they had received level one safeguarding training as part of annual mandatory training. However not all staff who had close contact with patients, those with line management or direct safeguarding responsibilities had undertaken further training as recommended in the Kent Safeguarding Adults Policy and Procedure Manual.
- Staff 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.
- Staff provided examples of when they were required to raise a safeguarding alert and confirmed the safeguarding team were on site for advice and support.

Mandatory training

- The trust had a mandatory training programme in place, which covered health and safety, manual handling, infection control, falls preventions, safeguarding children and young people.
- The majority of mandatory training was undertaken electronically and staff maintained individual electronic staff records. Managers and staff were able to access the staff records to monitor compliance. Staff told us there were issues with ensuring the electronic record was current and up to date but it generally was a better system.
- On Cambridge L Ward, ward manager assistants booked staff onto training courses and ensured training records and appraisals were up to date. Staff we spoke with valued their help and contribution.
- Staff were only able to complete mandatory training when there was enough cover on the wards. On the cardiac care ward, a mandatory training completion chart was available for all staff to view in the ward manager's office. The chart demonstrated that 70% of staff had completed their mandatory training, this was below the trust's target of 85%.
- On Cambridge M2 Ward, staff were not fully compliant with mandatory training. The ward sister told us their main priority was to ensure there were enough staff on duty to ensure the ward was safe rather than completion of training.
- 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 mandatory training updates as their training records were not held by the ward. All the staff we spoke with told us that accessing the annual mandatory training was not a problem although it was difficult to find the time.
- The integrated performance report stated that 87% of staff had completed their mandatory training by May 2016, which was slightly better than the trust target of 85%.

Assessing and responding to patient risk

- Staff recorded patient observations electronically. The results informed the deteriorating patient assessment. The hospital used the national early warning scoring system (EWS) to identify patients whose condition was deteriorating. We reviewed a sample of EWS observation charts and saw that staff routinely used the charts and escalated patients appropriately.
- The trust supported staff to identify deteriorating patients through the deteriorating patient programme. This group was overseen by the critical care steering group and monitored critical care outreach referrals, cardiac arrest data, electronic data recording and the mortality of ward patients admitted to intensive care beds. The group analysed the information 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.

Medical care (including older people's care)

- Doctors supported staff on the wards when a patient's deterioration was sudden and resulted in an emergency. Although the response at night was slower because the doctors were so busy. Staff told us they felt well supported by the clinical outreach teams.
- On the cardiac care and respiratory wards, staff explained that although routine EWS scores were undertaken there was no specific score for escalation. This was because many of the patients with cardiac or respiratory disease had a high score even when stable. They told us they were always "Vigilant". The senior nurse carried a ward electronic tablet where the patients' observations were summarised. The information was used to inform ward rounds and multidisciplinary.
- There were individual risk assessments in all of the patient records we reviewed. These included assessing the risks of falling, pressure damage, nutrition and continence. However, not all were fully completed or updated appropriately.
- Venous Thromboembolism (VTE) was recorded as one of the trust's top five risks. Every patient should have a documented VTE risk assessment as part of nationally quality requirements. The latest data from July 2016 indicated that 85% of patients had a completed VTE risk assessment. This was worse than the national standard of 95%. The trust monitored individual consultant and divisional compliance monthly. The trust had an action plan in place to improve compliance. This included weekly consultant reports, including VTE compliance in consultants' appraisals, ensuring all patients leaving theatre or the clinical decision unit had been risk assessed and developing electronic support to remind practitioners and prompt appropriate actions to prevent VTE.

Nursing staffing

- Nurse staffing was a concern raised at the two previous inspections in 2014 and 2015. Staffing concerns across the medical services was included on the divisional risk register. There were actions in place to reduce the risk however staffing remained a concern. The managers we spoke with told us they regularly conducted interviews for new staff. One manager told us they had seven interviews the following week with two staff appointed awaiting a start date.
- On the cardiac care ward, there were two staff vacancies. The ward had already filled one post and the other one had two interested applicants. Staff told us there had been 18 applicants for a recent healthcare assistant vacancy. They reported no problems with filling posts.
- On Cambridge M2 Ward, there were three qualified staff on long-term sick and two on maternity leave. One qualified nurse and a healthcare assistant had been seconded to Cambridge M1 Ward. This meant there were substantial staff vacancies on the ward. Although agency and bank staff were covering these vacancies, we were told, "The level of nursing [staff] across the hospital is a concern, with so many agency staff and many permanent staff not working in their own speciality area." Permanent staff regularly swapped wards, as a shift could not be staffed solely by agency workers.
- Staff on Cambridge J Ward, told us they were always short staffed. At the time of the inspection, they had three qualified nurse and two healthcare assistant vacancies. Although management were able to book agency staff. Staff told us agency workers often cancelled or shifts could not be covered. Staff were often pulled from other wards to help cover. Junior staff were counted as a Band five on the rota, but until they had completed their competencies were not functioning at that level. This put an additional burden on the other staff. They told us that although the ward manager was supernumerary there was not enough time for management duties as they were usually included in the numbers.
- Staff told us that the staffing issues meant that they were no always able to give appropriate care for patients. On Cambridge J Ward, staff told us they usually could not give one to one care for patients who required positive pressure airway support. Staff told us that sometimes dressings were left and there was never enough time to chat with patients. One nurse told us "Patients miss having someone to talk to." Although patients told us the staff usually answered the call bells promptly, we observed bells going unanswered for several minutes.

Medical care (including older people's care)

- On Cambridge L Ward, the two nurses who were on the rota as supernumerary had to work on the ward because of staff shortages. Staff told us this was not unusual.
- Managers discussed staffing shortfalls at the daily operational meetings. Management relocated staff working on wards with extra capacity to support other clinical areas. Staff regularly reported staffing shortfalls on the electronic incident reporting system.
- However staff reported the acuity of patients was increasing. This was verified by emerging data from the dementia dashboard, which 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. The William Harvey Hospital also experienced a 76% increase in admissions year-on-year, which meant that last year approximately 1000 extra patients were admitted.
- Staff we spoke with told us that staffing levels remained their main challenge and although levels had improved, the increasing acuity of the patients meant that it always felt short staffed. Staff told us that caring for patients who required constant supervision or were at risk of deteriorating meant they always felt under pressure.
- The 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, to addressed staffing shortfall . However, we found that although there was an increased staff headcount at this inspection, there remained a large number of vacancies covered by agency and bank staff.
- Staff reported that there was no problem in requesting agency or bank nurses when needed however they were not always available. Staff told us it was difficult to find cover for day shifts as agency nurses preferred working at night.
- The trust supported the overseas nurses until they had adjusted to nursing in England. This included a period of supernumerary nursing, a mentorship programme and competency support. We spoke with overseas nurses who were full of praise for the support they had in learning basic English and adapting to the British nursing model of care.
- On medical wards staffing numbers have been increased and the trust monitors safe staffing levels. However, there was a lack clarity amongst staff about theacuity based tool (to assess appropriate staffing for the complexity of patients cared for) andleaves staff convinced that there is still insufficient staff on duty for many shifts.
- The most recent review in July 2016 reflected that there had been a substantial financial investment in staffing due to the escalation wards. The review reported a 78% uptake in newly qualified staff joining the trust and the positive impact of appointing the overseas nurses.
- The trust reported actual staffing versus planned staffing on a monthly basis. The trust reported a 95% vacancy fill rate and concluded that ward-staffing levels were satisfactory overall.
- The ward used a three shift pattern, which meant there were periods of overlap which was used by staff for completing nursing records, administrative tasks and training.
- There was administrative staff available to support the ward managers. The managers we spoke with valued this resource. They told us it helped a lot and enabled them to concentrate on their leadership and management roles.

Medical staffing

- The trust had a lower percentage of consultants and junior grade medical staff (4% lower) and a higher percentage of registrars than the England average. For example, the medical staffing percentage for registrars was 48%, higher than the national average of 36%. Junior doctors made up 16% of medical staff compared to an England average of 21%. This meant the trust's medical workforce was more reliant on registrars and middle grade doctors than the national average.
- There were two junior medical teams on duty, a 'Hot' team and a 'Cold' team. The Hot team consisted of a registrar, two senior house officers and a junior doctor. This team covered the emergency take, the clinical

decision unit and the cardiac care unit. The Cold team consisted of two registrars and two junior doctors who covered the medical wards. At weekends, the Cold Team provided the medical cover.

- Medical staff told us the registrar rota was onerous with frequent nights on duty. They told us that the appointment of acute consultant physicians had made a big difference. Staff told us there was no respiratory consultant cover at the weekends.
- The Health Care of Older People (HCOOP) consultants cared for the elderly patients over 75 years of age. The HCOOP consultants visited their patients every day. Staff allocated HCOOP patients to one of the specialist care of the elderly wards, another medical speciality or an outlier ward in the hospital.
- Staff told us there were no problems with the consultant cover of the cardiac care unit. However, there were only three of the five cardiology registrars in post. The registrars covered the wards, the catheter laboratory, ward echocardiograms, outpatient clinics and referrals. At night and at weekends, cardiology consultants were on call for emergency interventions only. The one cardiology registrar on duty at weekends undertook daily ward rounds on the cardiac care unit and Cambridge K Ward. Nursing staff told us they relied heavily on the duty medical registrar, but would call the cardiology consultant if needed.
- There was a designated cardiology consultant each week, who carried out a full ward round every weekday starting at 8am. Staff told us the management of heart failure differed between the four consultants, which was confusing for staff. In order to address this, staff used a single protocol for patients undergoing procedures in the cardiac catheter laboratory. Staff told us there should be three cardiology registrars to cover the ward, the caterer laboratory and the clinics. However, one was on annual leave, one had left and one was an unsuitable locum who left after three days. There were two junior doctors. We spoke with one of the junior doctors who told us they felt well supported by the consultants and nursing staff.
- There were four gastroenterology consultants. Staff told us the endocrine consultants had "either all left or retired." Locum consultants covered for this specialty. Staff on Cambridge M2 told us that although the aim was to hold daily board rounds, the timing of the consultant visits varied. Two of the consultants attended their patients daily whilst the others visited two or three times a week.
- There was a full complement of junior medical staff on the ward, although they were not always available because of commitments elsewhere such as working for the "Hot" on call medical team. Staff told us the "Cold" medical team was not adequately staffed to cover the medical wards out of hours. This meant that routine medical tasks such as discharge and diagnostics may not be undertaken quickly out of hours.
- Lack of medical cover was included on the divisional risk register. We noted that the medical staffing risks on the division risk register provided for inspection dated back to 2013. There were actions in place to reduce the risk however medical staffing remained a concern.
- Staff recorded lack of medical cover as incidents on the trust's electronic reporting system. For example, in July 2015 lack of medical cover at night was raised as an incident by the consultant because the lack of medical cover caused a significant amount of stress for the staff and potentially compromised effective patients care.
- Staff told us that the trust was aware of the gaps on the medical consultant staffing rota and told us "reorganisation is being considered."
- The trust informed us that the level of consultant cover in other medical specialties were adequate for the needs of the trust.

Major incident awareness and training

- The trust had business continuity plans in place, which included major incidents, emergency preparedness, cold and hot weather plans, pandemic influenza plans and the patient flow and escalation policy.
- The trust made staff aware of these through both electronic and paper means. The current policy was available on the trust's intranet with hard copies on the wards.
- The high risk of a major incident was included on the divisional risk register. The main risks included the number of high-risk locations such as the Channel Tunnel, docks, nuclear power station, airports and motorway network. The trust had reviewed the major

incident plan and identified a number of actions to ensure the safe management of any incident. This included the management of support services such as switchboards and reception.

- The William Harvey Hospital would be a primary trauma centre in the event of a major incident. This meant that any local major incident would have a direct impact on the day-to-day activities of the hospital. The medical wards and services would usually be involved in a major incident through admitting patients from other areas and specialities to free up trauma beds in other areas.
- We found the hospital consistently worked at capacity and bed availability was a constant problem and pressure across the medical services. This may have an adverse impact on the trust's ability to respond in a timely fashion to any major incident.

Are medical care services effective?

Good

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

- We found medical care was evidence based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. Staff routinely measured care delivered to ensure quality and adherence to national guidance and to improve quality and patient outcomes.
- 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 that staff training was good with ongoing training and development opportunities available.
- There were suitable arrangements in place to ensure that further training and development was available for staff to enable them to improve their skills and develop their competencies. The majority of staff we spoke with told us they felt well supported and encouraged to develop.
- Throughout medical services, we found effective multidisciplinary working. Medical and nursing staff as well as support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- The hospital scored better than the England average for both elective re-admissions and non-elective readmissions across the majority of medical services.
- The hospital performed well in the sentinel stroke national audit programme (SSNAP). The hospital had improved its performance over the past year.

However;

- The 2015 Lung Cancer Audit report indicated only 25% of these patients were seen by a specialist nurse against the national average of 80%. Although the other results were only slightly lower than the England average, the lack of specialist nurse support was a concern.
- In the 2013/14 Heart failure audit, the hospital performed worse than the England average for the majority of in hospital care measures and performed similarly to the England average for discharge care measures. The percentage of patients referred for cardiology follow up was 11%, which was significantly worse than the England average (54%).
- Due to staffing vacancies, the trusts audit programme was stretched. Therefore, staff did not have the capacity to complete local audits or implement action plans.
- We found the hospital was not offering a full seven-day service. The trust had not addressed constraints with capacity and staffing. Consultants and support services such as therapies operated an on-call system over the weekend and out of hours. This limited the responsiveness and effectiveness of the service the hospital was able to offer.

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

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 current trust guidelines. We noted there were appropriate links in place to access national guidelines if needed.
- Staff used standardised care pathways that 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, staff vacancies in the Audit Department meant 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. The trust had revised the local audit schedule in order that staff could concentrate on successfully completing a smaller number of audits.
- The clinical audit summary report for 2015/16 identified that the medical specialties had been over ambitious with the number of audits undertaken during 2015/16. The report identified that staff were not always submitting action plans in a timely manner and had not always implemented the identified actions. There had been no audit lead in the neurology specialty for the past six months. Staff planned 14 audits for the 2016/17 audit cycle.
- Minutes from various departmental and divisional meetings showed staff discussed audit results and put plans in place to address issues. For example, the minutes from the heart failure meeting in January 2016 documented that staff discussed the recent heart failure audit results
- 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 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, the trust implemented a multidisciplinary board level falls steering group to follow up the results of the National Falls Audit. Staff reported all falls that resulted in moderate or severe harm or death to the board through quality and risk committees, who then undertook a critical incident review.

Pain relief

- The trust had a pain management policy in place that was available to staff on the trust's intranet.
- The care assessment charts included space for recording patients' perception of pain. Staff used 'intentional rounding' (where staff attended patients at set intervals to check if they were comfortable) as a reminder to assess pain. In the June 2016 Executive Performance report the trust raised the compatibility of the electronic devices when assessing pain.
- The trust had a specialist pain team available to support staff and staff knew how to contact them.
- The trust had a person centred pain tool in place for patients with communication difficulties. Staff used this tool when undertaking pain assessments for patients living with dementia, confusion, learning disabilities or stroke.
- The patients we spoke with told us there was no problem with obtaining pain relief.

Nutrition and hydration

- The trust used a nationally recognised tool to assess patients' nutrition and hydration. We reviewed a sample of risk assessments on each of the wards we visited which included nutritional assessments.
- We found that in general, the nutritional risk assessments were in place but staff had not always kept them updated. However, staff did not always weigh patients, which affected the risk assessment score. Inaccurate nutrition scores could affect patients care and treatment.
- Additional support from the dietician service was available when needed. Dieticians monitored patients who received nutrition through a nasogastric or parenteral feeding tube. Nasogastric and parenteral

feeding are processes by which a patient receives nutrients without the food passing through their mouth. They reviewed the patients' individual needs and wrote a plan of care. Dieticians reviewed the plan after three days and then weekly. The dietician service was not available out of hours or at weekends.

