East Kent Hospitals University NHS Foundation Trust

Kent and Canterbury Hospital

Quality Report

Ethelbert Road
Canterbury
CT1 3NG
Tel: 01227 766877
Website: www.ekhuft.nhs.uk

Date of inspection visit: 6, 19 and 20 March 2014
Date of publication: 13/08/2014

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

Ratings

Overall rating for this hospital	Inadequate
Emergency care centre	Requires improvement
Medical care	Requires improvement
Surgery	Inadequate
Critical care	Good
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected services at Kent & Canterbury (K&C) Hospital, including the Emergency Care Centre, Medicine, Surgery, Critical Care, Children's services, Outpatients and End of Life Care.

The hospital's A&E department closed in 2005 and was replaced by an Emergency Care Centre and an Urgent Care Centre. The hospital has 287 beds in total.

We spoke with a number of patients, relatives and staff while inspecting the hospital and we also held a listening event in Canterbury on 4 March 2014. We spoke with around 25 people at this event, who came to share their views on this and the other hospitals managed by the trust.

We undertook unannounced visits to Kent &Canterbury Hospital on 19 and 20 March 2014.

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

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

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

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

Our key findings were as follows:

We observed areas of good practice, including:

- The critical care unit promoted the use of patient diaries to support patients with memory loss and poor recollection.
- Patients being cared for on medical wards gave positive feedback about the care they received.

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

Importantly, the trust must:

- Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.
- Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.
- Ensure that, at a board level, there is an identified lead with the responsibility for services for children and young people.
- Ensure all staff are up to date with mandatory training.
- Protect patients by means of an effective system for reporting all incidents and never events of inappropriate or unsafe care, in line with current best practice, and demonstrate learning from this.
- Ensure that paper and electronic policies, procedures and guidance that staff refer to when providing care and treatment to patients are up to date and reflect current best practice.
- Ensure that the assessment and monitoring of patients' treatment, needs and observations are routinely documented to ensure they receive consistent and safe care and treatment.
- Ensure that the environment in which patients are cared for is well maintained and fit for purpose.

Summary of findings

- Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are undertaken.
- Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply, and that in-depth cleaning audits take place in all areas.
- Ensure that staff in children's services audit their practice against national standards.
- Implement regular emergency drills for staff, and ensure relevant policies are up to date.
- Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.
- Ensure that procedures for documenting the involvement of patients, relatives and the multidisciplinary team in 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times. All forms must be signed by a senior health professional.
- Ensure that patients are not experiencing unnecessary waits for follow-up appointments with outpatients clinics, and when waiting in outpatients to be seen, that they are not delayed.
- Ensure there is adequate administrative support for the outpatients department.
- Assess and mitigate the risk to patients from the high number of cancelled outpatient appointments and the delay in follow-up care.

In addition the trust should:

- Take all appropriate steps to inform potential service users in the local community of the remit of the Emergency Care Centre.
- Ensure appropriate signage to reflect that the hospital provides an Emergency Care Centre and not an Accident and Emergency department.
- Consider national guidance is reflected in medication policies.

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?
Emergency care centre	Requires improvement 	There is no accident and emergency department at the Kent and Canterbury site. Instead it hosts an emergency care centre (ECC), which is run by medical doctors and caters for patients with medical emergencies and a minor injuries unit, which is nurse-led. Children with minor injuries are accepted 24 hours a day, but those with illness can only be treated between the hours of 9am and 5pm. There are no doctors or nurses based in the centre with training in looking after children.
Medical care	Requires improvement 	Patients gave us very positive feedback, and told us they felt safe and well cared for. However, there were not always enough nurses and doctors to care for patients (this had got worse during the winter when extra beds had been made available). Some patients received care according to national guidelines, although this could vary. We did not see any evidence on the wards that clinical audit was being used to improve the quality of patient care. In the 2012 Adult Patient Survey, patients said that their discharge had been delayed for more than four hours due to waiting for medication or to see a doctor. Despite this, the trust had not yet taken appropriate action. Staff told us they felt well supported by their immediate line managers and felt they could raise issues and concerns with them. However, staff said they were stressed and under pressure because of the staff shortages and that senior management did not listen to their concerns.
Surgery	Inadequate 	Patients told us that their care and treatment was good. They felt involved in their care and told us that the staff were very caring and they felt safe. Staff were well motivated, enthusiastic and proud of the care they were giving. However, we found significant staffing issues on some of the wards. The staffing levels at night were not always safe. Auditing was not always effective: infection control audits were not identifying potential problems and we did not see evidence that action was being taken to address the issues that were identified.

Summary of findings

Critical care

Good

Patients were cared for in a clean environment and staff showed good practice in mitigating the risk of cross-contamination of infection. There were enough staff overall. However, the out-of-hours deployment of nursing staff across the ICU and HDU, and the out-of-hours arrangements for anaesthetic consultants, meant that the trust could not be sure that enough staff would be deployed at all times. Patients and relatives spoke positively about their care and treatment. The unit promoted the use of patient diaries so patients could learn more about their experience on the unit after their stay. There was evidence of learning from incidents and that best practice had been incorporated into the learning process. Each patient received appropriate consultant and multi-disciplinary team input. There was strong leadership on the unit.

Services for children and young people

Requires improvement

The Children's Assessment Centre provided a safe environment to care and treat children. There were suitable numbers of appropriately trained nursing staff and the skill mix reflected current guidelines. In general parents were happy with the care and support and said that the facilities were very good. But they raised concerns about the distances they had to travel between the three hospitals and that not all the children's staff were appropriately trained in the emergency care of children.

The service was well-led at a local level, but staff did not recognise that there was a board level member of staff with overall responsibility for ensuring that the voice of the child was heard. Across the trust, we found that risk management and clinical governance relating to the care of children was not managed robustly. We did not find any monitoring of the service to ensure that key performance indicators were being met. Staff did not audit their practice against national standards. Areas identified as serious concerns had not been addressed for long periods. The Children's Assessment Centre provided a safe environment to care and treat children however the general outpatients where children were seen and treated had not been risk-assessed to make sure that it was a safe and suitable place to treat children. The general environment in the main outpatients was not child-friendly.

Summary of findings

End of life care

Requires improvement

The trust's specialist palliative care (SPC) team showed a high level of specialist knowledge and across the trust provided advice on up-to-date holistic symptom control for patients. Patients and relatives spoke positively about the care they received. Staff showed a good understanding of the issues they needed to consider to maintain people's dignity in the later stages of their lives. Patients and families were involved in decisions about their care. Since the trust had stopped using the Liverpool Care Pathway, nursing staff had found it harder to identify which patients on wards were receiving end of life care and treatment. As a result, care planning for patients who hadn't been supported by the trust's SPC team was ad-hoc and inconsistent. Also vulnerable adults were being put at risk as Mental Capacity Act assessments were not always completed. This inconsistent approach highlighted the lack of an end of life care champion at board level who could steer the end of life care strategy throughout the trust.

Outpatients

Requires improvement

All the patients we spoke with told us that the staff in outpatients were polite and caring. The department was led by a manager and matron who were respected and liked by their staff. We did, however, receive multiple complaints from patients about cancelled follow-up appointments. Some clinics were very busy and staff routinely overbooked patients because the number of appointment slots did not always reflect patients' needs. Patients could therefore experience long waiting times. Also follow-up letters were not always being sent to GPs promptly. We found that staff were collecting data on waiting times and overbooked clinics, but they felt unable to make improvements. Some areas of outpatients were not cleaned to the required standard. Cleaning audits had failed to identify issues within the department. Patients and staff had been put at risk as two fire escapes were unsuitable for people with limited mobility. The department did not have enough storage, and equipment and stock were crammed into small cupboards or left in the corridors, at times blocking fire exits.

Kent and Canterbury Hospital

Detailed findings

Services we looked at
Emergency Care Centre; Medical care (including older people's care); Surgery; Critical care; Services for children and young people; End of life care; and Outpatients

Contents

Detailed findings

Background to Kent and Canterbury Hospital

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because it represented a variation in hospital care according to our new Intelligent Monitoring system. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, East Kent was considered to be a high-risk service.

Our inspection team

Chair: Diane Wake, Chief Executive, Barnsley Hospital

Head of Hospital Inspections: Siobhan Jordan, Care Quality Commission (CQC)

The team of 57 included CQC senior managers, inspectors and analysts as well as doctors, nurses, a pharmacist, patients and public representatives, Experts by Experience and senior NHS managers.