Patient outcomes

- Management monitored Mortality and morbidity trends on a monthly basis through SHIMI (Summary Hospital-level Mortality Indicator). The SHMI score of 84.36 in March 2016 indicated that the trust had reduced the number of deaths from August 2015 when a rate of 91.14 was recorded. Over the past year, there had been a month-by-month improvement in the SHMI score. Reviews of mortality and morbidity took place at local, speciality and directorate level within a quality dashboard framework to highlight concerns and actions to resolve issues. We reviewed the minutes of the mortality and morbidity meetings and reviewed the presentations into the investigations to share learning.
- The hospital episode statistics (HES) covering the period February 2015 to January 2016 showed the overall standardised relative risk of readmission at William Harvey Hospital was generally the same as the England average.
- 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 Hospital Episode Statistics (HES) Standardised Relative Risk of Readmission (01/02/2015 - 31/01/2016), indicated that the hospital scored better than the England average for elective re-admissions and slightly worse for non- elective readmissions across the majority of medical services. The outliers were cardiology and stroke medicine, which scored worse than the England average for elective readmissions and geriatric medicine for non-elective readmissions. Elective general medicine readmissions scored much better than the England average.
- The hospital had a mixed performance in the sentinel stroke national audit programme (SSNAP) with the SSNAP level fluctuating between level D to level B between April 2015 and March 2016. A is the highest and E the lowest level of attainment. The current SSNAP level for January to March 2016 had improved from level D to level B with five of the patient centred domains and four of the team centred domains improving. The thrombolysis score had deteriorated from C to D in both the team and patient centred audit results.
- 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 that in the William Harvey Hospital there was poor provision of speech and language therapists, which had affected the score.
- In the 2013/14 heart failure audit, the hospital performed worse than the England average for the majority of in hospital care and discharge care measures. The hospital scored higher than the England average for input from specialists whilst in hospital and referral to a heart failure liaison service on discharge. All other measures were worse 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) 2013/2014 scores at the hospital for the care of patients with nSTEMI were lower for two of the three measures compared the England average. The number of nSTEMI patients seen by a cardiologist or a member of the team and those patients referred for angiography after discharge were worse than the England average and worse than the 2012/2013 audit. The number of nSTEMI patients admitted to a cardiac ward was higher than the England average.
- Scores in the National Diabetes Inpatient Audit 2015 were better than the England average for nine of the 17 measures audited and worse for eight measures since the 2013 audit. The results indicated a slight improvement in the diabetic services undertaken at the hospital. Areas for improvement included the care of patients admitted with foot disease and the catering service.
- The 2015 Lung Cancer Audit showed the trust was below the level suggested for three of the four indicators for process, imaging and nursing measures. Staff reviewed 89% of these patients at a multidisciplinary team

meeting, which is worse than the national average of 94%. Sixty-two percent had a pathological diagnosis, which was worse than 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%. A specialist nurse saw 25% of patients in comparison to the national average of 80%. Although the results were only slightly worse than the England average, the lack of specialist nurse support was a concern. The hospital could not ensure patients got the information and support needed to manage their condition.

- The endoscopy suite was currently not Joint Advisory Group (JAG) accredited. JAG accreditation demonstrates that the endoscopy service has met nationally recognised endoscopy standards. The endoscopy manager told us that there were plans in place for to achieve JAG accreditation by the end of the year. Staff explained the loss of JAG accreditation was due to waiting times. The lack of endoscopy capacity was included on the divisional risk register. The trust had plans in place to address this through the appointment of additional gastroenterologists and nurse endoscopists. These were due to start in October 2016.

Competent staff

- The trust had in place recruitment and employment policies and procedures together with job descriptions. 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). Nurses and midwives must be registered with the NMC to legally practice in the UK.
- All new employees undertook both corporate and local induction with additional support and training when required. Staff we spoke with confirmed they had received an adequate induction.
- The trust recorded all training undertaken on a central electronic training record. Management used clinical supervision and the appraisal process to monitor staff competencies and ensure staff had appropriate skills and training. Management identified learning and development needs during the appraisal process.
- Staff throughout medical services told us of the additional training and development they undertook to improve their skills and develop their competencies. Staff reported that until junior or new staff had completed their competencies they did not undertake the tasks. On Cambridge L Ward staff gave an example of two of the qualified nurses who did not have medication administration competencies, who did not undertake medicine administration. Although this was good practice it did put an additional burden on the other staff.
- A wide range of specialist nurses supported nurses on the ward, for example, the dementia care team, palliative care team, safeguarding leads, diabetes care team and discharge co-ordinators. The link nurses attended regular link meetings and a study day to ensure they kept their practice current.
- The medical staff praised the nurses especially the specialist nurses and nurse consultants. They told us they were "Brilliant" and a valuable asset to the team.
- Consultants participated with appraisals and there were systems in place to support their revalidation with the General Medical Council (GMC) registration.

Multidisciplinary working

- Throughout medical services, we found effective multidisciplinary working. This included effective working relations with speciality doctors, nurses, therapists, specialist nurses, community services and GPs. Medical and nursing staff, and support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- We observed positive and proactive engagement between all members of the multidisciplinary team (MDT). Each ward held a daily MDT board round. We found that the ward rounds were well organised and well attended by all members of the multidisciplinary team.

- Medical, nursing and therapy staff of all grades all described the good working relationships between staff and directorates.
- Doctors, nurses and other healthcare professionals shared integrated patient records between teams. 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. The hospital had a service level agreement with the local community mental health trust that provided a Kent wide service.

Seven-day services

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

Access to information

- The hospital used mainly paper-based records. This meant there were sometimes delays when sharing information between hospitals and with other providers who used electronic records and means of communication.
- Ward staff told us there was prompt access to the results from medical tests. Clinical staff who told us they had access to diagnostic results such as blood results and imaging to support them to care safely for patients. Staff retrieved patients' old notes from the hospital archives when required immediately.
- There were safe systems in place to transfer information when a patient moved between wards or hospitals.
- Site managers and senior staff routinely collected site data to inform the management of the hospital and the trust as a whole.
- All the staff we spoke with told us there was good communication and access to information between staff and between medical specialities. We observed staff handovers at the nurses' station and noted that staff shared all relevant information quickly and effectively. This gave patients continuity of care and ensured important medical information was shared between staff safely and efficiently.
- Staff held ward and departmental meetings on a regular basis. The minutes from these meetings confirmed that information was shared including clinical updates and lessons learnt from incidents and complaints.
- We saw that staff used whiteboards to give all healthcare professionals quick and easy access to relevant information.
- 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 staff obtained consent prior to any invasive procedures such as endoscopy investigations and patients undergoing cardiology procedures. The sample of consent forms we reviewed were all completed completely and in full. However, there were no written forms on the cardiac care unit to check patients' identity. Although each patient had wrist and ankle identification bracelets on admission, staff sometimes removed these during clinical interventions.
- Across the medical division, we saw that staff had a good awareness of the legislation and best practices regarding consent, the mental capacity act and DoLS. Staff we spoke with on the cardiac catheter ward told us DoLS were rare on the unit but they were clear about their responsibilities in relation to gaining consent from people, including patients who lacked capacity to consent to their care and treatment.
- MCA and DoLS checklists were available to staff on the intranet together with a 'delirium pathway' checklist. The checklists promoted staff to discuss with the patients' families and indicated when best interest meetings should take place.
- On some of the wards such as Cambridge M2, staff said that DoLS and safeguarding reporting happened very infrequently. The hospital safeguarding team and the ward information folders were valuable resources in ensuring staff followed the appropriate procedures when they did occur.
- The patients we spoke with confirmed that staff always asked for consent when undertaking even the simplest of tasks or treatments.

Are medical care services caring?

Good

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

- During the inspection, we observed staff generally treating patients with compassion and saw evidence that staff anticipated patients' needs.
- Staff treated patients with dignity and respect and showed caring and compassion when meeting patients' needs. 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 William Harvey Hospital over the past few months. This positive 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.

However;

- We noted occaisions where staff did not always protect patients' pricacy, dignity or wellbeing.

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 hospital (35%) was better than the England average (26%) for the most recent data to May 2016.

- We saw Friends and Family information was displayed on notice boards around the wards and departments. Each ward and department collected the feedback monthly and then displayed the information for staff, patients and visitors to view. Comments were overwhelmingly positive across all the medical wards. Patients and their relatives praised staff for their kindness and consideration in looking after them or their relative.
- A score above 50 is considered a positive indication that patients would recommend the hospital to family and friends. We saw across medical services that feedback was consistently positive, with between 80% 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 in May 2016 were the Cardiac Catheter Suite and the Richard Stevens Unit, which both scored 100%. The lowest scoring were the Clinical Decision Unit (83%) and Cambridge L Ward (80%). We noted the average response rate varied between 19% in the Clinical Decision Unit to 76% on Cambridge K Ward.
- Staff usually treated patients in a sensitive and considerate manner. We observed this during our inspection and patients confirmed that were always thoughtful in maintaining their dignity especially when they were being washed or undergoing a procedure. The patients we spoke with told us the nurses were all kind and helpful.
- However, staff did not always maintain patients' dignity when they were unable to care for themselves. For example, on Cambridge J Ward, we saw two confused patients with exposed limbs not covered appropriately.

Understanding and involvement of patients and those close to them

- We spoke with patients receiving medical care on most of the wards and units we inspected. Staff provided patients with up-to-date information and took time to explain care and treatment plans. Staff provided patients with adequate information about their treatment and explained risks, benefits and alternatives.
- During the inspection, we observed staff members introducing themselves to patients and relatives and explaining any treatment they would be receiving.
- The Francis report was a report on the inquiry into the failings at Mid-Staffordshire NHS Foundation Trust. The report contained many recommendations for both public bodies and the NHS on keeping patients safe and improving patient care. The Francis report in 2014, recommended that every hospital patient should have the name of the consultant and nurse responsible for their care above their bed. The report recommended this to ensure that patients had a clinician with overall responsibility for their care and a nurse who was directly available to provide information about their care.
- The patients we spoke with knew who their nurse was. On The Richard Stevens Stroke Unit, patients told us their nurse was displayed on a sign above the sink. They told us staff were always visible and the care on the ward had been "Fabulous."
- Each ward displayed staff photographs at the entrance to bays so patients could see who would be treating them. Patients we spoke with could name their consultant and the nurses and healthcare assistants who were caring for them in accordance with the NICE QS15 statement three: which states "Patients are introduced to all healthcare professionals involved in their care." This demonstrated the hospital complied with the recommendations in the Francis Report.
- On Cambridge L Ward, relatives were encouraged to help in the care of their relative if they wished. Staff gave examples of them helping with feeding at mealtimes.

Emotional support

- Clinical staff provided emotional support in the first instance. The hospital had arrangements in place to provide emotional support to patients and their families when needed, which included support from clinical nurse specialists, such as the end of life team, diabetes nurses, and dementia specialist nurses.
- Patients also had access to physiotherapists and occupational therapists that provided practical support and encouragement for patients with both acute and long-term conditions. Patients spoke highly of the therapy staff and told us of the help and support they received from them.

Medical care (including older people's care)

- 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 received on the ward.
- On the Richard Stevens Stroke Unit, patients praised staff telling us they were encouraged to ring the bell if they were worried about anything. They told us staff were very good and attentive. One patient told us staff had offered counselling following their diagnosis. They singled out one healthcare assistant for special mention. They told us this member of staff was kind and gentle and made everyone's life happier.
- 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?

Requires improvement

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

- Although the hospital had improved the number of bed moves patients experienced during their stay, a fifth of all medical patients moved wards more than once during their stay. This meant the hospital transferred some patients several times before they had a bed on the right ward and this put additional pressures on the receiving wards.
- Patient access to prompt care and treatment was worse than the England average for a number of specialities. 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.

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 the trust had identified delays to the patient pathway, actions were taken to address the issues; such as rapid access clinics, rapid discharge team, the integrated discharge team and outsourcing diagnostic investigations.
- The average length of stay for all admissions was better than the England average.
- Elective stays in general medicine, cardiology and geriatric medicine were better than the England average.
- Non-elective stays in general medicine, geriatric medicine and rheumatology were better than the England average of 6.1 days.
- There was good provision of care for those living with dementia and staff took the range of different patients' needs into account.

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

Service planning and delivery to meet the needs of local people

- The East Kent Hospitals University NHS Foundation Trust provides services to the population of Kent. Staff admitted patients to medical wards at the hospital through direct referral from their GP or through the emergency department.
- The trust was in the process of redesigning the clinical strategy for delivering medical care across the trust. This involved reorganising the acute medical model, implementing an acute frailty pathway, improving discharge pathways and reorganising the acute medical units.
- The trust was working with 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 flow of patients through the hospital and delayed discharges remained a concern. This was a complex

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

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

Access and flow

- In the 12 months from March 2015 to February 2016, the trust had over 80,000 admissions to medical services. This was higher than the majority of trusts in England. The William Harvey Hospital had 31,546 admissions. Over half of the admissions were general medicine with gerontology, cardiology 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 William Harvey Hospital for all elective stays at 1.5 days was better than the England average of 3.9 days. The average length of stay at the hospital for non-elective stays, 3.4 days, was better than the England average of 6.7 days.
- Elective stays in general medicine (1.5 days) was better than the England average of 4.0 days. The elective stay in cardiology (1.2 days) was better than the England average of 1.9 days. The average length of stay for rheumatology (1.1 days) was better than the England average of 2.7 days.
- Non-elective stays in general medicine (3.6 days) was better than the England average of 6.2 days. Non-elective stays in geriatric medicine (7.7 days) was better than the England average of 9.8 days. Non-elective stays in cardiology (4.8 days) was better than the England average of 5.5 days.
- As set out in the NHS Operating Framework and NHS Constitution, patients have a right to start consultant-led treatment within a maximum of 18 weeks. Referral to treatment within 18 weeks was below the 90% national 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 referral to treatment national standard 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 where there were six weeks delays.
- Across medical services, staff told us they admitted patients to inappropriate beds because of the pressures on bed capacity. This meant staff sometimes transferred outlier patients several times before they had a bed on the right ward. Outliers are patients who are admitted to wards outside of their speciality. On the day of our inspection there were 17 outlier patients receiving care in areas outside of their speciality.
- On Cambridge M2 Ward, staff told us when patients transferred between wards and were under the care of different consultants, they struggled to find a consultant who would take on the care of the patient.
- Data on bed moves indicated staff treated the majority of patients (71%) in the correct speciality bed for the

entirety of their stay. This was slightly worse than the previous year (2014/2015) when 74% of patients did not move wards. During the period June 2015 to May 2016, 20,069 patients out of 70,079 patients experienced one ward move or more; 14,755 (21%) patients were moved once; 3,325 (5%) patients were moved twice; 1,184 (2%) were moved three times and 805 (1%) were moved four or more times.

- We visited Kennington Ward, which was a gynaecology Ward with six medical outliers. Out of 11 beds on the unit, six were medical outliers. The ward was not staffed for the additional acuity of the medical patients. The medical staff also used a lot more stock and equipment than the average gynaecology patient, which had implications for the ward stocks. Staff asked for additional support at night as the gynaecology patients would not usually require so much support at night. Staff on the ward told us it was difficult to get the right medical team to attend the patient. They told us they sometimes went through five medical teams before they found the right person. However most outlier patients had daily visits from their consultants during the week.
- On King Ward, there were three medical outliers staff reported similar problems. They told us the medical patients were at a higher risk of falls and confusion, which required additional nursing support. They confirmed there was no problem with requesting additional support or one to one care for a patient if their condition required it.
- Dedicated rapid access clinics were now in place to provide additional capacity. The clinics were consultant led supported by clinical nurse specialists. General managers reviewed patient target lists weekly. Management reviewed the results and actions at monthly cancer board meetings. were reviewed at the were held with
- 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.
- There was also a fast track discharge however staff on the wards told us that this was not always fast. Staff told us patient discharges also delayed because of the limited pharmacy service. On the Cardiac Care Unit, there was limited and infrequent pharmacy support.
- The integrated discharge team consisted of therapists, discharge managers, social workers and administrative staff. The teams included staff from the local community trust, social services and the acute trust who worked together under an agreement. We spoke with the integrated discharge team at the hospital, who explained that although there were areas where the integration worked well there remained external barriers and challenges when making referrals. They gave the example of lack of community placements for patients with complex needs who required a high level of care. The team worked 12 hours a day, seven days a week and supported staff with all discharges apart from paediatric.
- Staff told us that the daily board rounds had improved patient discharges as now all healthcare professionals were aware of each patients plan and what their responsibility was in making it happen. They told us that delayed discharges were now more about the lack of capacity in the community and the reduction in local rehabilitation beds. For example, four patients on Cambridge J Ward were awaiting discharge. However, because of social complications and needing to arrange four support visits a day with two carers the patients remained in hospital.
- The William Harvey Hospital held three operational bed management meetings a day. Ward staff reported on the number of empty beds on their wards, expected admissions and discharges. The information then fed into the trust wide video conferences that were held three times a day to monitor bed capacity, discuss staffing, risks and escalation.
- 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.
- 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

Medical care (including older people's care)

- In order to meet patients' individual needs, staff should assess each patient on admission. Staff should then devise a plan of care to meet the assessed needs. However, we reviewed 15 sets of patient records across the medical services and found that that nursing assessment, repositioning charts, food charts and personal care round records were not always completed.
- The wards used a system of 'intentional rounding' to ensure that patients' basic needs were met. Nursing staff usually carried out the rounds at set times through the days and appropriate records kept. However, we noted omissions in the majority of records, which meant staff could not verify whether the patient had been seen or if the round had taken place. We noted this at our previous inspection.
- The trust employed specialist nurses to support the ward staff. This included dementia nurses and learning difficulty link nurses who provided support, training and had developed resource files for staff to reference. Wards also had 'champions' who acted as additional resources to promote best practice.
- The trust screened over 90% of all patients aged over 75 years for dementia within 72 hours of admission.
- The trust provided additional support for patients with learning difficulties. The trusts website provided in depth guidance and information about the support available. This included pictorial aides and communication tools available for use with people with communication difficulties such as the healthcare passport, which was available to download.
- Staff modified the environment to provide assistance for those with limited mobility. This included ramps, assisted bathrooms and lavatories, mobility aids and manual handling equipment. Staff told us that specialist equipment such as bariatric equipment or specialist pressure relieving mattresses were available on request. This meant that the hospital was able to care for patients with mobility difficulties.
- We found many areas of the hospital were colour coded to help patients living with dementia to orientate themselves. Signage was clear and dementia friendly.
- The relatives' room on the cardiac care unit was a small, windowless, cramped space. Patients waiting for procedures in the cardiac catheter laboratory also used the relatives' room on the cardiac care unit. This meant there were limited facilities for confidential conversations and breaking bad news on the unit.
- Cambridge L Ward did not have a quiet room or a room where relatives could speak with staff. We were told there was one planned. The window curtains on the ward required replacing and the bed curtains were very short making it difficult to maintain patients' privacy and dignity.
- In May 2016, the trust reported to the Quality Surveillance Group that the hospital adhered to the mixed sex accommodation policy. The 2016 patient-led assessment of the care environment (PLACE) assessment rated the hospital at 84.5% for privacy and dignity, which included changing facilities and appropriate separation of sleeping and bathroom/toilet facilities for single sex use.
- The 2016 PLACE survey showed the trust scored 83%, 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.
- Staff ensured patients were not interrupted at mealtimes through the use of protected mealtimes. However, this was not always enforced.
- We spoke with patients about the catering service. Patients told us staff always served the food hot and there was a good selection available. One patient told us "The food is smashing." Staff served hot drinks and snacks throughout the day and nurses always served patients a hot drink before bedtime.
- Staff used red trays to identify patients who needed assistance with feeding. Staff noted eating and drinking requirements above patients' beds on a white board. We saw instructions such as "thickened fluids only", "nil by mouth" and "Red tray" to remind nursing and catering staff of the patients individual needs.
- Across the hospital, we saw that there were leaflets and useful information available to help patients and their relatives understand their conditions and the treatment options available. These were easily accessible and

prominently displayed on most of the wards we inspected. However, printed information was only available in the English language. This meant there was little information readily available to support those whose first language was not English. According to the 2011 census Kent had a large population of over 63,000 people whose first language was not English. Staff told us that an interpreter service was available for those patients whose first language was not English.

Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas. Staff could also access the complaints policy on the trust's intranet.
- We saw information on raising complaints was readily available on all the wards and departments we inspected. Patients had access to the Patient Liaison and Advice service (PALs), who provided information about NHS services and supported patients dealing with concerns or complaints.
- The senior nursing staff and managers told us that complaints were discussed at clinical governance meetings and information disseminated to staff through team meetings, briefings and the governance feedback bulletin 'Risky Business'. We reviewed a sample of governance meeting minutes and noted that complaints were discussed and monitored.
- Staff were aware of the complaints process and knew how to direct patients and support them with their complaint. Staff 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. This supported staff training and learning through reflective practice.
- Patients told us they would raise any issues or concerns with the ward staff in the first instance, but they were aware of the formal complaints process.
- The management of complaints was included on the corporate risk register. The issues included an increase in the number of complaints, delays in response time, poor written responses and poor communication. The trust was investigating a web based complaints system to improve response times and communication between divisions and departments.
- Each speciality reviewed complaints in depth on a quarterly basis. 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.
- Management produced a trust wide complaints newsletter that was used for disseminating learning from complaints. The trust sent out the first issue 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 included case studies identifying service improvements within the trust because 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 clear corporate vision and strategy, which engaged staff. Management reflected the opinions of clinicians, staff and stakeholders' when developing the strategy for medical services.
- 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 were 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;

Medical care (including older people's care)

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

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

Vision and strategy for this service

- The trust had well-documented and publicised vision and values which included medical services. 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 trust's vision was to provide 'Great healthcare from great people', with the mission statement 'together we care: Improving health and lives'. The staff we spoke with on the medical wards took pride in the progress they had made to date in improving services for patients.
- The medical directorate divisional leads told us of the trust's "Improvement journey." All staff we spoke with from those on the wards to directors knew and understood the terminology "Improvement journey." They 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 previously in 2014 and 2015 and found that medical care services at the hospital required improvement. This was because we identified concerns with the environment, medical staffing and nursing staffing, support for patients with a deteriorating condition, the storage and management of medicines, record management, and infection control procedures.
- The trust wide improvement plan identified 30 actions. The trust reported monthly on their progress against the action plan to all relevant stakeholders. Although there had been much reported progress, the trust acknowledged staffing remained a concern, which in turn affected day-to-day activities and patient experience.
- The Division of Medicine Directorate Management Team divisional leads told us of the new ideas and structural framework for the division. Staff had been involved in the design of the new structure, which was now "bottom up rather than top down" as was the case previously. The strategic direction and strategy for medical services across the trust was under review. The trust was working with 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.
- Over the past year, the trust had introduced 'Triumvirate working'. This was a structure, which ensured that both clinicians and managers were involved in the management and planning of hospital activities at every level. The Triumvirate model usually consisted of a lead clinician, a senior nurse and a manager. Each of the triumvirate leadership teams had responsibility for designated wards and departments.
- The trust identified that the divisional structure had to work across all locations and specialities taking into consideration the unique factors of the individual hospitals but ensuring consistency across the trust. There were monthly trust wide clinical and quality assurance meetings together with a risk group to look at emerging issues.

Medical care (including older people's care)

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

Leadership of service

- Across the medical services, local ward and department leadership was good. Staff told us they felt well supported, valued and that 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.
- Staff told us everyone works very closely together now, from consultants to facilities management contractors. Staff consistently told us the trust had improved "Out of all recognition from the place it was before."
- The managers we spoke with were aware of the trust's improvement plan and their role in implementing it. There was a structure of daily site meetings, which occurred twice a day at the hospital. These fed into the trust wide 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 the communicated the outcome back to teams.
- There were educational programmes designed to support and develop new leaders in the organisation. These included the nationally recognised Clinical Leadership Programme, the Aspiring Consultant Programme and the Medical Clinical Leadership Programme.
- Staff told us about the monthly open forums lead by the Chief Nurse where nursing issues could be discussed. The senior nurses we spoke with told us this was a useful initiative and they had adopted a similar approach on the wards.

Culture within the service

- Following the last inspection the trust had initiated the "great place to work" initiate. The actions form this included the executive development programme, which was to start in October 2016, targeted interventions for the "respecting each other" campaign, the health and wellbeing group, embedding value based appraisals and medical engagement. The trust was auditing the engagement of clinicians during the inspection.
- We heard from all staff groups throughout the hospital that the trust was "On a journey." Staff were positive about working for the trust, and spoke with pride about how far the trust had come in such a short time. They told us they now felt valued and that their opinion mattered. Although they acknowledged there was still a lot of work to do they felt part of the plan to put things right. For example, staff remained under pressure to deliver high quality care with an increasing workload and low staffing levels. The change in culture meant they now felt able to escalated the staffing issues and senior managers worked together to find solutions.
- The trust monitored workforce performance indicators in order to plan recruitment and monitor trends. The June 2016 staffing data indicated 11% vacancy rate, 10% turnover rate, 68% appraisal rate, sickness absence

of 4% and mandatory training at 87%. This was similar to other NHS trusts. The staff survey action plan for the urgent care and long-term conditions division was working towards reducing sickness absence to 3.5%, improving the vacancy rate to 10%, the mandatory training and appraisal rates to 95%. The action plan gave a target date of September 2016.

- Staff told us that the culture in the hospital was now inclusive and supportive. One staff member described how management had supported them to undertake flexible working. We spoke with the integrated discharge team, which consisted of staff from external stakeholders. They told us that the trust was moving forward and felt "different now". They said it now felt "patient driven" and although there were challenges staff were talking and managers were listening.
- The trust had raised the profile of appropriate behaviour through the implementation of a confidential report line and the introduction of the "Respecting each other" campaign. Staff told us since this campaign had started there were less incidents of bullying reported. Both nursing and medical staff told us the trust had addressed bullying and dignity in the workplace. They told us "Attitudes have definitely changed". Staff who felt bullied now could challenge that behaviour by making a complaint confident the trust would take action. Staff told us that bullying usually "Came from above – usually due to management pressures over bed availability".
- The June 2016 Family and Friends Test indicated that 80% of staff had never experienced bullying or harassment and the majority of staff would feel confident in reporting such issues. Ninety six percent of staff were aware of the trust's anti bullying initiatives. This showed the trust had been able to improve the culture of medical services.

Public engagement

- The trust's website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and the public a wide range of information about the safety and governance of the hospital.
- The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch, feedback from the Friends and Family Test, inpatient surveys, complaints and the 'How Are We Doing?' initiative.
- The stroke services organised ward based patient groups run in conjunction with charitable organisations. Staff ensured patients and their families had 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 discussed good ideas put forward by staff at weekly ward meetings and monthly team meetings. Each ward or departments held staff meetings, and/or issued newsletters to staff to keep them informed. Management passed on useful suggestions and good ideas to the clinical and quality boards. All staff we spoke with at the William Harvey Hospital felt informed and involved with the day-to-day running of the service, and its strategic direction.
- 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.
- The trust recorded a positive staff friends and family test result with 57% of staff recommending the trust as a good place to work (up 8%) and 78% recommending the trust as a good place to receive treatment (up 4%).
- All staff we spoke with assured us they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested that the trust had an 'open culture' in which staff could raise concerns without fear.

Innovation, improvement and sustainability

Medical care (including older people's care)

- Across the medical directorate senior managers, directorate leads and front line staff told us that the trust had another two years of hard work ahead to improve the quality of care. All staff were aware of the term 'Improvement journey' and told us that there was little risk of slipping back because of the changes at both senior management and ward level.
- The hospital'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. Staff ran the hubs and provided topics of interest suggested by co-workers, which could be accessed at any time the hub was open. The hub at the William Harvey Hospital was open every Thursday between 10am and 2pm. Staff told us the hospital hubs were a good open forum where new ideas could be presented and discussed by those present.
- Staff from the Richard Stevens Stroke Unit gave the example of developing positional aids for stroke patients with the aid of physiotherapists. Staff from the unit presented the solution at the trust conference, which was shared throughout the trust and with another stroke team in Liverpool.
- We saw the programme of events developed by staff to educate and support each other on the improvement journey. These included dementia, sepsis, and staff wellbeing. Staff developed a fortnightly newsletter used to spread information resulting from the hubs activities. The staff we spoke with spoke highly of the value of this means of communication and the only drawback was there were sometimes insufficient resources on the ward to release staff to attend.
- Staff told us they felt valued and listened to. If they had an idea, they could raise it with their manager or a link nurse. One nurse told us about awards the trust gave staff, and how innovation and doing a good job was acknowledged and encouraged.

Maternity and gynaecology

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

Information about the service

The William Harvey Hospital in Ashford delivers more than 4,000 births annually. There is antenatal (before birth) and gynaecology clinics; a fetal medicine unit; a maternity day care unit; a 28 bedded antenatal and post-natal (after birth) inpatient ward; a consultant led labour ward with three induction beds, eight labour rooms and a birthing pool; there was one obstetric theatre; and a midwife-led unit with six rooms and two birthing pools.

We have also included our findings of the services at Kent and Canterbury Hospital in this 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.

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

On our previous inspection, we found issues with understaffing across women's health services. At the time, the trust was actively recruiting and agency and bank staff were being used. However, it was routine practice for staff to go without meal breaks or work over the end of their shift in order to ensure the ward was covered, to catch up on documentation and to keep women safe. We identified a culture of bullying and harassment. Staff felt there was a lack of leadership and strategic direction within women's services. There were also issues with the general environment and lack of equipment across the obstetric department. There was a shortage of basic medical equipment such as resuscitation equipment.

Maternity and gynaecology

Summary of findings

We rated this service as requires improvement because;

- Lack of staffing affected many areas of service planning and the care and treatment of women including; not meeting national safe staffing guidelines, therefore 1 in 5 women did not receive 1:1 care in labour; staff did not have the time to attend risk meetings or complete incident forms.
- The physical environment was not conducive to the safe care and treatment of women. The bereavement suite on Folkestone ward did not meet department of health standards. Some areas of the department were intolerably hot, although there had been some improvements on the delivery suite since our last inspection.
- Hospital management did not ensure robust governance, for example, hospital data of the number of surgical abortions was incorrect as figures included women who had miscarried and had a surgical evacuation.
- On our previous inspection, we found there was an ingrained bullying culture within women's services. This had since improved, however the culture of the service needed more input to support the improvement journey. For example, innovation hubs had increased in popularity, however there was still a lot of disengagement amongst staff and at the time of inspection there was no audit of the hubs to monitor benefits.

However;

- Staff were supportive of one another and worked well as a multidisciplinary team. Staff provided a caring, empathetic environment for women during their pregnancy and labour.
- Care and treatment was evidence based and patient outcomes were in line with other trusts in England.

Are maternity and gynaecology services safe?

Requires improvement

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

- Equipment availability, for example CTG machines.
- The high temperatures on the delivery suite had been improved by installing air conditioning.

However;

- There were substantial and frequent staff shortages.
- The maintenance of medical devices was not adequate.
- Mandatory training completion rates were below the trust target.
- Although temperatures in the delivery suite had improved, the physical environment in other parts of the department was not conducive to safe treatment and care of women or staff.

Incidents

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

form to be sent for future cases – All Consultants to be aware" with no information detailing how the hospital would ensure alert forms would be sent in the future or plans to ensure consultants were aware of issues.

- There were 186 trust wide serious incidents in women's services between July 2015 and June 2016. The trust investigated serious incidents in accordance with the 'Serious Incident Framework 2015'. Postpartum haemorrhage (PPH) greater than 1000ml (the loss of blood from the genital tract within 24 hours of birth) should be reported as a serious incident. However, the trust incident summary showed postpartum haemorrhage was reported when greater than 1500ml, not 1000ml. Therefore, the trust may be under reporting PPH serious incidents as it was only monitoring the number of incidents over 1500ml when it should include those of 1000ml and over.
- We saw the trust incident summary from July 2015 to June 2016. The document did not allow the user to categorise the information, for example by ward, in order to monitor trends and themes. Therefore, senior members of staff would not easily be aware of recurring issues.
- Staff reported non-clinical incidents such as staff shortages on the computerised incident system. However, management did not always follow up non-clinical incidents. Staff advised us they did not know what happened to incident forms after reporting, but staffing levels had not improved.
- Staff provided examples where policy and practices had changed because of incidents. For example, monitoring of twins had improved after an incident involving cardiotocography (CTG) errors. CTG is the recording of a fetal heartbeat and the uterine contractions during pregnancy. After the incident, changes to procedure ensured a registrar or consultant reviewed all results. Staff had good knowledge of these changes.
- Staff reported that they did not always have the time to complete incident forms.
- There were no never events reported to the Strategic Executive Information System (STEIS) at William Harvey Hospital or Kent and Canterbury Hospital between July 2015 and June 2016. NHS England describes a never event as "Serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers."
- Management shared feedback from reported incidents and learning during team meetings, ward meetings, email communications and the clinical governance newsletter 'Risky Business'. The hospital held regular risk meeting to discuss incidents and learning, however staff advised us they found it difficult to attend these due to lack of staff on the ward.
- We saw copies of the 'Risky Business' newsletter on staff notice boards giving details of learning from recent incidents. Staff discussed learning from incidents at midwifery development days. However, staff advised us where there had been clinical mistakes, this often led to disciplinary action.
- Staff triggered a duty of candour notice when they entered certain criteria into the incident reporting system. Staff had good knowledge of duty of candour and knew their roles and responsibilities. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Duty of Candour aims to help patients receive accurate, truthful information from health providers. However, at the time of inspection, staff were unable to give us examples of where duty of candour was discharged.