How we carried out this inspection

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

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

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

- Accident and Emergency (in this case the Emergency Care Centre)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Children's care
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. This included clinical commissioning groups and Health Education England.

We carried out an announced visit on 6 March 2014. During the visit we held focus groups with a range of staff in the hospital, including nurses, doctors, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We talked with patients and staff from all areas of the trust including the wards, theatre, outpatients and departments. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care and treatment records.

We held a listening event on 4 March 2014 where patients and members of the public shared their views and experiences. We returned to the site unannounced on 19 and 20 March 2014 to collect additional information as part of the inspection.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both accident and emergency and outpatients.

Emergency care centre

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

Information about the service

The Kent and Canterbury Hospital does not have an accident and emergency department. Instead it hosts an emergency care centre (ECC), which treats adult patients with acute medical illnesses (e.g. heart attack or stroke) as well as a minor injuries service (for injuries such as fractures and sprains) for all age groups.

The ECC is open 24 hours a day, 365 days a year for adults, and is open for children with minor injuries between 9am and 4pm Monday to Friday. Children outside of these hours or with more serious illness must attend either the A&E department at William Harvey Hospital or the Queen Elizabeth The Queen Mother Hospital. The minor injuries unit (MIU) is nurse-led.

The ECC sees approximately 100 patients a day (36,500 a year). We were provided with data which showed that numbers of people presenting to the MIU varied between 30 and 60 a day, and that between 20 to 30 patients were seen in majors. A further 20 to 30 patients were seen by the GP and the practice nurse, who were based in the minors' area. The ECC sees approximately 130 patients per day.

The model of care provided was supported by the Emergency Care Intensive Support Team.

We talked to patients, relatives and staff including nurses, doctors, consultants, managers, support staff and paramedics. We observed care and treatment and looked at care records for four patients in majors and 10 patients from the MIU.

Summary of findings

There is no A&E department at the Kent and Canterbury site. Instead it hosts an Emergency Care Centre (ECC), which is run by medical doctors and caters for patients with medical emergencies and a minor injuries unit, which is nurse-led. Children with minor injuries are accepted 24 hours a day, but those with illness can only be treated between the hours of 9am and 5pm. There are no doctors or nurses trained to look after children based in the centre. We had serious concerns regarding the governance of the department and issues, such as out of date guidelines and policies, staff shortages and care for patients with psychiatric needs, had not been addressed.

Emergency care centre

Are Emergency care centre services safe?

Requires improvement

Incidents

- We spoke with staff about incident reporting. They used an online system to report incidents. Medical and nursing staff told us they would not use this system to report when the unit was very busy.
- Staff told us they had received e-mailed information and feedback about incidents that had been reported.
- ECC staff were very good at reporting identified pressure damage to patients that was found on arrival to hospital. The follow-up action of appropriate referral to the tissue viability team and the use of pressure relieving equipment was done quickly and efficiently.

Cleanliness, infection control and hygiene

- The Emergency Care Centre (ECC) was visibly clean and uncluttered on the day of our inspection. The staff raised no issues with the standard of cleaning provided by the contractor Serco. However, there were no cleaning schedules in place.
- We observed that all staff were bare below the elbow and used appropriate protective equipment designed to reduce the risk of cross infection.
- There was a good supply of hand washing materials and hand gel dispensers.
- All bays and cubicles had fabric curtains with dates to identify when last cleaned or changed. There was no set policy to guide staff as to when they should be cleaned.
- Paper notebooks for checking the resuscitation trolleys were placed on the top of the trolleys near the open sharps bins and not protected from spills.
- There was a stool in the resuscitation area that was ripped, with exposed foam and open to contamination.
- All patients attending the ECC had an MRSA swab immediately after they arrived. We asked the rationale behind this and were told it was a standard procedure. This procedure was not consistent in emergency departments across the trust.
- Trolleys were stripped after each patient, but staff did not wipe down the trolley or equipment with a cleaning agent before the next patient.
- There was no infection control champion in place at the time of our visit; the shift manager was taking the lead.

Environment and equipment

- There were two separate checks to be completed to make sure that all the equipment had been checked and was working. However, only one of these checklists was up to date despite staff having raised concerns previously. For example, in September 2013 a staff member identified that items had expired in February 2013, and there was no oxygen cylinder and other basic items, which had delayed critical care.
- There was a central monitor connected to all cardiac monitors in the cubicles which can be viewed at the nurses' station
- The layout of the department also meant that patients could not be observed from the nursing station. We saw two occasions when patients wanted staff assistance but had no way of alerting staff to their needs. One patient had become unwell and suffered a vasovagal episode. This was unnoticed by staff until a member of the medical team walked past and noticed the patient had collapsed.
- All electrical equipment had a portable appliance testing label that was in date.

Medicines

- The medication cupboards and fridges in the resuscitation area were locked and we saw that the fridge was at the correct temperature and recorded daily.

Records

- All patient treatment pathways and records were in a paper format and all health care professionals documented within this document.

Safeguarding children

- Staff knew what action to take to safeguard vulnerable people and children from abuse.
- 95% of staff across the trust had received level one training. All staff who provide direct care to children should have level three training.
- The receptionist told us that they had access to the child protection register. All children attending the department are checked.

Initial assessment of patients

- Patients bought in by ambulance were automatically assessed by a qualified nurse in the majors area. Patients who walked in were streamed by the receptionist to either the majors or minors area.

Emergency care centre

- Once streamed, patients could wait up to two hours to be seen by a triage nurse. During this time they would not receive any medication such as pain relief. We saw patients wait for two hours before being sent for x-ray and a patient in discomfort who waited several hours to be treated. In addition in November 2013 a patient complained after they had visited the ECC after a fall and had a lengthy delay in significant pain, with a fractured shoulder.
- We were told that there had been inappropriate ambulance arrivals that the ECC were not set up to manage, but these had reduced since the 111 service had received guidelines of the services available. However, we found that several inappropriate arrivals had happened from November 2013 to February 2014. For example, in November 2013, a patient was brought to the ECC via ambulance with bowel obstruction. The ECC does not treat surgical emergencies.

Mandatory training

- The training matrix provided showed that training for staff was not up to date. The shift manager told us that they had identified training issues and that there were plans to develop training and competency books for all levels of staff throughout the trust.
- Staff told us that access to training was difficult due to insufficient staffing levels. Staff were not always able to access further training for their professional development.
- We were told that staff had completed specific emergency care training, such as cannulation, plastering, wound gluing and suturing, but we were not able to find evidence to support this. One technician told us they'd had no training since they were first taught to apply plaster eight years ago.
- Staff had knowledge of the Mental Capacity Act and deprivation of liberty safeguards but had not received training. They were not fully aware of how to ensure a patient's best interests were promoted.
- Staff had not received training in managing violence and aggression.

Nursing and medical handover

- Nursing handovers occurred at the beginning of each shift and when there were changes to bed status or patient. This meant that the team was kept informed of all eventualities.
- Medical handover occurred twice a day and was led by the senior doctor in the department.
- Staff told us that patients transferred to other parts of the hospital, including wards, were accompanied by a nurse or healthcare assistant. We observed that patient safety was maintained as a member of staff accompanied these patients.

Management of deteriorating patients

- The unit used a recognised adult early warning tool. There were clear directions for patient escalation protocols printed on the reverse of the observation charts and staff were aware of the appropriate action to be taken.
- We looked at completed treatment records and saw that staff had escalated correctly, and repeat observations were taken within the necessary time framework.

Nursing staffing

- We were told that reviews were undertaken regularly to decide the actual number of staff required on each shift. The department offers a selection of shift patterns ranging from 7.5 to 12 hours. Staff we spoke with were concerned about staffing levels when the unit was full.
- On the evening of the unannounced inspection on 19 March 2014, the ECC staff were short of one nurse and one health care assistant. There had been regular reporting of staff shortages, including one technician or one nurse short with no replacement being found.
- There were no paediatric trained nurses in the ECC.

Medical staffing

- The majors and resuscitation area were managed by the Urgent Care and Long Term Conditions Division which incorporates medicine and A&E. This meant that all emergencies and referrals from the MIU were seen by a team of medical doctors.
- Although ambulances knew not to bring very unwell children to the unit, occasionally paediatric emergencies would self-present. In these cases they were dealt with by the medical team with back-up from the paediatric team in the nearby children's centre, which was staffed from 8am until 6pm Monday to Friday, out of these hours there was no access to paediatric trained staff. The medical doctors were not trained in Advanced Paediatric Life Support.
- There was an acute pathway for patients with a suspected stroke, which was provided by the specialist stroke team.