Safety thermometer

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

Cleanliness, infection control and hygiene

- There were no cases of Clostridium Difficile on the maternity or gynaecology wards for the period April 2015 to March 2016, which was better than the national average.
- Staff treated patients in areas that were visibly clean and tidy.

- There were infection prevention and control policies and procedures in place that were readily available to view on the trust's intranet. Staff knew how to access these.
- Hand washing sinks were readily available with sanitising hand gel throughout all the locations we inspected. Disinfection wipes were available for cleaning hard surfaces in between patients. Staff cleaned and labelled equipment it to indicate it was clean and ready to use.
- Clinical and domestic waste bins were available and clearly marked for appropriate disposal.
- An outside contractor undertook the cleaning of the hospital. Staff ensured linen cupboards were fully stocked and kept tidy, the cleaning equipment was colour-coded and used appropriately. We saw cleaning rotas and cleaning checklists completed appropriately by the contracted cleaners and checked by a manager.
- Trust wide figures for women's services showed 76% of staff were up to date with their infection prevention and control training, which did not meet the trust target of 85%.
- Staff were aware of the principles of the prevention and control of infection. We observed staff regularly use hand gel on entering clinical areas and between patients. The 'bare below the elbows' policy was adhered to and personal protective equipment such as disposable gloves and aprons were readily available in all areas.

Environment and equipment

- The trust did not have adequate maintenance arrangements in place for the medical devices used in maternity and gynaecology. Trust figures showed 74% compliance (which was worse than the improvement plan target of 95%) with 358 complete and 125 outstanding. A business case was approved in July 16 to ensure that there is sufficient staffing to ensure compliance across the trust. Equipment had been risk stratified to ensure that high and medium risk equipment was prioritised. The Royal College of Obstetricians and Gynaecologists 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' states equipment must be maintained in good working order.
- Staff could not ensure patients in the midwife led unit were secure as a fire escape from the neighbouring ward exited through the unit. This was a security as well as an infection control risk for the Singleton Unit, which was a secure unit. This was not on the departments risk register.
- At our previous inspection, we noted a shortage of equipment. On this inspection, staff on the Singleton Unit advised us they had no adult oxygen saturation machines and staff on Folkestone ward advised us there was a shortage of lights available for speculums. Therefore, the hospital had not addressed all issues related to equipment shortages identified at our previous inspection.
- All wards in women's services had locked doors. Staff used a personal pin code to gain access whilst visitors used a door buzzer system. However, we noted it was easy to tailgate on the delivery suite, as the reception was not located near the security door. Staff advised us they had repeatedly reported the issue, which at the time of inspection was not on the risk register. A security mirror had been removed removed on Folkestone ward to make room for a mural.
- Adult resuscitation equipment was available in both the obstetrics and gynaecology wards. Trolleys were fully equipped in accordance with guidelines and were checked and signed off daily.
- On our previous inspection, we noted a lack of equipment such as CTG machines, which monitor fetal heartbeat and the uterine contractions. Since then the issue was raised on the maternity risk register and the department now had sufficient CTG equipment in accordance with standards set by the Royal College of Obstetricians and Gynaecologists 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour'.
- On our last inspection, we noted the environment in women's services was incredibly hot. The trust had made some improvements in this area. For example, on labour ward all labour rooms had air conditioning installed. However, the hallway and clinical offices were still very hot as well as most other areas of women's services. We noted the heat on gynaecology ward where staff advised us the "Environment is hot in summer and cold in winter, we were giving some patients four blankets in the winter." Therefore, management still did not appropriately monitor the temperature of the environment.
- Each ward separately audited the patients' environment on a monthly basis. We saw an audit for Folkestone

ward at William Harvey Hospital. Staff rated the environment red, amber or green dependent on disrepair. The June 2016 audit showed, 27 out of 30 areas were rated green, none were rated amber and three were rated red. For the areas rated red, there was an action plan, timescale and responsible person.

- At Kent and Canterbury Hospital, the antenatal and maternity assessment unit had a flat roof, which staff advised us leaked when it rained. The hospital had a capital allocation for roof maintenance in the 2016/17 financial year, but other areas across the sites had been assessed as having a greater risk and therefore priority. However, the issue was on the estates risk register, gutters and down pipes were regularly clear of debris, roofing felt was applied over some of the copingstones and repairs were checked after a period of heavy rain. Therefore, the hospital took reasonable steps to respond to in issue, until repairs that are more robust could be completed.

Medicines

- At the last inspection, we found staff did not always safely store and manage medicines as several medicine cupboards and clinical fridges were unlocked. At this inspection, we found all medicine cupboards and fridges were locked and audit results showed good compliance with the hospitals medicines policies and procedures as well as the Nursing and Midwifery Council 'Standards for Medicine Management'.
- Staff clearly documented women's allergies on medical administration records and in patients' notes.
- Controlled drugs were checked twice daily by two members of staff and this was documented. Staff safely checked and disposed of controlled drugs appropriately when not required. We saw an audit of controlled drugs from April 2016 that showed good staff compliance. The document included actions and recommendations; however, some of the recommendations were vague. For example, "All registrants must be reminded of the importance of taking the CD register to the bedside and of the importance of documenting administration in the notes to facilitate a high standard of communication with colleagues." However, the audit did not state how registrants would be reminded or allocate responsibility for the task.
- We saw policies and procedures for the administration of antibiotics, which were compliant with the National Institute for Health and Care Excellence (NICE) standards.
- Staff checked medicine fridge temperatures daily; however, we did not see ambient room temperatures recorded in areas where drugs were stored. Some areas of the maternity wards were very hot, for example, the labour ward. When medication is stored over 25°C it can deteriorate, therefore there was a risk of the efficacy of medications being compromised.

Records

- We checked 10 patient records and found them to be contemporaneous, legible, dated and signed and contained full clinical details in line with the Royal College of Physicians 'Standards for the clinical structure and content of patient records 2013'.
- Women's hand held maternity notes provided a complete record of antenatal tests results in accordance with NICE guidelines.
- Staff completed risk assessments for patients, which detailed next steps as well as any further actions taken if needed. Where intervention was required, records clearly stated when follow up was required.
- Women's health records were stored securely away from areas where members of the public could easily access.
- However, at Kent and Canterbury Hospital, the maternity records room had two access doors. The entrance of the antenatal care unit was locked from the main corridor, however, we found the door inside the clinic was not locked or manned. This was immediately brought to the attention of the head of midwifery who ensured the door was locked.
- At Kent and Canterbury Hospital, the mother of a stillborn baby received a letter providing details of an upcoming BCG clinic that her baby should attend. Therefore, staff were not always checking patient records were up to date before sending correspondence to women.

Safeguarding

- The trust had separate safeguarding vulnerable adults and children policies, which adhered to statutory guidance such as 'Working together to safeguard children 2015'. The guidelines were readily available on the hospital intranet and staff showed us how to access information.

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

Mandatory training

- Mandatory training was a combination of e-learning and practical sessions. Trust figures for practical training were 57% for moving and handling and 82% for Hospital Life Support practical as of August 2016. Safeguarding training level 2 was at 54% for the number of staff who required it and infection prevention control was 76%. Adult resuscitation figures were organised by site with William Harvey Hospital achieving 82%. All training completion figures for mandatory training were below the trust target of 85%.
- The trust was below the NHS expected completion rate for all five areas covered in mandatory training. Therefore, the trust could not ensure staff were up to date with current practices, which may put patients at risk of harm.
- The Royal College of Midwives describes skills drills as "The accepted format by which healthcare professionals gain and maintain the skills to manage a range of obstetric emergencies." At William Harvey Hospital, the number of midwives up to date with their skill drills was 85%, which was in line with the trust target of 85%. However, staff completion rates varied greatly from ward to ward with the Singleton Unit being the only ward to meet the target with 93% as of 25 August 2016. All other wards fell below the 85% completion rate.
- On Gynaecology ward, nursing staff advised us they received protected time for mandatory training; however, healthcare assistants contradicted this, stating they completed training when they were able to "fit it in."

Assessing and responding to patient risk

- The trust did not meet the Venous Thromboembolism NICE risk assessment targets from June 2015 to May 2016. Therefore, patients were potentially at risk that deep vein thrombosis and blood clots would not be recognised and treated.
- Venous Thromboembolism data was not included on the maternity dashboard, which is a NICE requirement due to maternal deaths. Therefore, the trust was not meeting this standard.
- 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK' 2015 states fetal growth must be regularly monitored by measuring the symphysis fundal height (a measure of the size of the uterus used to assess fetal growth and development during pregnancy). Records showed measurements were taken; we also saw the escalation pathway for abnormal findings.
- Staff on the antenatal unit informed women of the importance of monitoring fetal movement as a method of fetal surveillance, in line with the Royal College of Obstetricians and Gynaecologists. We saw records that corroborated this.
- Gynaecology staff on Gynaecology ward received daily support from an outreach team to assist with deteriorating patients.
- The hospitals surgical policies complied with the World Health Organisations Surgical Safety Checklist. It is a tool for relevant clinical teams to improve the safety of surgery by reducing deaths and complications. We saw an audit of the checklist, which showed full compliance.

- An early warning score (EWS) is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the six cardinal vital signs (Respiratory rate, Oxygen saturation, Temperature, Blood pressure, Heart rate and Responsiveness). Staff used the EWS system to continually assess women admitted acutely, which was audited to ensure compliance.
- Obstetricians were involved in multidisciplinary discussions regarding emergency caesarean sections in accordance with the Royal College of Obstetricians and Gynaecologists 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour'.
- We saw completed risk assessments for raised Body Mass Index (a person's weight in kilograms divided by his or her height in meters squared. The National Institutes of Health defines normal weight, overweight, and obesity according to BMI rather than the traditional height/weight charts), gestational diabetes (diabetes during pregnancy), smoking and pre-eclampsia (a disorder of pregnancy characterized by high blood pressure and a large amount of protein in the urine) in accordance with NICE guidelines.

Midwifery staffing

- Lack of staffing was recorded as an incident. We saw a summary of all incidents at the trust between July 2015 and June 2016. The trust allocated incidents a severity rating; high, moderate, low or none. All incidents relating to staffing were given a severity rating of 'none'. The National Patient Safety Agency (2004) defines severity as: "No harm; Impact prevented (Near Miss) – Any incident that had the potential to cause harm but was prevented, resulting in no harm. Impact not prevented – Any incident that ran to completion but no harm occurred." However, lack of staffing occurred regularly, therefore, the trust may be underestimating the impact staffing issues had on the daily activity of the department. There was no easy way of categorising the information to find trends. However, we looked at the data and found Singleton ward had recorded staffing incidents 18 times, Folkestone ward 15 times, Gynaecology ward 10 times and the labour ward 5 times. However, some staffing issues had been categorised as 'staff wellbeing' others 'staffing level difficulties'. This made it difficult to analyse the information. We were advised staffing levels were under reported as staff got "fed up" of reporting the same issues, also staff stated they did not have the time to complete incident forms.
- The Royal College of Midwives Birthrate Plus is a midwife specific, national tool that provides insight to model midwifery numbers, skill mix and deployment. The Birthrate Plus Report showed women's services were 22 Whole Time Equivalent (WTE) staff short. However, in addition to this, 13 staff were in post but had not started at the hospital, 11.5 were on maternity leave and there were 4.5 vacancies. Therefore, not including sickness the hospital was actually 29.5 WTE short at the time of inspection.
- The NICE required staffing ratio was 1:28. For the entire service, staffing establishment was a ratio of 1:30; however, the actual ratio was 1:32. Therefore, the trust was not meeting this target.
- Staff sickness rate at the hospital was 7%, which was higher than the NHS England average of 4.4%. Staff we spoke with advised the reason for this was due to stress because of increased activity levels and staff shortages.
- Clerical and administrative staff had left the hospital but not been replaced. Staff told us they felt they were "Fire-fighting." Midwives advised us the lack of clerical staff put additional burden on existing staff and meant midwives and midwifery healthcare assistants were undertaking more administrative work. Staff told us it was very frustrating being called away from the patients' bedside to undertake administrative tasks.
- The Royal College of Midwives 'Evidence Based Guidelines for Midwifery-Led Care in Labour Supporting Women in Labour' states all women should receive 1:1 care during labour. The trust was not meeting this ratio with 1 in 5 women not having access to 1:1 care during labour due to staffing levels.
- The trust conducted a Quality Standard of Intrapartum Care in December 2015, which showed maternity staffing in providing 1:1 care in labour was an area of non-compliance. In response to this staffing was being recruited to turnover, increased sickness management, employment of agency staff and implementation of birth rate plus findings. However, staff in all areas of women's services said they were overworked and that activity had dramatically increased. Staff were unable to confirm whether the increased activity was being audited.

Maternity and gynaecology

- There was no agency staff on shift during our inspection. Agency staff could not support wards unless they provided an 'Intention of Practice'. Band seven staff ensured agency completed an induction of the ward, which was signed off and included fire policies and procedures.

Medical staffing

- There was consultant anaesthetists cover for the obstetric unit from Monday to Friday, with weekends covered by an emergency on call rota, which was in accordance with Association of Anaesthetists of Great Britain & Ireland 'Guidelines for Obstetric Anaesthetic Services' 2013.
- The hospital provided 70 hours of consultant cover a week, which is in line with Royal College of Obstetricians and Gynaecologists 'The Future Workforce in Obstetrics and Gynaecology'. However, we found this included cover for maternity, obstetrics and gynaecology, which may not be sufficient during busy periods. It is best practice to cover one of these areas, rather than provide cover for all three at the same time.
- Medical staffing skill mix showed the trust had a slightly higher percentage of junior grade staff when compared to the England average. However, the percentage of consultants was lower than the England average.
- Staffing numbers were publicly displayed in all inpatient areas in line with NHS England's 'Hard Truths' guidelines.
- We saw consultants complete two daily ward rounds in accordance with Royal College of Obstetricians and Gynaecologists 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour'.

Major incident awareness and training

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

Are maternity and gynaecology services effective?

Good

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

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

However;

- Appraisal completion rates were 46% below the trust target.
- Understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards was poor.

Evidence-based care and treatment

- A robust audit programme for obstetrics and gynaecology showed patient outcomes were in line with national standards. Audits were based on recognised national guidance including the National Institute for Health and Care Excellence (NICE), Royal College of Obstetricians and Gynaecologists 'Safer Childbirth: minimum standards for the organisation and delivery of care in labour'. Audits included; Management of women with anovulation, Maternal new-born and infant clinical outcome review programme and fetal abnormality.
- Staff completed assessments, which identified risks. For example, staff tested glucose tolerance for women presenting with symptoms of gestational diabetes, for

example increased thirst. This was in accordance with National Institute for Health and Care Excellence and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK guidelines.

- The trust completed an audit of the British Association of Perinatal Medicine New-born Early Warning Trigger and Track Tool. The audit included an action plan for improvement. However, staff had not included a time scale the changes would be implemented by, or a date for re-audit.
- There was a programme of planned audits for the next year that included reasoning for the audit and the audit lead. Planned audits included Paediatricians at delivery for meconium and Colposcopy in Pregnancy. These audits were based on recognised national guidelines.
- However, an end of year summary of clinical audits for 2015/16 stated "There has not been a specialty audit lead for some time since the previous lead retired, however the specialty now has an audit lead who is engaged in audit and meets with the audit team regularly. The project leads are generally not very good at responding to information requests in a timely manner." Therefore, staff engagement in auditing was not as strong as it had the potential to be.
- An obstetrician audit for 2015 showed the trust was meeting 8 out of 9 standards. The one standard not being met was the 100% post-anaesthetic follow-up rate was standing at 84%. We did not see an action plan to improve this figure.

Pain relief

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

Nutrition and hydration

- The trust performed an audit of staff understanding of the nil by mouth policy prior to elective surgery in March and April 2016. It found that senior staff had a better understanding and knowledge of guidelines. Because of the audit, staff planned to put up information posters on wards. Staff planned a re-audit to check for improved understanding. At the time of inspection, we did not have access to the re-audit results.
- Throughout the department we saw information leaflets for breastfeeding including; expressing techniques, information sheets for issues such as 'My baby won't breastfeed' and details for local breastfeeding support groups.
- The 'Protected Mealtimes Review' by the National Patient Safety Agency showed protected mealtimes improved patient outcomes in terms of increased weight gain where required, reduced food wastage and a reduced number of food complaints. We observed protected meal times on Gynaecology ward, which allowed patients to eat their meals without unnecessary interruption and enabled staff to assist patients unable to eat independently.
- Staff on Gynaecology ward had access to a speech and language therapist 7 days a week. This enabled staff to support the nutritional needs of women who had swallowing difficulties.
- Two infant feeding specialists with backgrounds in lactation support provided assistance for women across the trust. They felt women required further support as

when they started, there were seven infant feeding specialists across the trust. Staff on the delivery suite said they noticed when the infant feeding specialists were unavailable.
- Staff supported women to breastfeed their child and provided women with information regarding community initiatives.

Patient outcomes

- Readmission rates at the trust were better than the national average for women's services for the year June 2015 to May 2016.
- The trust's total caesarean rates including both elective and emergency caesareans were similar to other trusts this size for January to December 2015. However, the numbers had recently increased. The trust was not able to provide us with information regarding the reasoning for this.
- The number of third and fourth degree tears and the still birth rate reported at the hospital was very low compared to other hospitals of this size.
- As of 27 July 2016 there were no maternity outliers reported. Therefore, staff treated women on appropriate wards. However, during our inspection, staff on Gynaecology ward stated outliers were frequently on the ward and that junior doctors were slow to review their patients. Therefore, the ward at times experienced delays for gynaecology patients.
- Unexpected admissions to the Neonatal Intensive Care Unit were better than the national average and had improved over the period August 2015 to July 2016. Governance meeting minutes stated this was due to improved recording and a new maternity system.
- However, William Harvey Hospital did not meet 4 out of 5 indicators in the National Neonatal Audit Programme 2015. The one indicator they met was for retinopathy of prematurity screening (a pathologic process that occurs in immature retinal tissue and can progress to a retinal detachment, which can result in functional or complete blindness). We did not find any plans detailing actions for improvement.
- For the period July 2015 to June 2016, unplanned maternal admission to the ITU was worse than the England National Quality Standards.
- Hospital Episode Statistics showed, for the period January to December 2015, the trust was 'similar to expected' for both elective and emergency caesareans.
- Other delivery methods such as breech (a delivery of a baby which is so positioned in the womb that the buttocks or feet are delivered first) and ventouse (suction cup used to assist delivery of babies head), were in line with England averages. Low forceps cephalic delivery was better than the England average and other forceps delivery was worse than the England average.

Competent staff

- Appraisal completion rates in women's services were 39%; this was 46% below the trust target of 85%. Therefore, management did not identify staff learning needs, nor did they support staff to maintain and further develop their professional skills and experience.
- Staff opinion of appraisals varied between wards and staff banding. Midwives advised us they were given the appropriate time needed to prepare for and conduct a meaningful appraisal. However, some midwifery health care assistants stated appraisals were often a "tick box exercise" and they did not find the process supportive in progressing knowledge and skills. Staff advised us the quality of appraisal depended on who their appraiser was, as some appraisers gave the process more importance than others did. This was reflected in appraisal figures, for example, on the Singleton Unit, 95% of staff was up to date with their appraisal. All staff we spoke with on this ward advised us they found the appraisal process to be beneficial.
- Staff advised us they were supported during revalidation. We saw a revalidation folder, which provided guidance on writing a reflective account and practice related feedback.
- Staff on the Singleton Unit had identified a need for further new-born examiners to support the discharge process. Four members of staff were attending training in October 2016. However, initially the department had received funding for eight staff to complete the course but part of the funding had been removed.
- Staff on Gynaecology ward had the opportunity to attend preceptorship study days, which included; venepuncture and cannulation, intravenous drugs administration, venous thromboembolism, falls and pressure ulcers.
- Staff on Gynaecology ward were introducing a certificate scheme for staff mentioned in Friends and Family Test responses, which could be used as evidence for revalidation as well as appraisals.

- Specialist midwives were available to support patients and act as a resource for staff. These included specialists in screening, fetal medicine, teenage pregnancy, bereavement and the care of vulnerable women. There were lead midwives for health and safety, infection control and catheter care.

Multidisciplinary working

- Consultants and registrars examined patients on the midwife led unit when they were required, for example, complex tears. Staff on the unit advised us consultants and registrars were quick to respond. If medical support was required urgently, staff put out a 222 call.
- Staff advised us there was affective multidisciplinary working with GPs, which was supported by the community midwife team. Discharge summaries were sent to GPs electronically using the secure internal NHS emailing system. We saw the system being used in practice.
- Physiotherapists were available to support women during the week. Women and staff advised us there was good access and the service was responsive.
- There was a daily electronic handover with community midwives and on the Singleton Unit a daily morning telephone call in order that community midwives were aware of activity on the unit and vice versa.
- All staff we spoke with advised us there was good multidisciplinary working within women's services. However, the trust incident summary form for July 2015 to June 2016 showed 21 incidents at William Harvey Hospital and two incidents at Kent and Canterbury Hospital involved poor communication, usually staff to staff. The most common incidents involved theatre staff and patients transferred from other parts of the hospital, for example A&E. Therefore, there was areas the trust could improve multidisciplinary working.

Seven-day services

- The labour ward, Singleton Unit, Folkestone and Gynaecology ward were open 24 hours a day, seven days a week.
- Inpatients had seven day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and pathology in accordance with 'NHS Services, seven days and week priority clinical standard 5'.
- The day care unit was open seven days a week with opening hours Monday to Friday from 8am to 8pm and 8am to 4pm on weekends. Women were given contact numbers for the maternity departments and labour wards where there was staff available to answer questions and provide advice.
- At the Kent and Canterbury Hospital, the maternity day care unit was open seven days a week, from 9am to 5pm and the early pregnancy unit was open Monday to Friday. Outside of these hours, women could access emergency care by reporting to the emergency department. An early pregnancy nurse practitioner worked Monday to Friday from 8am to 1pm on the unit.
- At the William Harvey Hospital, the day care unit was open from 8am to 8pm, seven days a week and the early pregnancy unit was open from 7:30am to 2pm Monday to Friday and Sunday.
- Obstetricians provided cover on the delivery suite 7 days a week from 8am to 6pm.
- The hospital pharmacy was open 7 days a week from 8am to 5pm weekdays and 8:30am 1pm at weekends. Outside these hours, staff contacted the hospital co-ordinator who sourced required medications. Staff advised us this was a responsive service.
- However, staff on Folkestone ward advised us medication did not arrive from the pharmacy until 4pm. Therefore, ward staff were unable to discharge patients until late afternoon meaning some patients waited all day to go home.

Access to information

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

accessible, ensured staff were working with the most up to date information and supported effective handover as information was documented in one place rather than various folders and records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust consent policy was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details of the Mental Capacity Act 2005 (MCA) and checklists.
- Consent, MCA and Deprivation of Liberty Safeguards (DOLS), were all part of mandatory training. MCA and DOLS came under the umbrella of safeguarding training.
- Staff told us the community midwife completed the consent paperwork for antenatal screening at the woman's first booking appointment. We saw copies of signed consent forms in records we looked at.
- At our previous inspection, we found staff had a poor understanding of the MCA. During this inspection, we found knowledge and understanding of these areas was still poor with staff advising us they had not received training in the MCA. When we asked one sister how they would assess capacity, their response was "I would talk and listen to patients to assess their capacity." The Mental Capacity Act 2005 states, "A lack of capacity cannot be established merely by reference to—(a) a person's age or appearance, or (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity." Therefore, talking and listening to patients as criteria for capacity did not follow best practice and guidelines. Staff advised us that capacity was assessed by the community team before a woman attended the hospital. However, staff were still required to understand the MCA and be able respond appropriately to a situation.
- DOLS is part of the Mental Capacity Act 2005 and is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm. Staff did not show understanding of what to do in the event a patient had a DOLS in place. Staff advised us they had not experienced this situation; however, they should have knowledge of what to do if the circumstances arose.

Are maternity and gynaecology services caring?

Good

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

- Women were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. Women felt supported and said staff cared about them.
- Staff responded compassionately when women needed help and supported them to meet their basic personal needs as and when required. Privacy and confidentiality was respected at all times.
- Staff helped women and those close to them to cope emotionally with their care and treatment.

Compassionate care

- Women in all parts of the hospital praised staff and said they were "Very kind, efficient and understanding." However, some women advised us that staff appeared overworked and therefore at times women did not want to disrupt a staff member when they could see they were busy.
- On labour ward, an obstetrician registrar had received a letter from a patient thanking them for the care they provided during labour where there was fetal distress and consequently the baby was delivered by suction. The woman stated she was very happy with the care provided and felt "Very safe in your hands."
- The 2015 survey of women's experiences of maternity services showed the trust was rated the same as other trusts for patients feeling they were treated with kindness and understanding by staff after the birth, with patients rating the trust 8.2/10.
- The hospital was in line with the England average for Friends and Family Test results for women recommending the hospitals antenatal care, post-natal care and as a place to give birth.
- Staff on Gynaecology ward promoted NHS England's 6 C's of nursing (care, compassion, competence, communication, courage, commitment). All staff we spoke with knew the 6 C's and provided us with examples of how they used them in day-to-day practice.

Maternity and gynaecology

- We noted a photo board on the Singleton Unit had 56 photographs and thank you letters from parents who had delivered at the unit.
- On Folkestone ward, we saw a thank you card, which stated "Thank you for your time and care after the birth of our daughter. Cannot thank you enough."

Understanding and involvement of patients and those close to them

- The survey of women's experiences of maternity services 2015 showed, out of 19 questions, the trust was rated as the same as other trusts in 17 questions and better than other trusts for two questions. Advice at the start of labour, being given appropriate advice and support and Raising concerns, for raising a concern and having it been taken seriously.
- All wards had a 'you said, we did' board, which detailed the hospitals response to Friends and Family Test comments. However, apart from the midwife led unit, we saw only positive comments had been added to the boards. Therefore, 'you said, we did' boards were not reflective of patient comments and complaints.
- Women advised us that staff explained the reasons for a procedure including benefits and risks, what the procedure would entail and when results would be expected. One woman said, "At every step, staff were describing sensations you will feel."
- Women advised us they were given regular opportunities to discuss their health, concerns and preferences.
- In antenatal clinics, women were given information regarding different birthing settings early on in their pregnancy, including the benefits and risks of home birth.

Emotional support

- Women had a named midwife and consultant responsible for their care. This enabled women to build a rapport with staff. Women said this empowered them to feel more able to ask questions and raise issues of concern. Of the women we spoke with, all of them knew the name of their consultant. We also saw a consultant greet their patients by first name.
- There was a chapel on the hospital grounds, which was available to patients, family and staff. There was also a 24-hour chaplaincy service to provide emotional support at any time of day or night. We saw the chaplaincy was well advertised within the department and leaflets clearly stated the service was available for everyone, not just people who identified with a religion.
- Staff advised us in the event of a bereavement they supported parents in the first instance as well as provided them with details of local bereavement counsellors, charities and support groups.

Are maternity and gynaecology services responsive?

Requires improvement

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

- Facilities for partners, for example, recliner chairs had been installed on the delivery suite ensured there was space for partners to sleep next to women.

However;

- The needs of the local population were not fully identified, understood, or taken into account when planning services. For example, the percentage of pregnant women accessing antenatal care seen within 10 weeks was 34%.
- Staff had diverted women to another hospital on 28 dates between January 2015 and June 2016.
- Services were not delivered in a way that focused on women's holistic needs, for example, the bereavement room was not appropriately designed to meet women's needs. However, a new suite was in development at the time of inspection.

Service planning and delivery to meet the needs of local people

- The trust dashboard showed there had been no unit closures from August 2015 to July 2016. However, the trust also provided us with data showing the maternity unit at William Harvey Hospital had closed 28 times between January 2015 and June 2016. Senior management stated there were no 'closures' of the service and the data mentioned refers to 'diverts' which have happened between the units at William Harvey

Hospital and Queen Elizabeth the Queen Mother Hospital. These were noted separately on the trust dashboard. Therefore, the trust could not provide assurance it was recording accurate data regarding service planning.

- The Singleton midwife led unit provided a labour environment for low risk women. However, in order to support the busy labour ward, the unit accepted women assessed as higher risk, but had controlled conditions such as well-managed lupus. Although staff on labour ward advised us this initiative had helped with service planning, staff on neither ward had audited the positive impact this had; therefore, there was no evidence to show improvement.
- There were early pregnancy units and day surgery for gynaecology patients at the Kent and Canterbury Hospital, the William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital. Therefore, there was good access to services across the trust for women in early pregnancy who presented with gynaecology issues.
- Discharge forms included a checklist to ensure personal child health records or 'red books' (a national standard health and development record given to parents/carers at a child's birth) were completed, neonatal checks had been completed or had been arranged and information leaflets explained, provided and documented. There was also a section which signposted staff to send copies of the discharge to health visitors and GPs, which staff signed and dated when completed.
- On discharge after birth, women received a 'What you need to know guide' which included details on; biological nurturing-laid back breastfeeding, an National Childbirth Trust information sheet-how to know your baby is feeding well, details of Kent wide breastfeeding services, an expressing guide, information on how to upload the 'baby buddy' app and a sleeping arrangements safety sheet.
- Staff with managerial responsibilities were allocated administration days. However, we were advised these were often cancelled due to activity levels and staff shortages on the wards.
- Before discharging a mother home, staff organised a six to eight week physical examination for both baby and mother. These were carried out in timely manner and completed by a competent practitioner.
- Women on Folkestone ward advised they were often kept waiting for appointments, but understood it was a busy ward.
- The inspection team found obstetrics rather than gynaecology was an area of potential risk within the hospital.

Access and flow

- Since January 2015, eight clinical areas including gynaecology piloted the Draft Registered Practitioner Led Discharge(RPLD) Policy. The policy enabled trained and competent Registered Practitioner staff to identify patients ready for discharge and complete their Electronic Discharge Notification. Since the implementation of the policy, staff advised they could see the discharge process was more effective. However, figures were not available to show an improvement.
- The trust did not monitor the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour. The National Institute for Health and Care Excellence states analysing a delay of 30 minutes or more between presentation and triage is a method of monitoring a midwifery red flag event. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. As the trust did not monitor this, there was a greater risk management would be unaware of these issues.
- The trust wide bed occupancy levels were worse than the England average. In quarter 4 of 2015/2016, the trust had an occupancy rate of 73% compared to the England average of 60%. Staff stated activity had increased in recent months. Hospital occupancy levels, increased activity and staffing issues resulted in staff feeling the service was "Stretched".
- There was one obstetric operating theatre for both emergency and elective procedures. This led to frequent delays to the elective caesarean list. However, there was a second theatre in the main theatres that was available for emergency caesareans. Therefore, staff were able to quickly respond to women presenting with an emergency.
- If there was an obstetric theatre conflict, staff used the anaesthetic room at the William Harvey Hospital. The anaesthetic room was configured to operate as an operating theatre when an emergency occured. Management advised the main theatres were rarely used but were available should the need arise; main theatres were able to supply a theatre team. There were

plans in place that from January 2017, the hospital would have a second obstetric theatre available. Once established, all elective caesarean sections were to be performed within dedicated obstetric facilities.
- There are formal plans from January 2017 where the WHH will have a second obstetric theatre available. Once this is established we will be able to perform all elective caesarean sections within dedicated obstetric facilities.
- Women were invited to have a tour of the place they planned to give birth, for example, the midwife led unit, at 37 weeks. This ensured women knew where to go as well as ward checking in procedures before going into labour.
- Women were provided with contact details for a 24hr labour line that they could call when they went into labour but were not yet sure whether to present at the hospital.
- In 2015/16, the percentage of pregnant women accessing antenatal care seen within 10 weeks was 34% compared with the percentage seen within 20 weeks, which was 83%. The National Institute for Health and Care Excellence states in 'Quality Statement 22 Statement 1 services access to antenatal care' that service providers must ensure that systems are in place to support pregnant women to access antenatal care, ideally by 10 weeks 0 days. As 34% of women were seen within this timeframe, the trust was not ensuring these systems were in place.