Emergency care centre

- Overnight, patients were seen and treated by a medical registrar and two junior doctors, who were also responsible for the medical inpatients throughout the hospital.

Major incident awareness and training

- The major incident emergency policy which staff referred to and shared with the inspection team had not been reviewed or updated since 2011.
- Executive trust members advised that the trusts incident response plan had been reviewed and endorsed by the board of directors in November 2013 however staff in the emergency departments were not aware of this and did not refer to this updated document.
- We asked staff if they had emergency drills and were told that these occurred rarely. One staff member said that they had not been involved in an emergency drill in eight years.

Security

- There was one security guard on duty for day shift and one on duty for the night shift for the whole hospital.
- The security guard told us they were regularly called on to sit with patients living with dementia on the wards, meaning they were not able to cover the ECC during these times.

Are Emergency care centre services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Use of national guidelines

- Staff were not always able to access current national and good practice guidelines to deliver safe care.
- Although staff told us that trust policies were written in line with College of Emergency Medicine and NICE guidelines and were updated if national guidance changed, we found on the wall in the resuscitation area the anaphylaxis guideline displayed was dated 2001. The pulmonary embolism guideline on display was dated 2003.
- Other policies we found had not been reviewed since 2008, including the pain management guidance and protocol for the department.

Outcomes for the department

- The trust performed worse than the national average for unplanned re-admittance. The national average for unplanned re-attendance of a previous attendance at A&E is 7%. East Kent Hospitals University NHS Foundation Trust reported a consistent 9% to 9.5%.

Care Plans and Pathway

- We spoke with staff about the different treatment pathways that they followed in the department. They were knowledgeable about the stroke pathway, cardiac and unstable diabetes.
- We reviewed the notes of six children seen in the MIU and none of them had assessment of their pain documented.
- Staff we spoke with had not undertaken the training or been provided with cascaded information on the new syringe pumps introduced to the department in January 2014. We spoke to staff on the evening of the unannounced inspection on 19 March 2014, and they did not know that new pumps had been introduced.
- We saw that the nursing assessments and risk assessments were not always completed.

Multidisciplinary Team working and working with others

- The ECC worked closely with the stroke specialist team on the ward. We saw effective team working during our inspection.

Are Emergency care centre services caring?

Good

National Survey

- Data from the A&E friends and family test for the period of October 2013 to December 2013 was not disaggregated to location. The ECC did not display its own departmental score. Overall the trust performed lower than other emergency departments with a score of 38 compared with a national average of 56.

Compassionate care

- We spoke with a total of six patients and relatives in the department and the majority reported that staff were caring and kind. A relative commented, “They have been supportive to us as well as our relative.”

Emergency care centre

- We observed that staff communicated with patients and relatives effectively and in a kind and compassionate way.
- We saw that people's dignity was maintained whilst being treated.
- Staff and doctors talked to patients in a low voice in an effort to maintain patients' privacy.
- The department does not routinely offer patients hot or cold beverages or snacks regardless of the length of their stay. There was also no water fountain or beverage machine available for patients or their relatives to help themselves to.

Patient understanding and involvement

- Patients and relatives told us they were very satisfied with the care and treatment they received. However, some patients told us that they had not been kept fully informed including regarding the length of time that they would be waiting to be seen.

Emotional support

- We spoke with staff about the action they took to support relatives following bereavement. We were told that written information was provided to relatives and they were given as much time as they needed to spend time with the deceased patient.
- Leaflets were available for families about counselling following bereavement.
- Staff told us that they ensured the curtains were fully drawn and they could access a portable screen if required.

Are Emergency care centre services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access

- Since April 2013 the performance against the A&E waiting target which is a maximum of four hours to be treated or a decision to admit varied from 84% to 100%. In November 2013, December 2013 and January 2014 the trust achieved 90%, 91% and 92% respectively. This is trust level data, and therefore we are unable to comment on individual sites performance.
- We saw that some breaches of the four hour target were due to not being able to access transport for discharged patients and failures in multidisciplinary team working.
- Some staff reported that they felt pressure to discharge patients from the department to prevent breaches of the four hour target and felt that this was seen as more important than the overall quality of care.

Maintaining flow through the department

- There was a Clinical Decisions Unit to which patients could be admitted for up to 24 hours. There was a clear protocol for admission in place.
- The Clinical Decision Unit (CDU) was not compliant with mixed sex accommodation requirements. More than three months before our inspection, the Clinical Commissioning Group served a contract query notice in relation to mixed sex and non-declaration in the CDU. We witnessed a breach on our unannounced inspection. According to NHS England national data the trust has not reported any mixed sex breaches for the six months prior to our inspection.

Environment

- An Emergency Nurse Practitioner (ENP) in minors raised concerns that their working area was used as a corridor and impacting on their patients' privacy and dignity. Relatives for patients admitted to majors and the resuscitation area are unable to enter through ambulance doors, so come through the MIU.
- There was no separate area for children to wait or be treated in nor were any toys available.
- There was a comfortable relative's room where relatives could talk to the staff in private.
- There were no refreshment facilities available in the waiting room.

Meeting the needs of all people

- We spoke with staff about how they communicated with people whose first language was not English. They told us they had access to a telephone interpreter service and that some staff were bi-lingual and could be used to interpret.
- There was not a loop service in the reception area in use for those patients who had a hearing impairment. Staff had to speak loudly which impacted on patients' privacy.

Emergency care centre

- The training matrix did not provide evidence that staff had received training in caring for patients living with dementia and this was confirmed by some staff we spoke with.
- There were no registered mental health nurses in the department. Staff told us that the trust had a psychiatric liaison nurse that they worked closely with. Although they could be referred to psychiatric services 24 hours a day staff told us that patients referred to psychiatric services sometimes had to wait overnight before a member of the psychiatric services teams attended the department to assess them. The response of Child and adolescent mental health services was slow, with one incident report showing a 48-hour delay of assessment for a vulnerable child.
- Once seen by the crisis team and a decision to admit to a psychiatric ward was made, there was no further input from the crisis team. This meant that patients with a mental health need could be waiting in the unit unsupervised.
- We saw that there had been incidents of aggression by patients with mental health illness that had resulted in police being called to the department. Staff told inspectors that they had not received training in the management of dealing with aggression and violence.
- We were informed that new staff did attend conflict resolution training as part of their induction in preparation for dealing with violent and aggressive patients.

Communication with GPs, other providers and other departments within the trust

- The department had worked closely with the vascular surgeons to ensure that patients who had a potentially surgical diagnosis were seen quickly by a senior surgeon (usually a consultant). This pathway was seen to work well.
- Patients received information and follow-up advice when they left the department. Discharge letters were printed off immediately in the department and this ensured that the GP, carers or care home were aware of any treatment commenced and follow up requirements.

Complaints handling (for this service) and learning from feedback

- There was no process in place to monitor and review departmental complaints and complaints were not audited in order to identify trends.
- For the ECC and MIU we saw themes of poor communication, wrong diagnosis and delayed treatment in complaints.
- Apart from the apology given and staff being reminded of the importance of communication, there was no further learning for staff from the complaint we tracked.
- There was no evidence of either departmental or trust wide learning from complaints we reviewed.

Are Emergency care centre services well-led?

Inadequate

Governance, risk management and quality measurement

- We had significant concerns with regards to the governance of the department. During our inspection staff referred to and shared a major incident policy which was due to be revised in 2011. Following the inspection we were provided with evidence that the policy had been renamed and updated however staff were not aware of this and that the policy had been updated in line with national guidance. The Standard Operating Procedure for the 'Emergency Floor' (which was the umbrella term for the ECC and the other two A&E departments within the trust) made little reference to the ECC despite it having clearly very different processes and protocols given that it was run by medical not A&E doctors.
- Although quarterly governance meetings were held, lessons were not learnt across the trust despite there being transferable implications. The shortage of RN children trained staff had not been addressed and there was not a formal assessment of complaints from which to learn from.
- Complaints, incidents, audits and quality improvement projects were discussed at staff meetings. However staff did not feel that risks were escalated quickly and responded to, particular in response to staff training needs.

Emergency care centre

Leadership of service

- There was a divisional leadership structure which meant that the Emergency Care Centre and the two Accident and Emergency departments within the trust were overseen by one leadership team. On a day to day basis there was a band 6 or 7 nurse in charge of the shift.
- The MIU was staffed separately and had their own manager. Staff from both teams felt that they all worked as a team and supported each other. Staff told us that if they had had an emotional shift they would receive a debrief from a manager or senior staff about the situation.
- We were told by staff that due to shortages, they could not attend training as often as they should be. They did not feel that senior management listened to their concerns.

Culture within the service

- Staff said that they worked as a team but sometimes felt let down by a lack of beds, delays in referrals and staff absences not being replaced. The staff were proud of their ECC department and felt they worked well.
- Staff spoke positively about the service they provided for patients stating quality and patient experience was seen as a priority and everyone's responsibility.
- Staff worked well together and there was obvious respect between not only the specialities but across disciplines.
- The department engaged positively with the rest of the hospital and did not operate in isolation.

Innovation, improvement and sustainability

- The lack of supervision and refresher training for doctors, nurses and technicians impacted negatively on their ability to learn and develop.

Medical care (including older people's care)

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

Information about the service

Kent and Canterbury Hospital (K&C) has an acute medical unit, general medical wards, care of frail and older people and stroke and cardiac services. Medicine has a team approach to managing medical services across three sites which incorporate an approach to support frail older people. This approach (which started at K&C) was in response to the specific care and support needs of older people, as it was identified that 45% of patients admitted to K&C were recorded as being frail and elderly. The approach (known as the frailty model) is being implemented across the trust and is currently in place in two of the hospitals.

We talked with 21 patients, five relatives and 48 staff including nurses, doctors, consultants, senior managers, therapists and support staff. We observed care and treatment and looked at care records. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust and K&C.

Summary of findings

Patients gave us very positive feedback, and told us they felt safe and well cared for. However there were not always enough nurses and doctors to care for patients (this had got worse during the winter when extra beds had been made available). Some patients received care according to national guidelines although this could vary. We did not see any evidence on the wards that clinical audit was being used to improve the quality of patient care.

In the 2012 Adult Patient Survey, patients said that their discharge had been delayed for more than four hours due to waiting for medication or to see a doctor. Despite this, the trust had not yet taken appropriate action. Staff told us they felt well supported by their immediate line managers and felt they could raise issues and concerns with them. However staff said they were stressed and under pressure because of the staff shortages and that senior management did not listen to their concerns.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Incidents

- A 'never 'event' occurred on the stroke unit in December 2013 which involved a patient being fed through a nasogastric tube which was not in the stomach. The patient had subsequently died.
- An action plan was put in place to reduce the risk to other patients on the stroke unit and throughout K&C. We spoke with the ward sister who told us that the action plan had been implemented.
- On the stroke unit that stickers had been put into patients' notes advising staff about the new standard of practice which had been implemented for staff.
- This had been recorded in the clinical governance minutes and was reviewed monthly by the stroke service across the medical division and in the trust.
- Staff told us that they reported most incidents and were familiar with the electronic incident reporting process.
- One ward sister told us the incident reporting system was time consuming and sometimes did not always save the information which could be a problem if the staff member was called away while completing the report.

Safety thermometer

- K&C uses the national patient safety thermometer system. The system measures the incidents of new pressure ulcers, catheter and urinary tract infections (CI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism.
- We spoke with four nurses about the management of pressure ulcers. They told us that the surface, keep moving, incontinence, nutrition (SKIN) bundle was being used and we saw evidence of this in patients' care plans
- There were tissue viability link workers in place and two tissue viability nurses had delivered training to the link workers.
- Staff told us there was a lack of clarity around the management of CIs and UTIs. We were told on McMaster Mount ward that there had been two incidents of these in early 2014, but the ward sister was unclear about the actions the ward should take to prevent further infections as there had not been any shared learning from these incidents.

Cleanliness, infection control and hygiene

- Ward areas appeared clean and safe and we saw staff regularly wash their hands and use hand gel between patients. Bare below the elbow policies were adhered to.
- One sister told us there were problems with cleaning at weekends and this was being addressed by the contract cleaning service.
- MRSA and C. difficile rates for the trust were within expected limits and were displayed in some ward areas in the medical division.
- We were told that a patient had contracted C. difficile on the Kingston Stroke Unit in July 2013. A root cause analysis was undertaken by the site-based Infection Prevention and Control Clinical Nurse Specialist in conjunction with the Junior Ward Sister.

Environment and equipment

- We reviewed the testing and maintenance of equipment across wards and specialist medical units. All equipment was cleaned and maintained to the appropriate standard.
- The resuscitation trolleys on Harbledown ward and in the stroke unit had not been checked daily by nursing staff. Three dates had been missed on the stroke unit and one on Harbledown ward.
- Although the equipment on both resuscitation trolleys was correct, the layout was inconsistent and not in line with the recognised layout of resuscitation equipment resuscitation practices.
- There was no coordinated system in place to obtained pressure relieving equipment. The ward sisters on McMaster Mount, Marlowe wards and stroke unit, all told us that it was difficult to obtain sufficient pressure relieving equipment for patients who were at risk from developing pressure ulcers.
- We observed in patients care plans that it had been recorded if appropriate equipment was not available and the appropriate nursing interventions had been documented, such as frequent turns to relieve pressure and the use of pillows.

Medicines

- The handling, administration and storage of medicines was reviewed across the wards and specialist medical units we visited.

- On Invicta ward the medicine cupboard was not locked and the fridge records were missing. There was a lack of coloured bags to support the return of medication to the pharmacy department.
- We were told the recent lack of dedicated pharmacy staff on the ward was having an impact on the safe management of medication systems and processes.
- Pharmacy staff told us there were not enough staff to cover all wards and clinical specialist units in the medical division and across the hospital.
- It took up to five hours to dispense patients' medications from the time the pharmacy dispensing system was 'turned on' in the pharmacy department.
- Ward staff reported dispensing delays at ward level which were impacting on patient discharge.

Records

- All records were in paper form and all health care professionals recorded information in the same place.
- The notes on the stroke unit and Harbledown ward were well written records that were legible, and followed the patients care pathway.
- Patients' records were kept safe in the areas we visited.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Only 64% of staff had attended their safeguarding training.
- We noted that staff had supported a patient in the completion of a 'best interest' checklist concerning the patients future care arrangements, and where they would like to live.
- This demonstrated that staff on this occasion understood the Mental Capacity Act and were able to act appropriately to support vulnerable patients.

Mandatory training

- A ward sister showed us how they accessed the electronic training system and we that mandatory training was up to date for infection control and safeguarding.
- A matron and three senior nurses told us that the smart cards that were used to access the electronic training system were unreliable and had to be constantly 'uploaded' by the IT department. At the time of our inspection one out of five cards was working on the stroke unit.
- Ward sisters told us that ensuring that all staff attended their mandatory training was a challenge across the medical division. We saw evidence that mandatory training was not up to date. For example, on the stroke unit 95% of staff had attended Infection control training, 40% had attended Fire training and 64% had attended Safeguarding training. This demonstrated that mandatory training attendance was inconsistent and not up to date.
- We spoke with four ward sisters who all told us that they felt that staff had the appropriate skills and training to carry out their roles in the medical division.
- On Harbledown ward we saw a list of staff who had not completed their mandatory resuscitation training for two years. The ward sister had informed staff they were required to attend a resuscitation training session at the earliest opportunity. This showed that staff were not meeting their personal training requirements which could impact on the safety of patients in their care.

Management of deteriorating patients

- We spoke with staff about how they would escalate concerns about patients whose condition was deteriorating across the medical division. Staff told us that all patients were monitored using the hand held clinical monitoring system.
- The critical care outreach team closely supports the wards and clinical specialist units between the hours of 8am and 6pm Monday to Friday. Out of these hours the Operational Site Manager (OSM) provides emergency cover.
- There is an automatic escalation in place for patients who are flagged on the clinical monitoring system as being high risk. However, staff told us that the clinical monitoring system was unreliable (due to issues with Wi-Fi and that staff had repeatedly raised concerns over the last two years without resolution. In order to mitigate this risk, many wards were using paper records to record patient observations.

Nursing and medical handover

- Nursing handovers occurred throughout the day and staffing for the shift was discussed alongside any high risk patients or potential issues.
- We observed a board round on the stroke unit which was multi-disciplinary and was led by a consultant for stroke.
- We observed a medical handover on our unannounced inspection where the medical day team handed over to the medical team coming on night duty. The OSM was also present. They used paper handover sheets.