Meeting people's individual needs

- Information leaflets were available in Braille, large print and audio. The trust provided documents in various languages on request.
- Staff were able to support women whose first language was not English by using a 24-hour translation and interpreting service. Staff in the antenatal ward advised us they pre-booked interpreters when they knew a woman was presenting who did not speak English. Staff advised the service was responsive and easy to organise.
- In order to better identify and tackle domestic violence, new posters were being designed for display on wards. Staff advised us they asked women about domestic violence issues at least twice between first antenatal appointment and discharge after birth. We saw evidence that confirmed this.
- Women and their partners were provided with an information pack detailing; what to expect from their community midwife and a leaflet regarding 'Concerns about your baby' and 'How to recognise post-natal depression'.
- The hospital provided specialist equipment, advice and treatment for bariatric patients. We saw the bariatric policy, which included information on; moving and handling, admission and discharge. Staff advised us equipment such as specialist beds and mattresses was readily available from the equipment library.
- The trust completed the Quality Standard of Intrapartum Care in December 2015, which showed women having skin-to-skin contact with their babies after birth was an area of non-compliance requiring action. In response to this, the trust introduced staff training in skin-to-skin contact; appointed an infant feeding coordinator and implemented kangaroo care. Staff we spoke with knew the benefits of skin-to-skin contact and patients advised us they had been supported and encouraged to provide kangaroo care. These initiatives supported the trust in achieving level 1 in the BFI Baby Friendly Hospital Initiative and are currently working towards level 2.
- Women transferring between units were required to use public corridors and lifts, which affected privacy and dignity. Staff advised they were not informed if a lift was out of order but stated there were enough lifts that a woman would not be delayed in receiving care if a lift was not working.
- Delivery rooms on the labour ward had no en-suite facilities. Mothers had to cross the main corridor to use the toilets and bathrooms.
- On our previous inspection, we noted there were no facilities for partners on the delivery suite. On this inspection, each room had recliner chairs ensuring there was space for partners to sleep next to women on the ward.
- The birthing pool on the delivery suite took 45 minutes to fill, had no set temperature and no automatic fill. Therefore, a lot of staff time was taken up ensuring the temperature was correct and the pool did not overflow and was not very responsive to women in labour waiting to use the pool.
- The bereavement room on Folkestone ward was just off the main corridor. When the door was closed, we were able to hear babies crying in other parts of the ward. Therefore, the bereavement room was not ideally

located for grieving parents. The Department of Health recommends women and their families should have access to appropriate facilities should they suffer bereavement where they can grieve the loss of their baby at any stage of pregnancy. A woman who has lost her baby should not be accommodated on a ward where there are new mothers. In-patient facilities should be away from the birthing area and include a separate exit from the ward, for use in the event of bereavement. Therefore, the hospital was not meeting this standard. However, a new bereavement suite was being planned at the hospital with the support of the precious memories charity. The hospital was looking to open the suite by the end of 2016.

Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas. We saw information on raising complaints was readily available on all wards and departments we inspected.
- Staff we spoke with were aware of the trust's complaint policy and how to support patients if they wished to raise a concern or make a formal complaint. Staff told us that they usually received feedback from a complaint they had been involved in. Staff told us they rarely received complaints and that feedback was usually positive.
- Patients we spoke with told us they would raise any issues or concerns with the ward staff in the first instance, but they knew there was a formal complaints process available if needed. We spoke with patients who had raised concerns, and they told us they felt listened to and their concerns addressed.
- We reviewed complaints made between June 2015 and June 2016. Patients had made 52 complaints about maternity and gynaecology services at William Harvey Hospital, with seven complaints over the same period at Kent and Canterbury Hospital. There were no discernible themes or trends on either site.
- During our inspection, staff were unable to provide examples where policy or practice had changed because of a complaint.

Are maternity and gynaecology services well-led?

Requires improvement

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

- Risk management and quality measurement were not always dealt with appropriately or in a timely way. Risks and issues described by staff did not correspond to those reported to and understood by leaders.
- Staff satisfaction was mixed. Staff did not always feel actively engaged or empowered despite management improvement plans.

However;

- Staff were aware of the vision and values of women's services as well as the departments strategy for the future. However, at the time of our inspection, some parts of the strategy were not being achieved.
- Staff reported an improvement in culture since our last inspection. However, we were advised there were still pockets of staff who behaved inappropriately.

Vision and strategy for this service

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

Governance, risk management and quality measurement

- We found a number of areas where the trust was unable to show effective data collection, as reported figures did not reflect what we found on the wards. For example, the number of surgical abortions recorded by the hospital, which showed 28 carried out at Kent and Canterbury Hospital and 212 at William Harvey Hospital between April 2015 and March 2016. However, we found

this was a data error as the figures included women who had miscarried and had a surgical evacuation. Therefore, management were not collecting accurate data of departmental activity.
- Management advised us the reason 1 in 5 women were not receiving 1:1 care in labour was due to staff sickness. However, we saw no action planning for how the trust was to improve this figure.
- We saw minutes for the Women's Health Clinical Governance Forum for April, May and June 2016. The meetings included regular items on the agenda including; incidents, risk register, clinical audit programmes and maternity and gynaecology guidelines. All actions were allocated to a responsible individual and the item chased up at the following meeting.
- A range of patient safety and quality issues across women's health services were reviewed monthly including; clinical effectiveness reports such as mortality and morbidity meetings, health and safety, audits, quality and performance data, infection control, patient experiences, training, HR, trends from complaints and patient surveys.
- There was a full time maternity governance lead who reported to the specialist services governance framework and through the trusts governance framework to the Board.

Leadership of service

- Women's services was led by; a clinical director who was supported by a consultant site lead at William Harvey and Queen Elizabeth the Queen Mother Hospitals; a service lead who worked with two site operations managers; the deputy head of midwifery was a new managerial role that supported the head of midwifery and gynaecology nursing.
- We were shown the maternity department's improvement journey, which showed they had made improvements regarding; environment and equipment, women and partner experience and capacity. However, areas which still required improvement included; cultural change, staffing and medical leadership.
- Staff throughout women's services stated ward level management was approachable and were highly thought of and respected. Staff in the Singleton Unit particularly praised the unit co-ordinator. Staff advised us there had been an improvement in the visibility and accessibility of higher-level management, such as the chief executive, since our last inspection. However, staff stated there was still some disconnect between those working on the wards and higher management within the department. For example, when staffing issues were reported, ward staff felt there was not enough escalation and management had a "get on with it" attitude.
- Leadership had implemented new incentives, which were not always practical and "Died off." For example, on Folkestone ward patients had been noted as stealing equipment. In response to this staff were given suitcases of equipment to carry around, however it was not practical and staff eventually stopped carrying suitcases, although officially the policy was still in place.
- Staff reported there was an increase in experienced midwives leaving the trust due to staffing levels, increased activity and working on "goodwill." Management confirmed exit interviews were optional and they did not analyse trends regarding reasons staff left the trust. Therefore, management were unaware of and therefore unable to respond to issues, which resulted in staff leaving the trust.

Culture within the service

- At our last inspection, we saw there was an ingrained bullying culture at the William Harvey Hospital. On this inspection, staff reported an improvement, stating management were "Trying to deal with the issue." However; we found there were still pockets of staff who spoke inappropriately to co-workers. We were advised that some staff who had worked at the trust for many years were "set in their ways." Staff stated although they did not approve of the behaviour, that they had grown to accept it.
- Staff morale within women's services was mixed and varied greatly from ward to ward, with the main issue being staffing levels. More than one member of staff advised us they were "firefighting" to keep up with demand.
- Staff felt they formed an effective team within their wards and worked well with the community midwives. One staff member said, "It's busy but enjoyable, everyone pulls together." However, some staff told us that there were tensions between ward teams when struggling with staff shortages within the service. This was heightened when the service was busy.
- The trust implemented a 'cultural change' leadership programme for divisional management teams. There

was also the 'getting started' programme which focused on how managers could support cultural change. Band 8 and 7 managers had already attended this training and at the time of inspection, the programme was being rolled out to band 6 managers.
- Staff from the labour ward orientated on to the midwife led unit to get better understanding of how the unit operated. This provided insight into the environment as the midwife led unit was called on when the labour ward was short staffed. Staff we spoke with advised the initiative had improved the "Them and us" culture.
- Staff in different parts of women's services advised us that when things went wrong, such as incidents and clinical mistakes, this often resulted in disciplinary action. Staff felt this encouraged a "blame culture."
- However, good practice and achievement was shared and celebrated at team meetings. For example, Family and Friends Test responses often referred to specific members of staff. These were shared within the department.
- When asked 'What three words best describe the culture of the trust?' Our most common responses were "Good Team", "Hard working" and "Caring."

Public engagement

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

Staff engagement

- Women's Health had created a staff charter, which looked at nine elements which staff believed contributed to making the trust 'A great place to work'. Elements of the charter included; 'I am well managed and led' and 'I have a voice and am listened to'.
- The trust re-launched its 'Respect' programme, which was aimed at supporting open communication between staff. Workshops took place in June, July and August 2016, which showed the trust commitment to 'I am part of and supported by my team' as detailed in the staff charter. However, staff felt the workshops did not do enough to address issues within the department.
- Staff advised us they felt more engaged with middle management since the trust had introduced a deputy head of midwifery. However, some staff reported they felt those who were friendly with senior management were more likely to get a promotion.
- The trust had introduced bullying champions, an impartial member of staff who was available for peers to discuss any bullying culture experienced within the trust. They were used as a reference to provide further support and mediation if required. One member of staff said, "Getting bullying champions has helped. There is definitely a changing culture."

Innovation, improvement and sustainability

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

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 William Harvey Hospital (WHH), SPC team. In addition there were two clinical nurse specialists (CNS) who were based at the WHH, however, at the time of the inspection, only one CNS was in post with another due to take up post. The end of life facilitator; counsellor and social worker 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: Cambridge M1 and M2, Cambridge J and K, Kings ward B, Richard Stevens and Oxford wards, Accident and Emergency, Intensive Care unit and the Clinical Decisions Unit . We also visited the relative support office, mortuary, chaplaincy, and the porters lodge.

We reviewed the medical records of 10 patients who received end of life care. We spoke with 30 members of staff which included junior doctors, clinical nurse specialists, registered nurses, end of life facilitator, a relative support officer, ward matrons, medical director, heads of nursing and porters to assess how end of life care was delivered.

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

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

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

End of life care

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

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

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

Summary of findings

We rated this 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. These concerns had not changed since the last inspection.
- We found an array of service improvement initiates had been introduced across the trust since the last inspection. This included end of life care plan documentation, the appointment of an end of life facilitator, identification of end of life care link nurses, and a decision making end of life board. A stall at the Quality, Innovation and Improvement hub was used 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.
- Since the last inspection, we found the training of junior and speciality doctors had improved with the SPC team invited to divisional meetings. 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 and poor completion of nursing notes which made it difficult to access if patients were being reviewed regularly.
- There were no mental capacity assessments in place for vulnerable adults who lacked capacity. Do Not Attempt Cardio-Pulmonary Resuscitation (DNA CPR) orders were being countersigned by Registered

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Nurses (RN) without support being put in place around training and where a patient was identified as dying it was often confusing for staff as in many cases interventions were still being delivered.

- End of life training was not part of the mandatory training programme. We found some nursing staff on the wards had received training whilst others had not. A RN in Accident & Emergency commented end of life care was poor on the unit. 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. Staff in Accident and Emergency told us communication between the hospital, ambulance service, and GP's needed to improve to prevent inappropriate admissions to hospital
- 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..

Are end of life care services safe?

Requires improvement

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

- Staff understood their responsibilities to raise and report concerns, incidents and near misses. They were clear about how to report incidents and we saw evidence that learning was shared across the teams. However, the IT system was still slow with some staff suggesting not all incidents were reported because of this. This has not improved since the last inspection.
- Generally, we found out of date syringe driver prescription charts were no longer in use as raised during the last inspection. However, we found old syringe driver prescription charts in the Clinical Decisions Unit.
- A greater proportion of patients who were dying were recognised however; we found the decision often left staff confused as active treatments were still being delivered. Experienced staff were able to question practice 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.
- No seven day, face-to-face access to the SPC team was available which meant that processes out of hours were often difficult, and time consuming which could delay treatment times for patients and leave them with uncontrolled symptoms for long periods.
- Syringe driver prescriptions were inconsistently completed with long intervals between checks. This highlighted inconsistent practices across the wards we visited.

However, we found improvements since the last inspection these included:

- Portering training had improved since the last inspection. Porter's had received training around new trust policies and when new equipment was introduced.

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- 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.
- During the last inspection, the last offices policy was not embedded into clinical practice. Mortuary staff participated in a 'task and finish group' which led to the redesign of the '10 steps form' used by the nursing staff on the wards along with a communication campaign at the Quality, improvement and innovation hub(QIIH).

Are end of life care services effective?

Requires improvement

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

- Staff understood their responsibilities to raise and report concerns, incidents and near misses. They were clear about how to report incidents and we saw evidence that learning was shared across the teams. However, the IT system was still slow with some staff suggesting not all incidents were reported because of this. This has not improved since the last inspection.
- Generally, we found out of date syringe driver prescription charts were no longer in use as raised during the last inspection. However, we found old syringe driver prescription charts in the Clinical Decisions Unit.
- A greater proportion of patients who were dying were recognised however; we found the decision often left staff confused as active treatments were still being delivered. Experienced staff were able to question practice 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.
- No seven day, face-to-face access to the SPC team was available which meant that processes out of hours were often difficult, and time consuming which could delay treatment times for patients and leave them with uncontrolled symptoms for long periods.
- Syringe driver prescriptions were inconsistently completed with long intervals between checks. This highlighted inconsistent practices across the wards we visited.

However, we found improvements since the last inspection these included:

- Portering training had improved since the last inspection. Porter's had received training around new trust policies and when new equipment was introduced.
- 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.
- During the last inspection, the last offices policy was not embedded into clinical practice. Mortuary staff participated in a 'task and finish group' which led to the redesign of the '10 steps form' used by the nursing staff on the wards along with a communication campaign at the Quality, improvement and innovation hub(QIIH).

Incidents

- 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 that there had been no change in the workings of the reporting system.
- The trusts incident reports for July 2015 to July 2016 consisted of 53 incidents relating to end of life care, with 18 incidents reported at the William Harvey Hospital. Incidents reported included lack of medical staff to review end of life patients in a timely manner, long fast track process, and the late prescribing of end of life care medication resulting in poor symptom control management. From the data submitted, we were unable to see what actions taken to prevent similar incidents happening in the future.
- Lessons learnt from these events were regularly communicated through handovers and staff meetings. On Oxford ward, the ward manager described incidents, which had taken place on the ward; these included falls, incorrect and missed medications. Learning took place at ward meetings once every six to eight weeks. We reviewed the ward meeting minutes of June 2016 where top trust risks, incidents, safeguarding's, general ward issues, and end of life care learning were discussed.

End of life care

- The mortuary provided data about incidents across all three sites from July 2015 to June 2016. 48 incidents had been reported in the last year with 15 incidents having taken place at the WHH mortuary. The majority of the incidents reported were around failures in identifying deceased patients correctly and infection control procedures.
- We reviewed end of life board minutes and saw these incidents had been highlighted and extra training was to be introduced as part of the 'back to basics' nursing programme. However, reviewing the end of life board minutes we saw that ward incidents related to end of life care were not regularly discussed. However, a SPC CNS has told us that incidents had been recently introduced and were now being discussed at the end of life board, which had led to further training on a ward regarding the use of syringe drivers. We saw no evidence of this in the minutes we reviewed.
- During the last inspection, it was highlighted the last offices policy had not been embedded across the trust. This had resulted in mortuary staff participating in a 'task and finish group' for last offices procedure which led to the redesign of the '10 steps form' which was used by the nursing staff on the wards along with a communication campaign at the QIIH.
- Mortuary staff told us they had seen improvements since the last offices procedure was embedded with fewer incidents reported. If an incident takes place at ward level, mortuary staff would contact the manager and offer nursing staff to 'walk the path'. Mortuary staff attend the QIIH's /drop in sessions to educate staff.
- 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 WHH. This was recorded on the portering companies 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 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 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 didn't always learn on time that a deceased patient had had an infection.