Medical care (including older people's care)

Nursing staffing

- Nurses told us they often experienced shortages of staff. One patient said "The ward I was on was very understaffed and there were significant delays in my medication."
- We were told by staff on Harbledown ward that the staffing levels at night should be two nurses and two support workers. We saw on the nurse rota the ward had one nurse and two support workers to care for 26 frail dependent patients for the week of the inspection.
- We were told by one member of staff in a leadership role that with three staff they had to make a choice between completing patient's paper work and giving direct care to patients.
- Ward sisters told us that a nursing review had been undertaken in April 2013 and a £2.9 investment had been agreed for nurse staffing across the whole trust.
- Due to a shortage of doctors, when nurses on the wards need medication prescribed in the evening and through the night, they have to leave the ward and take the chart to ECC which leaves the ward with reduced cover.
- One ward sister told us there were currently three registered nurse vacancies on their ward, and that it could take up to 10 weeks to fill nursing vacancies.
- New nurses had also been recruited but were currently unable to take charge of a ward as they were still completing their induction programme
- Band 2 and band 3 support worker roles had been trained to undertake enhanced care roles to support nurses in the delivery of patient care.
- Agency staff were used to fill vacant shifts. However, it was not always possible to fill the vacant shifts, especially on the higher dependency wards such as Harbledown ward. Staff said they would often work extra hours to ensure that the ward was staffed safely.

Medical staffing

- Doctors told us their roles were getting busier. One doctor said "the quality of care I deliver to patients I know is affected by the workload".
- We were told by a senior clinician that currently 40% of registrar posts are vacant across the trust which equates to seven vacancies.
- We saw on the risk register that approval has been given by the trust to go to agency to help address the gaps in the doctor's rota and the trust was taking steps to help reduce the risk to patients from the shortage of doctors by looking at the possibility of recruiting overseas doctors to help fill the rota.
- We spoke to a doctor who told us that their major concern was that as a senior trainee in medicine; they were expected to manage seriously unwell children, injuries and surgical problems in the ECC for which they had received little training.
- Doctors and nurses said there were often delays in seeing patients promptly on the wards out of hours due to the need for them to be in the ECC.

Are medical care services effective?

Good

Use of national guidelines

- We saw evidence of effective pathways of care across the medical division and the management of stroke, falls, pressure ulcers and dementia.
- Staff told us about NICE guidance and how it shaped the care of patients. For example, dementia, falls, stroke and heart failure. Staff on Invicta ward, the stroke unit and Treble ward were able to show us the relevant NICE guidance.
- We noted the Sentinel Stroke National Audit Programme (SSNAP) from July – September 2013 published February 2014, demonstrated that the trust performance at this location was level D. Hospital stroke services are given a level from A to E depending on their performance against nationally recognised key performance indicators.

Consultant input

- A Consultant told us they felt they did comply with the national audit programme but that they needed to turn the national audit outcomes into local action.
- They told us that the medical division had a new Quality Assurance Board attended by key professionals that they felt would help them to manage clinical audit.

Outcomes for the department.

- For January 2014 the stroke service had a length of stay of 20.4 days when the expected national target was 17.2 days.

Medical care (including older people's care)

Multidisciplinary team working and working with others

- We saw evidence of good multi-disciplinary working across the medical division. For example, the Kingston Stroke Unit had a multi- disciplinary approach to care and support for patients who had experienced a stroke.
- We observed the stroke team working together to improve patient outcomes.
- Therapy staff were based on the unit which enabled stroke patients to have direct access to stroke rehabilitation services. One patient said "the therapy team are wonderful and as they are on the ward most days I know that I get more therapy than I would on a normal ward". .

Seven day services

- We were told that hospital was working towards seven day services and the risk register highlighted a requirement for a seven day consultant presence across all divisions.
- Seven day working was in place for services who supported the medical division to ensure continuity of care, such as pathology and radiology. There were plans to develop seven day pharmacy and therapy support.

Are medical care services caring?

Good

Compassionate care

- Patient comments included "the nursing staff care for you really well and always respect your privacy and dignity" and "the nurses are really dedicated and I always feel safe in their care".
- The interactions between care staff and patients were kind and friendly and it was evident that staff listened to patients concerns and patients trusted the care staff.
- A patient in the Coronary Care Unit told us "the nursing staff are really brilliant, they are as cheerful when they go off duty as when they came on duty".
- One patient on Marlowe ward told us "the nursing care was good but the ward was so busy and understaffed at night that I had to wait a long time for my pain medication which I was really unhappy about".
- One patient told us about a previous experience at the hospital and said that they could not praise the support of staff highly enough and that they would recommend K&C for the wonderful care and kindness that was shown to them and their family.
- Patients told us that they were treated with dignity and respect by all members of the care team. One patient told us "the nurses and doctors always treat me respectfully and I know that I can trust them to care for me while I am at the hospital".

Patient understanding and involvement

- On the NHS Choices web site that K&C had an overall score of four out of five stars for involvement from over 50 respondents.
- However, the stroke unit only scored 67 on the Friends and Family Test (FFT).
- On the FFT some wards and acute specialist units in the medical division scored below the trust average of 73% for overall patient experience of respect and dignity, cleanliness, involvement, pain control and care and food.
- Marlowe ward scored 59 and Invicta 69 which meant that these areas scored below the trust average.
- Patients were unhappy with the food. A patient said that the fish and chips they'd had for lunch the day before the inspection was so dry it was '"inedible". They had taken a picture of the meal that they showed us.
- The ward sister told us that the service provider had changed the way patients meals were prepared and served. Service was now at ward level and since the change in February 2014 patients had complained about the quality of the food. The ward sister told us this had been raised many times with the service provider but to date the concerns had not been addressed.

Are medical care services responsive?

Good

Access

- We spoke with a member of staff in a leadership role on Harbledown ward who told us that there was a system in use which enabled patients with a diagnosis of dementia to be identified across the hospital.
- We were told that Harbledown ward was unofficially recognised as the dementia ward at K&C, and staff said

they had good access to dementia nurses who would visit patients daily (Monday to Friday) for support. Dementia nurses acted as a liaison between services and are supported by the safeguarding team.
- A ward sister told us the support from Social Services was good and this helped the ward to facilitate the effective discharge of patients who were vulnerable and would be better supported in a more appropriate care environment.
- Frail elderly patients who were not cared for on Harbledown ward would be cared for by the consultant who specialised in the patient's specific medical condition.

Maintaining flow through the hospital and discharge planning

- Nursing staff told us there could be a delay of up to five hours in the prescribing, ordering and dispensing of patients medication. The delays were caused by doctors being unable to prescribe patients medication promptly.
- We spoke to the staff in the pharmacy department who told us there were staff shortages which had resulted in reduced cover to the wards and departments.

Meeting the needs of people

- We saw examples in the care records of vulnerable adults who had been supported by the Mental Health team to make life changing decisions about their future care and support.

Complaints handling (for this service)

- Staff on the wards told us that they would always report any concerns or complaints that patients may have to the ward sister. Staff were aware of complaints that had been made in their area and staff were informed of the outcome of complaint investigations.
- The stroke unit had received complaints about the failure of complex discharges. We were advised that six patients should have been assessed for eligibility for continuing health care. A delay in submission meant that patients had to stay longer than necessary in the hospital.
- After these failures a review was completed by the lead nurse for stroke. The report identified that education and training was needed for the care team regarding complex discharge planning. The identified improvements had been implemented to mitigate the risk of a repeat of these failures.

Are medical care services well-led?

Requires improvement

Vision and strategy for this service

- We spoke with three ward sisters who all told us that their matron was approachable and they felt they could raise any concerns they had with them, and they would be listened to.
- There was a limited understanding about the trust vision and strategy across the medical division.
- Staff were able to tell us about the clinical leadership programmes that had been implemented but had little knowledge of how it would affect them at their level in the organisation.
- Ward sisters were aware of more local leadership programmes that could be completed on line but did not think there was a corporate approach to leadership development.
- The plans to ensure that ward managers were supernumerary had not been implemented and some ward managers told us they were supervisory for up to 50% of their clinical time only. We reviewed a rota and noted that a ward manger had only had two days supernumerary in a four week period.
- We saw evidence that the Chief Nurse, Director of Quality and Operations communicated with the wider nursing team through email. Information was shared with the lead nurses but there was limited information passed from the lead nurses to the matrons and ward sisters.

Governance, risk management and quality measurement

- Junior doctors told us they felt concerned about the gaps in the medical rota and expressed concerns about the 'Cold Team' (support team for wards in the evenings and at weekends) which was being used to support sick patients in the acute care areas and the ECC).
- There was a lack of clarity about the consultants taking responsibility for the care of patients who were admitted through the ECC out or hours and at weekends Junior doctors felt pressurised to stop patients waiting longer than four hours in the ECC
- Some of the junior doctors expressed concerns about the difficulties of being released to attend training and

supervision sessions. This was supported by the Junior Doctors Training Scheme survey which highlighted the doctors' workload as being 'worse than expected' in the medical division.
- We spoke to staff across the medical division who were able to tell us about the clinical governance arrangements in their area and how it helped to support the care of patients.
- Junior doctors told us they were involved in quality improvement programmes
- The ward sister on the stroke unit told us there was a joint approach to the management stroke across the trust. The stroke teams meet to learn from complaint and concerns, serious incidents and, never events.
- We saw the clinical governance minutes for January and February 2014. We were told that significant changes trigger team meetings and audits of clinical practice. For example, the changes put in place following the 'never event' and the patient who had contracted C. difficile whilst on the Kingston Stroke Unit.

Culture within the service

- A junior sister shared that they did know who her matron was, and another nurse on that ward had not met their matron.
- One ward sister told us they had been regularly exposed to aggressive behaviour from patients and relatives who were unhappy about the delays in dispensing medication at discharge.
- A relative told us they had witnessed inappropriate behaviour by a nurse to a trainee nurse who had been caring for the relative of the family member. The relative said "I did not feel safe leaving my family member in the care of the nurse". The relative told us they had complained to the ward sister.
- We spoke to the ward sister who told us the nurse's behaviour had been addressed and there had been no further incidents reported. The relative was satisfied that the ward sister had dealt with their complaint appropriately. The relative told us that other than this unfortunate incident, they were very happy with the care of their relative. The relative said "The ward has cared so well for my family member that I feel my relative has been given a 'second chance' at life. This demonstrated that the relative had been listened to and the appropriate actions had been taken by the ward sister to ensure that patients and their families were treated with dignity and respect.
- The trust was rated 'worse than expected' in the NHS Staff Survey. The themes included the non-reporting of near misses, violence between staff, bullying and harassment and work related stress.
- A sister told us "I would not say there is a bullying culture but there is a tendency for complaints not to be escalated as you know nothing will ever be done about it".
- Another nurse on a medical ward stated "we will not whistle blow here as we know what will happen, we will be moved and our concerns will not be addressed, it is best to keep quiet here" they went on to describe low staff morale in the trust however on that particular ward they felt they worked well and supported each other as best they could.

Innovation, improvement and sustainability

- We saw evidence of formal staff appraisals which were documented and up to date on the wards that we visited.
- The majority of staff across the medical division knew who the Chief Executive was and some had attended the Dragons Den and the Chief Executives Forum.

Surgery

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

Information about the service

The Kent and Canterbury Hospital has a fracture clinic, a day surgery unit, five theatres and a vascular surgery centre. The hospital currently provided specialised vascular and urology services for the East Kent area. There is no provision for emergency or elective general or orthopaedic surgery at this site.

During our inspection we visited all of these areas. We spoke with 13 patients and 34 members of staff and with 11 relatives. We looked at patient records both in theatre and on the wards we visited and saw eight sets of patient records in total. We also attended a listening event to gather the views of people who had used the hospital and lived in the local area.

Summary of findings

Patients told us that their care and treatment was good. They felt involved in their care and told us that the staff team were very caring and they felt safe. Staff were well motivated, enthusiastic and proud of the care they were giving. However, we found significant staffing issues on some of the wards. The staffing levels at night were not always safe. Auditing was not always effective: infection control audits were not identifying potential problems and we did not see evidence that action was being taken to address the issues that were identified.

We were concerned that despite the significant staffing issues and potential compromise to patient care that this had not been addressed by the divisional leadership team. In addition, the approach to which the world health organisation checklist was undertaken was unacceptable and needed to have been addressed urgently. Formal risk management in terms of up-to-date or 'live' risk register was not observed, despite our team finding areas of substantial concern.

Surgery

Are surgery services safe?

Inadequate

Incidents

- On the wards and in the theatres incidents we tracked were appropriately recorded on the hospital system and analysed to see where lessons could be learned.
- A theatre efficiency action group met at the hospital on a monthly basis and looked at accidents and incidents that had occurred within theatre and where changes could be made or lessons learned.

Safety thermometer

- We saw evidence on all of the wards we inspected that the patient Safety Thermometer was in use. Most of the wards displayed the results on a notice board.
- The Safety Thermometer showed that the numbers of falls, pressure ulcers and catheter and urinary tract infections on each ward was well managed. Staff were aware of the need to ensure that people were not at risk of developing pressure ulcers and any risk of falls was minimised.
- This was done using a range of risk assessments to identify patients at risk and identify measures that would reduce the incidence of pressure ulcers or falls such as pressure relieving mattresses or bed rails.

Cleanliness, infection control and hygiene

- Infection control procedures were in place on all wards that were visited. We found that the hospital was clean at the time of our inspection. Hand gels were in place at the entrance to each ward together with instructions for their use to reduce the risk of infection.
- However, the infection control measures were not backed up by effective audits. We discussed this with senior staff on Clarke ward and although cleaning and infection control checks were carried out, we were told that the cleaning standards required by the trust had not been achieved in the first two months of this year.
- Curtains around patient beds were not routinely changed and washed, only when there was an obvious need. This was a potential risk of infection.
- Facilities used for dermatology surgery were an unsuitable environment and the risk of infection had not been properly assessed. We were told a business case had been put forward to develop the unit, which had yet to be agreed by the trust. Floor coverings were worn and walls were cracked and needing repair. This meant that the unit was difficult to keep clean and risks of infection were present.

Medicines

- The trust controlled drugs policy stipulates that only one signature is required when signing for controlled drugs. This is not in line with NMC guidance which recommends that all entries should be signed by a registered nurse, midwife or operating department practitioner, and should be witnessed preferably by a second nurse/clinician. If a second nurse is not available then the transaction can be witnessed by another registered practitioner or by an appropriately trained healthcare assistant.
- National guidance (DH) states that healthcare organisations should carry out a risk assessment to determine whether double checking for administration of controlled drugs is necessary as an additional risk reducing measure within the organisation. We noted on inspection and in line with the trust policy that control drugs were administered with only one nurse checking. The trust advised us that they had risk assessed this practise.
- We looked at the management and storage of medication. This was generally of a good standard. Records were well maintained and clear.

Records

- Records were generally well completed, although some inconsistencies in the integrated pathway documents used with some older documentation still being used. All records in current use should be consistent to ensure that information is recorded consistently and clearly.
- Theatre records were of a good standard and the integrated care pathway documents clearly recorded the medical and anaesthetists input together with details of time spent in the recovery suite. The pathway document also contained a detailed record of equipment used which provided a clear audit trail.
- We looked at eight sets of patient records. These included their integrated care pathway which detailed their care form admission through to discharge. The records also included completed World Health Organization (WHO) surgical safety checklists.
- Theatre staff told us that they checked on the completion of the WHO checklist before the patient left the recovery area and recorded whether the check list

was complete. They informed us that any incomplete records were returned to the surgical team for completion, this invalidating the purpose of the check list as it is a requirement that it is completed contemporaneously prior to the patient leaving theatres to protect patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Measures were in place at the hospital to ensure that vulnerable patients or those who lacked capacity received the highest standard of care.
- Specialist support nurses experienced in the care of people living with dementia and those with a learning disability were on site and available to provide support and guidance to ward staff. This formed part of the patient's pre-assessment visit where relevant information was taken to establish the best support plans for that person.
- All staff received training in the requirements of the Mental Capacity Act (2005) as part of their mandatory training and when we asked staff how they would manage a patient with limited capacity to make their own choices or decisions, they were clear of the process that would be instigated if patients did not have capacity. The staff told us that they would also arrange for a meeting to discuss the person's capacity and ensure any decisions made were in that person's best interests.
- They also told us about an initiative introduced called 'Patient Watch'. This utilised the on-site security staff to observe and monitor any patients who may be a danger to themselves or others. Staff we spoke with explained how a detailed assessment was carried out before considering this an option. They showed us the risk assessments used to assist them in the decision making process.
- Staff we spoke with were very positive about this initiative. They told us that the security staff had received appropriate training and only stepped in following a risk assessment on the ward.