Environment and equipment

- Staff told us they had access to equipment needed for caring for patients at the end of their lives including syringe drivers, pressure relieving air mattresses, and air cushions. These were readily available through the equipment library. Staff on the wards told us that there were no issues securing equipment in and out of hours to support patients.
- The trust used nationally recommended syringe drivers to deliver consistent infusions of medication to support patients with complex symptoms. Patients were discharged with the syringe driver in place. This did raise issues as the syringe drivers were not being returned to

the hospital after use. However, by discharging a patient home with a syringe driver in place meant patient's symptoms were keep 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%.
- Access to the WHH mortuary was through key fobs. The mortuary was accessible by mortuary staff including consultant pathologist, porters, and estates staff.
- We saw records in the mortuary confirming hydraulic trolleys and hoists were regularly serviced. There had been no issues replacing damaged equipment.
- Mortuary fridge temperatures were managed electronically. On-call mortuary staff were able to view the temperatures remotely. If the fridges were outside the range after a set time, the on call technician would visit the site. The electronics and medical engineers were available in and out of hours to check for faults and an engineer from the fridge supplier was available.

Medicines

- Patients receiving end of life care were prescribed anticipatory medicines to enable prompt symptom relief at whatever time the patient develops distressing symptoms. The SPC team had introduced 'guidance for patients in the last hours or days of life', which set out the management of patients who had been recognised as dying. The guidelines gave easy to follow instructions on the drug management of symptoms in the dying patient. We saw that guidance was available in the ward resource folder and on the end of life care web page. On Richard Stevens, Oxford, and Cambridge K wards we saw end of life patients had been prescribed anticipatory medications.
- On Kings Ward B we reviewed a patient's medical notes. We saw that the appropriate end of life drugs were prescribed by the SPC team during their review of the patient however, we saw a delay in these medicines being prescribed of three days from when end of life care was commenced.
- A RN on Richard Stevens ward told us that PRN (as needed) medication was prescribed for end of life patients and we saw this was in place in the four prescription charts we reviewed. If more than three PRM's were 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. Patients symptoms were reviewed two hourly along with checking the syringe driver. However, on Kings B ward we found syringe driver prescriptions were inconsistently completed with long intervals between checks. This highlighted inconsistent practices across the wards we visited.
- A RN on Richard Stevens ward told us that PRN (as needed) medication was prescribed for end of life patients and we saw this was in place in the four prescription charts we reviewed. PRN stands for 'pro re nata' and refers to mediation that should be taken only as needed. If more than three PRN's were 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. Patients symptoms were reviewed two hourly along with checking the syringe driver. However, on Kings B ward we found syringe driver prescriptions were inconsistently completed with long intervals between checks. This highlighted inconsistent practices across the wards we visited.
- One junior doctor (CT2) told us end of life resources were good. Training and support were provided by the SPC team and the prescribing of anticipatory medications would be prescribed once symptom control management commences towards the end of life (days).
- Medical teams could contact the SPC team if patient symptoms persisted, or the patient had a complex medical condition such as diabetes. We saw that guidance was in place to support patients with end stage renal failure and heart failure.
- Staff on the wards we visited told us medication for end of life care was available on the ward and was easily accessible. We observed locks were installed on all storerooms, cupboards, and fridges containing medicines and intravenous fluids. Nursing staff held medication cupboards keys.
- We saw controlled drugs were handled appropriately and stored securely demonstrating compliance with relevant legislation. Staff working on the wards we visited regularly checked controlled drugs. We checked the contents of the CD cupboard against the controlled drug register on two wards and found they were correct.

End of life care

- 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 majority of prescription charts, we reviewed during the inspection we found a sticker had been introduced referring to the correct syringe driver now in use. However, on the Clinical Decisions Unit we found an old syringe driver prescription chart still in use.

Records

- We reviewed the paper medical records of one patient on Cambridge K ward receiving end of life care. The medical records had documentation demonstrating the SPC team had supported and provided evidence-based advice, for example, on complex symptom control and support for the patients and families as they pass along the care pathway. This specialist input by the SPC team ensured that a high level of expertise was used to ensure evidence based care was delivered to end of life care patients. The staff on the ward were completing the 'end of life care record' daily which demonstrated possible symptoms with comfort measures including food and oral care were being reviewed four hourly.
- The 'record of the end of life conversation' (RELC) documentation was not in use at the time of the last inspection but had been introduced across the trust in December 2015. On Cambridge K ward, the patient's records we reviewed, we saw the RELC form had been completed by the registrar.
- The RELC document, when completed, would be faxed to the general practitioner (G.P) and the SPC team. We found no evidence in the patients' medical notes that copies were faxed to the GP or the SPC team.
- On Cambridge J ward, the documentation of end of life records was good however, in a set of records we reviewed, we found the patient was close to death suggesting that end of life care should have commenced earlier. We found the medical and nursing patient records difficult to navigate however, we found a good conversation with the patient and family recorded and a plan of care agreed by the all concerned.
- We reviewed the medical records of five patients on Richard Stevens and Kings ward B. We found inconsistencies on when patients were considered to be nearing the end of their life with treatments still being delivered causing confusion. We also found consultant reviews were not always performed in a timely manner.
- On reviewing patients, medical records we did see 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.
- On Cambridge K ward, we found the ward staff were using the end of life care record. The care record was commenced when the decision was made to place the patient on end of life care. We saw care records were completed for each day the patient was in receipt of end of life care.
- As part of clinical audit data, the SPC CNS, following a patient review, would place information onto an electronic palliative care episode summary sheet. Information documented included diagnosis, date of referral, investigations, spiritual and social needs. This would be completed and placed in the patient's medical records.
- In nine patients' medical records, we found Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) orders at the front of the medical records allowing easy access. However, we did see 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 no copy of the order was kept in the clinical notes as a record.
- Medical records were stored securely and patient confidentiality was protected. 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 were able to demonstrate their knowledge and understanding of safeguarding vulnerable individuals, including signs and symptoms and the action to be taken.

- On Oxford ward we saw records which confirmed adult safeguarding training was at 57% compliance with children's safeguarding training at 90%.The adult safeguarding training is below the trust target and needs improving. On Cambridge K ward the adult safeguarding was at 97% compliance.

Mandatory training

- All of the SPC team and mortuary staff were up-to-date with their mandatory training. The majority of the mandatory training was e learning with some face-to-face training.
- 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 generalist 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 that 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 on this inspection that there were still issues when staff tried to access the IT system for training.

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 Cambridge K ward staff were able to demonstrate the system; we saw one patient receiving end of life care had monitoring reduced to a minimum. We saw in the last two days observations were stopped following the medical consultants ward round.
- For patients, where the progression of their illness was clear, the amount of clinical intervention and observations were reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible, at all times. 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. On Cambridge K ward we saw in the last two days, monitoring had been stopped following the consultants ward round on a patient receiving end of life care.
- 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 the decision, the use of ventilation and haemofiltration, 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. On Richard Stevens ward we reviewed the medical notes of four patients and found no ceilings of care clearly documented despite the patients having severe medical conditions.
- Staff on Cambridge M2 told us doctors was not completing ceilings of care and no handover plans were in place for the weekends or out of hours. The head of nursing for specialist services told us the ceiling of care was part of the end of life board agenda as it had been recognised they required a more consistent approach around ceilings of care.
- On Oxford ward, we observed a surgical consultant reviewing a patient prior to the Thursday MDT to ensure the appropriate decisions had been made regarding the management of the patient. The review was clearly documented in the patient's medical records with clear instructions of the patient's management plan.
- We reviewed a set of patients records and found that a 'rounding checklist' was in place .This included checks for pain, comfort and food or drink.. However, we found there was poor completion of the rounding checklist.
- We found inappropriate reasons for putting DNA CPR orders in place including fragility and dementia.

Nursing staffing

End of life care

- The clinical nursing staff levels of the SPC team had not changed since the last inspection with a trust-wide nurse consultant and one SPC CNS presently at the WHH site. No cover was available for annual leave or sickness for the nurse consultant role. The nurse consultant covered holiday periods for the 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, including complex symptom control, patient involvement in decision-making and to deliver education and training to the staff across the hospital.
- End of life care 'link' nurses were available on individual wards. We were told that 100 link nurses had agreed to take on the role during the inspection.
- An end of life facilitator had been recently appointed to the team. This role would spend one day each week on each site and any extra time would be spent where support was needed. This role was not a clinical post but supported the training and education needs of all staff across the trust.
- Two McMillian funded nursing posts had been put on hold by the trust. Discussions were still taking place to decide the best role to support the SPC service across the 3 sites.
- Nursing staff told us that there were insufficient numbers of staff to ensure that needs of patients were meet. Staff told us that no extra staff were allocated when end of life patients were being nursed on the wards.
- A counsellor and social worker were part of the SPC team. They provided support across the three sites.
- There had been no increase in the salaried chaplains since the last inspection. A good network of volunteers and seven sessional chaplains were available.
- The porters told us they do not have enough at night (two porters). During the inspection we were told there was currently nine vacancies and two new recruits commencing soon.

Medical staffing

- There was 0.2 WTE palliative care consultant visiting WHH 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 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 plan.
- Mortuary staff told us that if demand was high across the trust 24 extra spaces were provided at WHH mortuary. If all fridge spaces were occupied, mortuary staff would work with funeral directors who would accommodate up to six patients per site within the hour throughout the week.

Are end of life care services caring?

Good

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

End of life care

- Staff at WHH 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.
- Mortuary staff reported the nursing staff appropriately prepared deceased patients after death in line with hospital policy. Nursing and Mortuary staff confirmed hospital porters transferred deceased patients to the mortuary in a discreet and respectful manner.
- We found ward staff 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.

Compassionate care

- 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 end of life care board have discussed the findings and actions sanctioned which include the end of life on line training modules to be agreed to improve advance care planning, symptom control, communication and the management of the last days of life and SPC CNS to target ward hot spots and improve end of life care across the trust.
- The survey asked bereaved relatives a variety of questions to gain an understanding of the care delivered across the trust. The areas covered included the overall quality of care, communication, dignity and respect, emotional care, spiritual care and symptom control. From the survey, 81% of the bereaved relatives reported the overall quality of care delivered was good to excellent with only 5% reporting care was poor.
- With regard to communication, 85% of bereaved relatives reported family members were kept informed of their loved 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.
- The critical care team described how they routinely write 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. The unit have recently surveyed bereaved relatives. However only one bereaved relative responded.
- During the inspection, we were able to observe an end of life care patients being reviewed by the SPC CNS on Oxford ward. The SPC CNS performed the review in a sensitive, caring, and professional manner, engaging well with the patient. During the patient consultation, a holistic assessment was undertaken which covered PPC, pain management, medication prescribed, symptoms and any emotional needs. The SPC CNS explained to the patient that on the next family visit there would be a consultation with the family with the patients consent.
- 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 influenced the overall service.
- We spoke to a relative on Cambridge J ward who told us they were treated very well and care has been wonderful. The relative said staff always listened to the family concerns and wishes. The patient was very comfortable, being nursed in a bay however the plan was to move to a single room.

End of life care

- On Cambridge K ward, the nursing staff told us the porters were very respectful when transferring patients from the ward to the mortuary. Porters draw the curtains when transferring deceased patients on the wards. At all times dignity was maintained, a single sheet covered the deceased patient in addition to the shroud.
- Hospital porters transferred deceased patients to the mortuary in a discreet and respectful manner. The mortuary staff ensured, from the documentation, that any particular religious or cultural wishes were respected. Mortuary staff said the porters treated the deceased patients with respect during the mortuary processes.
- The RSO was introducing a survey to bereaved relatives to monitor the service. This was in response to the recent bereavement survey. Relatives spoke about delays in getting the medical certificates of cause of death (MCCD) and how relatives felt they were handled in a rushed manner.
- The same survey suggested relatives did not always feel conversations were conducted in a sensitive manner by the medical staff. Medical staff received extra training.

Understanding and involvement of patients and those close to them

- We reviewed ten patient medical records and saw patients referred to the SPC team were kept actively involved in their own care and relatives were kept involved in the management of the patient with patient consent. On Cambridge J ward, we observed a comprehensive discussion with the family and a care plan agreed. The discussion was documented in the medical records.
- The ward manager of Cambridge K ward told us that staff liked 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 loved ones included mouth care and making sure the patient was supported to lie comfortably. Relatives could be asked to support their loved ones at meal times.
- On the wards we visited staff were not involved in preparing advanced care plans with patients and their families. As part of the interagency policy GP's and community nurse team leaders were expected to ensure anticipatory & advance care plan (ACP) were completed and agreed with the patient, carer or family. However, we saw no ACP in place during the inspection.
- On two wards we visited, the ward managers told us 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 two skills which supported several NICE Guidelines in Oncology. This highlights the provider supported staff to gain the knowledge and skills

required to meet the needs of patients requiring palliative and end of life care.

- The trust counsellor and social worker linked closely with the local hospices. This enabled them to signpost patients towards community support after leaving the hospital. These included bereavement counselling and support groups as well as local site-specific tumour groups.
- The Chaplain was available to provide spiritual and religious support when asked by the patient/families and medical and nursing staff. There were trained volunteer chaplains who provided further support to patients and staff.
- 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.

End of life care

Are end of life care services responsive?

Requires improvement

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

- In the wards we visited, 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. However, during the inspection the majority of patients receiving end of life care were being nursed in bays as single rooms were not available. This meant there was little privacy from surrounding patients, relatives, and the workings of the bay for patients 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. However, we did see an increase in the number of certificates meeting the target through service improvement initiatives.
- During the last inspection, it was highlighted that there were delays in discharging patients to their 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, we found the timeliness of installing equipment at home had improved and care packages could be requested in four hours. However, if patients PPC were 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 found improvements since the last inspection these included::

- 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 above the national average of 28%
- During the 2016 audit of the end of life record of conversation documentation it was found the PPC was discussed in only nine out of the fifteen forms completed, this was a 60% compliance rate. This had increased from the 2015 audit where there was only 33% compliance. Discussions about PPC are vital if the wishes of patients and their families are to be fulfilled
- The SPC nurse consultant sat on the group that developed the interagency policy. By being part of this policy group the trust could ensure their services were developed to meet the needs of the local community and help more people at the end of their life to be cared for and die in the place of their choice.
- On the WHH site, a suite was available specifically for relatives of patients receiving end of life care. The suite consisted of a sitting room, a shower, and a kitchen with access to a garden. They provided a place of quiet and peace for relatives to rest, freshen up, and make themselves drinks.

Service planning and delivery to meet the needs of local people

- The four East Kent Clinical Commissioning Groups (CCGs) had an end of life work stream group. The SPC Consultant Nurse attended the East Kent CCG work stream in order to feed back into the end of life care board at the Trust in order to deliver a service that meets the needs of the patients that are admitted to hospital.
- An interagency policy was in place across all the providers in East Kent. This policy ensured services was developed to meet the needs of the local community and help more people at the end of their life to be cared for and die in the place of their choice.
- There was no dedicated specialist palliative care ward. People reaching the end of their life were nursed on the main wards in the hospital
- 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 with infectious conditions took priority. On the wards, we visited the majority of end of life patients were being nursed in bays.

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- If a patient was nursed in a bay, privacy was maintained by keeping the curtains drawn, if requested by the patient or family.
- The trust had opened a suite on all three sites specifically for relatives of patients receiving end of life care. The suites consisted of sitting rooms, a shower, and a kitchen with access to a garden. They provided a place of quiet and peace for relatives to rest, freshen up, and make themselves drinks. Staff on the various wards we spoke to were able to tell us they signposted relatives to the suite.
- On the critical care unit, staff told us they had access to a flat in the nurse's residence consisting of two bedrooms and shared kitchen and lounge. This was available to families staying over with their relatives.
- On the wards and critical care unit, no camp beds were available for relatives to stay by the bedside. Families would have to use the chairs available at the bedsides.
- We found little evidence of family rooms on the wards. Staff would use the day room or nursing/doctor's room to provide a quiet place for relatives. These rooms did not always provide the appropriate surrounding and privacy relatives required at such a time. On Cambridge K ward, we found the nurses room to be small and cluttered and did not provide the surroundings necessary to support families at this difficult time. However, we were told the 'reflection room 'on Richard Stevens ward can be used. This room was re furnished by donations from a relative of an end of life patients and was available to break bad news.
- We saw a room in A&E was available to perform the last offices on deceased patients.
- 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 and would had processes in place to ensure adequate storage spaces were available at all times.
- The Human tissue Authority inspected the mortuaries across the trust. The inspections took place every four years. The last inspection took place in November 2012 and all actions (minor) were completed. The next inspection is due October 2016.