Mandatory training

- Staff we spoke with were all able to access training, much of it electronically. They told us that their training was up to date and they were always reminded when it was due. This included mandatory training undertaken every year and other patient specific training such as diabetes care.

Management of deteriorating patients

- The surgical department had access to a critical care outreach team to provide additional support to deteriorating patients, which was available 8am to 6pm Monday to Friday. After 6pm and at weekends this support was provided by the site clinical manager who has the relevant skills to manage these patients outside of core hours.

Nursing staffing

- Clarke ward accommodated up to 36 patients. A staff member told us that on the night prior to our inspection; the ward only had one qualified staff member working and three health care assistants.
- A senior member of staff acknowledged the problem with staffing and told us it was a result of long-term sickness, other leave and an inability to fill shifts through their bank or agency arrangements. They also acknowledged that this had been a problem for several months and happened on average one or two times every week.
- Funding for additional staff was available but we were told of the difficulties in recruiting sufficient experienced staff to meet the needs of patients. A senior staff member we spoke with told us that there was no block on recruitment but they were still unable to fill shifts.
- We looked at how the staff shortages affected patient care. One person, who had a diagnosis of diabetes, had been admitted to the ward at 8pm the previous evening having arrived at the Emergency Care Centre at 10.30am. They were on a range of medication including insulin for their diabetes and they told us they usually tested their blood sugars three times daily. They had not had a lunchtime meal, were given a sandwich after their admission to the ward, but were not given their required medication or had their blood sugar levels tested. Their blood sugars were not tested until 7am on the day after their admission and were higher that their usual range. Their records did not contain a blood monitoring sheet and we raised this at the time of discovery with the ward sister.
- On another ward we identified that a shift the previous night had been covered by two agency staff with no permanent nursing support.
- We found staffing levels in the theatre were acceptable and staff we spoke with did not report any concerns about staffing.

Surgery

Are surgery services effective?

Good

Outcome data

- There was no up-to-date outcome data for the type of surgery performed on this site.

Care plans and pathways

- Integrated care pathways were in use. These were documents that covered both the medical and nursing notes from admission to discharge. This gave an easily accessible record of the procedures undertaken.
- We examined eight sets of patient records during our inspection. The records we examined were stored securely and clearly showed the input of the various specialisms.
- Vascular surgery for the three hospitals in the trust was managed and performed at this site. The vascular surgery programme carried out by the hospital was very positive, with excellent comments from staff and patients.
- Consultants outcomes were similar to others according to the national vascular registry

Multidisciplinary team working

- Throughout our inspection we found good evidence of multi-disciplinary work throughout the surgical department.
- In all areas that we went to during our inspection we found that there was a strong multi-disciplinary team which included members of the medical team, anaesthetists, physiotherapy, occupational therapy, speech and language, pharmacy and dieticians.
- There was clear evidence at both ward and theatre level that decisions about patient care were made in a multi-disciplinary forum
- We looked at the records of treatment for eight patients who had recently had surgery. The records contained detail of all the multi-disciplinary input which included the medical and anaesthetic teams, recovery detail and therapy when back on the ward such as physio or occupational therapy.

Seven day services

- A move towards more seven day services was planned by the hospital but had not yet been implemented. However, better use of theatre facilities was being made during weekdays with an earlier start time for the theatre.
- The day surgery theatre currently works on a Saturday morning to reduce waiting list times.

Are surgery services caring?

Good

Compassionate care

- During our inspection we observed care and spoke with patients who were receiving treatment. They were happy with the care and treatment provided.
- During our inspection we observed staff as they carried out their day to day duties and spoke with 13 patients. One patient we spoke with told us that they had been a patient, "off and on for thirteen years and always had excellent service."
- Patients receiving treatment and support were treated with dignity and respect, particularly on the wards. Curtains were drawn around the bed before any conversations or treatment was given.
- Doctors discussed with patients what was happening and the plans for discharge during their ward rounds.
- Staff spoke appropriately to patients at all time, and during our inspection we saw how members of the multi-disciplinary team involved patients and their families in discussions about the future.

Emotional support

- During our inspection we also noted some of the emotional support that was in place for patients recovering from surgery.
- The hospital chaplain was available for people should they wish to have any spiritual support and we were told that other faiths were represented from the wider community.
- Friends and family were encouraged to visit. Waiting times were detailed in information packs given to patients and we were told that where there were special circumstances, the wards used their discretion and allowed visiting at other times.

Surgery

Are surgery services responsive?

Good

Are surgery services well-led?

Inadequate

Maintaining flow through the hospital and discharge planning

- Two other people we spoke with commented on the lack of adequate car parking spaces. They thought that the trust could use land behind the hospital for further parking. This was in fact planned and detailed in the trust newsletter but it appears that the wider community may not be aware of the plans.

Meeting the needs of people

- We found during our inspection that the day surgery unit did not offer segregation between men and women although screens were in place between beds. This had not been reported as a breach of mixed sex wards in keeping with national Department of Health guidelines.
- Arrangements were in place to meet people's cultural needs and access to interpreters and translation services available.

Complaints handling

- We looked at two complaints that had been received in the last year on Kent ward. It was clear that people's concerns had been listened to and action taken as a result.
- One complaint was around noise levels at night, particularly staff talking. We discussed this with the sister on the ward. They told us that this had been discussed at a staff meeting.
- Another person complained about the admission time for afternoon surgery. we saw the detailed report and response made into this compliant and noted the changes made in practice to resolve the problem
- Other concerns had been raised relating to a lack of Wi-Fi access on this ward. We were told that an IT project was looking into the problems but had yet to resolve. A senior staff member told us that Wi-Fi could was a problem on the K&C hospital site.
- We looked at a copy of the staff meeting minutes from January which recorded the discussions held regarding the complaints.
- We were also shown details of two compliments received on the same ward in the last two months.

Vision and strategy for this service

- At a trust level, there appeared to be a clear vision and statement of values. However, this did not appear to be clear at individual ward level. Staff we spoke with during our inspection were unclear on the overall vision of the trust or the values represented.

Governance, risk management and quality measurement

- Formal assessment and mitigation of risks did not appear to have been seen as a priority. The risk register we were provided with had not been recently updated, and did not include some of the areas our inspection raised as significant concern.
- The approach to the completion of the world health organisation was unacceptable and yet had not been addressed by the leadership team within the division.
- Staffing issues had been identified at board level as a major concern. However, although funding was agreed in April 2013 delays in recruiting into vacant posts and continued recruitment difficulties were affecting the delivery of care across all of the hospital sites.
- Staff meetings were held at ward level to discuss key localised issues. The minutes from one meeting on Kent ward were shared with us and demonstrated the discussions held which included looking at complaints, comments from friends and family responses and patient safety thermometer data.

Leadership of service

- During our inspection we spoke with staff at all levels. We found that from the ward manager down staff felt supported and encouraged to carry out their day to day duties. Most of the staff we spoke with were dedicated to the role they filled and showed great enthusiasm.
- Although aware of some of the pressures on front line staff and the ongoing recruitment difficulties, we were not sure that the staff on the wards were being kept up to date with the programme of recruitment or when new staff would be available to ease pressures.
- Regular annual appraisal meetings were in place to offer staff the chance to discuss their development needs together with quarterly updates.

Surgery

Innovation, improvement and sustainability

- We saw some evidence during the inspection on Kent ward that learning had taken place following comments received from patients and procedures changed to reflect this.
- Staff at ward level were proud of the service they offered. The friends and family data was displayed for patients and visitors to see and the patient safety thermometer on display. Staff were keen to tell us of successes they had achieved, and staff on one ward had listened to patients' views and made changes to improve the patient experience.

Critical care

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

Information about the service

The Critical Care Unit (CCU) at the Kent and Canterbury Hospital has eight beds in two geographically separate areas. There are four level three beds and four level two beds. Between January 2013 to December 2013, 537 patients were admitted to the unit.

An outreach team of three nurses work throughout the hospital and assist on the management of critically ill patients on wards and departments across the hospital. The outreach team work between the hours of 8am to 6pm, Monday to Friday after which cover is then provided by site clinical managers. The outreach team use an electronic clinical monitoring system to manage the deteriorating patient, promoting early detection and intervention.

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

Summary of findings

Patients were cared for in a clean environment and staff showed good practice in mitigating the risk of cross-contamination of infection. We witnessed a shortage of nursing staff on the day we inspected the unit.