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Meeting people's individual needs

- There was no electronic system to alert the SPC team if a palliative care or end of life patient was admitted, the ward staff would make the necessary electronic referral to the SPC team if their support was required. In Accident and Emergency (A&E) if an end of life patient was due to be admitted ,the link nurse would contact the SPC team however most SPC reviews would take place when the patient arrived on the wards.
- All patients with complex symptoms within the trust who required end of life care had access to the SPC team. Referrals were accepted from any member of the health care team or by self-referral. Consultation with the patient's hospital consultant or a doctor in the team would be attempted on referral and after the assessment. Referrals to the SPC team could be made by telephone, bleep or electronically on the hospital management system.
- Once a patient was referred to the SPC team, treatment and care took account of the patient's individual needs. This could be working in conjunction with other specialist nurses to support patients with complex symptoms as well as those with complex needs being cared for by generalist teams. On Cambridge K ward, the ward manager told us that the heart failure nurses remain closely involved with the patients and liaise with the GP's and community teams if patients are due to be discharged to their PPC.
- 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 inspection, we were able to observe a patient being reviewed by the SPC CNS. The SPC CNS planned with the patient's consent to speak to the family on their next visit to the hospital.
- On two of the wards that 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 each ward we visited, staff spoke of the need for opening visiting hours for families whose relatives were receiving end of life care. On Cambridge K and Oxford wards, staff confirmed that visiting hours were between two and eight pm however for patients receiving end of life care families were able to come in outside these hours. During the inspection, we observed family members visiting throughout the day.
- Staff on Cambridge K ward told us that relatives were updated daily on their relative's condition when they

visited and if contact was made with the ward. For patients who had no family visiting and were approaching the end of their life, a member of staff would be allocated to support the patient and be by their side.

- After a death had occurred, relatives were given a bereavement leaflet called, 'Help the bereaved, A practical guide for families and friends' and the number of the nurse in charge of the ward as they left the hospital. The families would be asked to contact the relatives support officers (RSO) who would confirm the details and arrange an appointment to collect their relative's belongings and the medical certificate of cause of death (MCCD).
- Staff told us relatives could stay on the ward after a patient died to help with the after care of the deceased patient. However, we were told that this rarely happened in practice.
- A porter told us that two porters would transfer a deceased person to the mortuary out of hours as per hospital policy. For access to mortuaries, the porters were provided with a key fob or pin codes.
- The Relative Support Office was open from 10 am to 4 pm Monday to Friday. The RSO booked all appointments for families following a death, liaised with funeral directors and ensured that the medical records and all documentation was in place for the doctors to complete the MCCD which enables the deceased's family to register the death. Information leaflets such as the "The funeral funding service" was available and given to relatives when required.
- The relative support officers told us the MCCD was available for relatives ideally within the trust target of three days, or slightly longer if the death happened at the weekend. However, this did not always happen and there had been delays in releasing the MCCD. We reviewed the data and found at WHH for July 2016, 66 certificates were issued of which 16 certificates took between 3-6days, 47 took 24 hours, and three took 36 hours .A RSO told us the time taken to issue a MCCD had improved since consultants had taken a more pro-active role in promoting this at junior doctor's induction. The trust has plans to extend this by introducing a routine slot in the junior doctor's induction. Consultants also chase up junior doctors on a daily basis to speed up the process however further work was required to further improve the MCCD issue times for relatives.
- The RSO explained they work with the chaplain to meet requests for next day funerals such as for patients from the Muslim or Jewish faith. Relatives normally understood if an MCCD could not be issued within 24 hours however, RSO try to speed up the process to meet their needs.
- The RSO told us children who have lost a parent were dealt with by the staff in the wards/departments and the coroners team. For patients who have no relatives the RSO investigate by using "Finders" to establish if the patient has a family or not. The chaplain was contacted and a 'contract funeral' will be organised .The funeral costs were covered by the trust.
- Families attending for appointments were escorted to a quiet room for discussion, advice, and information. Patient belongings were stored there.
- The Chaplain was available on site from 9am to 5pm Monday to Friday. An on-call service was provided for out of hours. We saw on Kings Ward B a request was made to the chaplaincy in the morning and the priest visited the ward on the afternoon highlighting the responsiveness of the service. In A&E staff told us that there was little focus on the cultural and religious needs of the patients.
- During the last inspection, we visited the mortuary and observed the viewing suite where families came to spend time with their relatives after their death. The waiting area had neutral décor to take into account all faiths. Religious symbols were displayed when requested. There were comfortable seating, water, and tissues available. A call bell is available for the family. Information leaflet "funeral funding service" was available for relatives. A bible was available when requested. Staff will receive support and direction from the chaplaincy with any other religious / cultural requirements.
- Mortuary viewings took place between 11.30am to 15.30pm Monday to Friday. Outside these times, viewing could be arranged in exceptional circumstances, for example, a baby or child. No viewings take place in the evenings, weekends, or bank holidays. Staff will advise relatives that viewing may be affected by noise from tools and unpleasant smells (post mortems) and would encourage viewings after midday because of this. Viewings are supported by mortuary staff and sometimes include RSO administrators.

- Mortuary staff told us they catered for other cultures and faiths. For example, they were able to allow Muslim families to undertake washing of the deceased and a Japanese family to use incense sticks.

Access and flow

- During the last inspection, we noted 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, entering a terminal phase, were supported in their PPC as quickly as possible. Staff told us the discharge process was anything but fast with many patients not achieving there PPC due to the length of time the process took to facilitate the discharge. On the wards visited all staff told us the process took weeks rather than hours or days to complete. On Cambridge K ward, we saw a patient was being discharged home the following day. The process had commenced 11 days earlier.
- There was a multi-professional approach to discharge processes. This included doctors, nurses, physiotherapists, and occupational therapists working together to ensure that patients had all the necessary clinical support and medical equipment in place for the patients discharge. The SPC senior team told us that since the last inspection, installing equipment at home had improved and that care packages could be requested in four hours. However, if patients PPC was a nursing home or hospice delays were introduced whilst a bed became available leading to a long and cumbersome process which could result in the patient not receiving there PPC.
- As part of the interagency work, it was the responsibility of the GP's to identify the patients PPC/PPD. However, this was not always in place .When patients were admitted the 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 only nine out of the fifteen forms completed, this was a 60% compliance rate. This had increased from the 2015 audit where there was only 33% compliance. Discussions about PPC are vital if the wishes of patients and their families are to be fulfilled.
- The trust did not audit the percentage of patients that achieve their PPC or PPD. Patients were discharged to their home, hospice, or nursing home. The SPC team records showed in 2015/16, 49% of patients were discharged home with between 9-12% being discharged to the hospices.
- 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 which was well above the

national average of 28%. This 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 only patients with the most complex needs were referred to the SPC team. This remained unchanged in the last year, as there was no increase in the SPC staffing. The SPC team acknowledged they did not have sufficient resources to support generalist staff to have the skills and confidence to care for patients at the end of life. However, with the appointment of the end of life facilitator and link nurses the skills and confidence of generalist staff was expected to improve.
- The SPCT CNS reviewed patients depending on their needs, offering them support and reviewing their care needs. Patient contacts ranged from 15 to 60 minutes depending on the need of the patient and their families, with many end of life patients requiring more than one contact in a day. Palliative care medicine consultants reviewed complex cases during the twice-weekly ward rounds and spoke to medical teams and carers in-between the ward rounds if required.
- The portering service recorded the time of each patient when removed from the ward to the time the transfer was completed. This was recorded as taking from 30 minutes to an hour for all three sites.

Learning from complaints and concerns

- The end of life care and palliative care service did not receive a high number of complaints. We were provided with the complaints log for the period June 2016 where two complaints were received. Both complaints occurred at the WHH and were related to releasing

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deceased patients after death. We saw measures were in place to ensure similar incidents did not happen in the future. No complaints had been made against the SPC team in the last year.

- The end of life board reviewed end of life complaints. The complaint process demonstrated that systems were in place to respond to complaints in a timely manner. We noted a good governance structure and a service that learned from its complaints. A RN on Cambridge J ward told us they had received a complaint from a family who felt their relative was not monitored enough as they approached the end of their life. The learning from this complaint was nursing staff had to monitor patients even when the family was present.
- The RSO told us if relatives raise concerns regarding the care their relative had received, they would listen to the issue and contact the relevant medical team to meet or speak with the relative. The RSO provides PALs contact details and explains the trust complaint process.

Are end of life care services well-led?

Requires improvement

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

- The end of life strategy for East Kent was a working document. However, the majority of the agenda was to be implemented by the SPC team. The sustainability and success of its implementation is questionable due to the current size of the SPC team and their continuous clinical commitment to support patients with complex symptoms. The trust had been in negotiations with a cancer charity and had secured funding for two further nursing posts.
- Since the last inspection, a clear governance structure was in place to support end of life care. The end of life care board was well represented by a multi-disciplinary membership, which covered a variety of specialities across the trust as well as with outside stakeholders. The terms of reference for the end of life care board had recently been changed and it was now a decision making board.

However, we did not see that end of life care incidents from across the trust were discussed at this meeting. This meant the board did not have a comprehensive overview of the service and an awareness of the wards that were providing the best or worse care.

- No separate risk register was available for palliative /end of life care. A separate risk register would allow the risks to this patient group to be discussed regularly at the end of life board, and allow plans to be made to alleviate any identified risks.
- The service level agreement between EKHUFT and the hospice was still not finalised. The signing of the contact will allow the trust to establish the gaps in their service provision.

However we found improvements since the last inspection these included:

- 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.
- 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.
- Communication had improved since the last inspection. For example, there was a trust general manager on each site and information about the trust was being cascaded to portering staff via the portering manager and supervisors.
- To address end of life leadership at ward level, end of life care was to be led by the end of life care link nurses with support from the end of life facilitator and SPC 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.

Vision and strategy for this service

- End of life care sits in the Specialist Service Division and there was a Trust-wide End of Life Care Board met bi-monthly. The head of nursing and consultant nurse for palliative care attended this board. The four East Kent Clinical Commissioning Groups (CCGs) had an end of life work stream group and was setting the end of life

strategy for East Kent in which the Consultant Nurse for Palliative Care attended so feedback was given to the end of life Board at the Trust. The trust had an improvement plan in place to implement the strategy.

- During the last inspection, we saw the strategy was only available in draft form. The East Kent End of life strategy has now been ratified and was a working document and available to review on the EKHUFT web site. The strategy stated a commitment to improving the end of life experience for patients and their relatives and involved all parties working closely together. It considered an expected increase in demand for both cancer and non-cancer end of life care in the region. This was reflected in the referrals to the SPC team, which have increased, by 16% in the last year.

Governance, risk management and quality measurement

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

Leadership of service

End of life care

- 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 where circulated to the trust board.
- Staff we spoke to across the trust were passionate and committed to delivering quality care to patients and their families at this difficult time. However, we found this was still frequently managed in an ad hoc and reactive manner as need was recognised. To address this at ward level, end of life care was to be led by the end of life care link nurses with support from the end of life facilitator and SPC 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 through an education programme.
- We saw strong leadership of the SPC team with the appointment of a new head of nursing for the specialist service division. One matron described how supported they felt by the head of nursing for the specialist division. We observed that the SPC team were visible, responsive and were active in policy and audit. Team working within the SPC team was of a high standard and all the staff we spoke with who told us the SPC team was 'responsive and very supportive'.
- The hospital chaplains led the chaplaincy service. We observed that the chaplaincy team were visible, responsive and were involved in policy and auditing. The lead chaplain was an integral member of the end of life board.
- Through the end of life board, formal links were in place with stakeholders from the community, hospice, and CCG's. This meant that stakeholders opinions were included in the decision making process.
- The Critical Care team had an end of life group chaired by the ward manager who was also a member of the end of life board. This was a trust wide group ensuring clinical practice and documentation was consistent across the trusts critical care units.
- Across the trust 'Schwartz Rounds', had been established for staff to regularly come together to discuss the non-clinical aspect of caring for patients, including: psychological, emotional and social challenges associated with their work and help staff deliver compassionate care. We saw that end of life care was on the agenda of the next Schwartz round.

- Porters told us that communication had improved since the last inspection. For example, there was a trust general manager on each site and information about the trust was being cascaded to portering staff via the portering manager and supervisors. Porters told us they did not get to hear about all new policies, only the few policies that were applicable to the portering staff then training was provided accordingly.
- The RSO we spoke to felt very well supported by their line managers. They also said the new senior management team including the Director of nursing, CEO, medical director were more visible. All staff we spoke to felt they were working very hard to help the trust get out of special measures.
- Staff on the wards we visited felt generally supported by their clinical leaders.

Culture within the service

- Across the trust, it was being communicated that end of life care was everyone's responsibility. We saw that through a variety of methods including the end of life care board, with its multi-disciplinary membership, the Quality, Improvement, and Innovation Hub, the appointment of end of life facilitator and link nurses and a structured education programme, end of life care was not being delivered in isolation. The SPC team told us they were changing the focus and trying to change the culture and release the burden from the SPC CNS's by empowering the ward teams. We saw that this shift in culture was work in progress.
- We saw that the SPC team integrated well with nursing and medical staff, there was obvious respect between specialties, and disciplines.SPC team members we spoke with were passionate about supporting patients, families, and staff in end of life care. This was confirmed when we spoke to staff on Cambridge K Ward who told us the SPC nurse was lovely and even although there was a huge workload at the moment , the SPC nurse would always be supportive and offer telephone advise to doctors, support families and sort beds out at the hospice.
- All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how

their work influenced the overall service. The SPC CNS told us staff were much more involved and aware of what was expected of them in the delivery of end of life care. Since the last inspection, staff told us there was a heightened focus on end of life care with the introduction of syringe driver competencies and end of life care plan documentation. However, several nurses told us they were not using the documentation, as they were unsure when to introduce it.

- The mortuary and RSO told us they were all working very hard to take the trust out of special measures. Staff felt supported and moral had improved.
- All staff we spoke with described an improving culture since the new Chief Executive Officer (CEO) and other changes in the senior management team had taken place. Staff also told us the CEO and Head of Nursing were seen on the wards. Staff could talk honestly and felt the senior team were generally interested on what was going on in the wards. The CEO had an on line blog. Staff felt it was becoming a more open organisation and was changing for the better.

Public engagement

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

Staff engagement

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

Innovation, improvement and sustainability

- The SPCT submitted data to the National Minimum Data Set, which allowed the team to benchmark their service nationally and use the findings to improve their service to ensure they fit the needs of the local community. The team also inputted data into a specialist cancer database.
- The SPC team had introduced the end of life care plan documentation which was based on the'5 priorities of care' to support the delivery of good care by the generic staff on the wards. All the new documents were set out in an easy to follow manner following national recommendations. We saw limited up take on the wards of the documentation. However, this was work in progress.
- The 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 were undertaken since the last inspection, to gather the views of the end of life care delivered across the wards as well as the views of the staff. This meant the SPC team were using the views of service users and staff to initiate change.
- The SPC team were working with the community teams to develop a provider wide prescription chart.
- Staff from the therapies including Occupational, Speech and Language therapists, and Physiotherapists shadowed the SPC CNS to support them in their role, as no formal training has been available.
- The trust took part in the National Care of the Dying audit: Hospitals 2015 to gather further views of the care delivered. An action plan was in place to address the issues raised.
- The SPC team was implementing the end of life care agenda. With a team that had not increased in size since the last inspection and a large number of deaths that took place across the trust, it was questionable as to how the small specialist team could deliver the agenda and support the delivery 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. Staff ran the hubs and provided topics of interest suggested by co-workers 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 implement systems that ensure accurate, complete and contemporaneous records are kept and held securely in respect of each patient.
- The trust must ensure 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 there is sufficient staff available to complete its agreed audit programme. Audits must identify deficiencies and have clear action plans that are developed and subsequently managed within the trust governance framework.
- The hospital must review staffing numbers in maternity and gynaecology services.
- The hospital must improve staffing appraisal completion rates.

Action the hospital SHOULD take to improve

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17-(1) Systems or process must be established and operated effectively to ensure compliance with requirements of this Part. (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

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

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...