Patients and relatives spoke positively about their care and treatment. The unit promoted the use of patient diaries so patients could learn more about their experience on the unit after their stay.

There was evidence of learning from incidents and that best practice had been incorporated into the learning process. Each patient received appropriate consultant and multi-disciplinary team input. There was strong leadership on the unit.

Critical care

Are critical care services safe?

Requires improvement

Incidents

- We spoke with the matron who told us about problems with a haemofiltration device. There had been 19 medical device /equipment issues between September 2013 and February 2014.
- Incidents had occurred across all three CCUs within the trust. The critical care steering group and procurement sourced an alternative piece of equipment that is now being used on the unit.
- Between September 2013 and February 2014 there have been seven incidents related to medication errors. The most serious incident occurred in February 2014 and was reported as a on the Strategic Executive information System. A risk assessment was completed about the incident on the 5th March 2014 and actions were identified to reduce the risk of recurrence.

Safety thermometer

- Safety Thermometer information was displayed, but it was not in a highly visible area. The noticeboard displayed how the unit had performed, there was an example of how a patient had developed a pressure sore, there was evidence of the learning that had taken place from the incident and best practice to follow.
- The unit had made improvements in avoiding device related pressure sores and had introduced new practice for securing nasogastric tubes and endotracheal tubes. Risk assessments for this were being completed appropriately on admission.

Cleanliness, infection control and hygiene

- The unit was visibly clean and there was a cleaning schedule displayed. We saw staff regularly wash their hands and use hand gel between patients. The policies of bare below the elbow were adhered to.
- We were told that there were five microbiologists who cover all three CCU sites across the trust.
- We were informed that the microbiologists maintain lines of communication by telephone conferencing taking place every day at 11:30am, when the microbiologists speak with one another. The microbiologists rotate across the sites every month.
- Routine surveillance is undertaken on every patient in the unit on a Monday and Thursday for sputum, wound swabs and urine. The antibiotic policy is available on the intranet.
- During the inspection we saw that the blood gas analysis machine and a computer and keyboard used by theatres; as well as other testing equipment were situated in the sluice. It was housed on a countertop above the linen skips and directly across from the bedpan washer.

Environment and equipment

- During the inspection we saw that the blood gas analysis machine and a computer and keyboard used by theatres; as well as other testing equipment were situated in the sluice.
- On the ICU the resuscitation equipment was clean and there was a tamper evident tag in place.
- Equipment management and replacement was good, but there was not enough storage space. A completed risk assessment had been carried-out which had assessed the lack of storage as a moderate risk.
- The problem identified was equipment stored in the theatre corridor, including chairs and a hoist, could potentially block access for ICU patients from recovery. Management responsibility had been specified, with review dates and a proposed action plan.

Medicines

- We were told that there is no dedicated pharmacist for the CCU, and cover is not provided by the same person each day; so therefore there is limited contact with critical care staff.
- The pharmacist does not attend the daily ward round, but reviews the medicines and drug charts and there is good out of hours support.
- We looked at the medicines and equipment on both the ICU and the HDU. On the HDU improvement was needed in the process for regularly changing of medicines cabinet codes. The refrigerator was not locked and there were incomplete medicines refrigerator records.
- We also saw that a medical gas isolator had a broken valve cover.
- There was a record of the current temperature of the refrigerator; however, there needs to be a facility to record the minimum and maximum temperature as well.

Critical care

Records

- Standardised nursing documentation was kept beside the patient's bed area.
- Observations were well recorded; the timing of such was dependent on the acuity of the patient.
- Care bundles were in situ and monitored daily on the charts. All records were in paper format and all health care professionals documented in one folder and on the patient's intensive care observation chart.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told that there has been Mental Capacity training for key members of staff. One of the senior nurses leads on Mental Capacity; there is a working group across the three CCUs looking at how to introduce the delirium assessment.
- We were told that there is a trust lead for the Deprivation of Liberties Safeguards who staff can contact.

Mandatory training

- We were told that there had been issues with the SMART cards, which has meant that the clinical nurse educator has been unable to gain an overview of all training that has been undertaken.
- There were problems with staff accessing eLearning training which often meant it could not be completed.
- On the unannounced inspection to the CCU we requested a copy of the unit's completed mandatory training matrix. The training matrix was out of date and therefore we could not verify the compliance of the staff in relation to having completed all requisite training.

Management of deteriorating patients

- There was an outreach team of three nurses that covered from 8am to 6pm provided by site clinical managers alongside their other operational responsibilities.
- There were five clinical site managers; on the night we undertook our unannounced inspection visit and we met two of the site managers. The role of the clinical site managers combines both clinical and operational responsibilities.
- We were told that the outreach team and the site clinical managers utilised the prevention and management of the deteriorating patient policy. The teams use an electronic trigger system which provides a recording mechanism for patient's vital signs and essential screening tools.

Nursing staffing

- We saw that the nursing staff rotated between both the ICU and HDU areas. The two areas are geographically apart and the staffing rotas were marked so that each member of staff knew which area they would be working in when the duty rotas were published.
- The HDU usually has two nurses on per shift, however during our unannounced visit we found that there was only one registered nurse looking after four patients. This contravenes professional standards for nursing levels for patients requiring high dependency care and junior doctors confirmed that they were concerned about nursing staffing levels out of hours.
- On the ITU the staffing ratios are usually one to one for a level three patient, and we were told it was not normal to have a supernumerary co-ordinator.
- The CCU also has two support staff, one of whom can look after level two patients including taking handover, writing up care plans and giving oral medication.
- The clinical nurse educator works with both pre and post registration nurses providing support and supervision; as well as supporting doctors undertaking an induction to the unit and training staff on using equipment.
- We were told that the unit normally supports two students a year to undertake a post registration critical care course. Out of the current 42 members of staff, just over 50% (22) have a post registration qualification in critical care. This is in line with professional standards.

Medical staffing

- Cover for the unit was provided by four intensive care medicine trained (ICM) consultants through the normal working day 8am to 6pm on a five day block; out of hours cover was shared by 14 anaesthetic consultants who are on call from home.
- At present there are insufficient trainees in anaesthesia and intensive care medicine and thus only 1:8 are substantive trainees from the Kent Surrey and Sussex deanery. Locums provide cover for the rest of the rota in addition to permanent associate specialist and trust doctors.
- Out of hours there are two consultants and a registrar on call to cover anaesthetics and the critical care unit.

Are critical care services effective?

Critical care

Good

Use of national guidelines

- The critical care unit used a combination of NICE, Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment they provided.

Outcomes for the department

- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. Results from ICNARC show patient outcomes that are within the expected range.
- ICNARC data was displayed clearly on a noticeboard but the information was not easily accessible.
- Mortality meetings are held monthly using the safety template. Information of findings / outcomes of reviews are circulated and there is an option to link via video conferencing for anyone who cannot attend the meeting. Minutes go to the safety board and an end of year report is written.
- The mean length of the stay in the unit during January 2013 to December 2013 was 3.8 days.
- We were told that trainees are not currently undertaking any audits, it was felt that this was related to issues relating to the trainees rota.

Care plans and pathway

- The unit used a daily handover sheet which was completed during the ward round.
- Nursing documentation was kept in the patients' bed area and was completed appropriately.
- Care bundles were in situ and monitored daily on the charts (CVP and ventilation bundles) or on clinical monitoring system (urine catheter, peripheral cannula) or specific bundle charts in the patient's records.

Consultant input

- Consultants undertook ward rounds twice daily.
- All potential admissions had to be discussed with a consultant.

Multidisciplinary team working

- There was a daily ward round but not all members of the multidisciplinary team were able to attend at the same time, but had daily input from dieticians, pharmacy, microbiology and physiotherapy. At the weekends, pharmacy and physiotherapy provided on call cover.
- The NICE guidelines for critical care (CG 83) are being introduced across all critical care units within the trust. We spoke with the matron leading on this project. They told us that work is currently in progress.
- One of the resources we were told about was a video where patients who have been in intensive care talk about the benefits of attending rehabilitation classes.

Seven day services

- A physiotherapist comes to the unit on a daily basis. Weekend cover is on-call basis.
- Pharmacist was available five days per week and came to the CCU. Weekend cover is on-call basis.

Are critical care services caring?

Good

Compassionate care

- The unit is geographically split between two areas; we spoke with staff members who were caring for patients in both areas. We were told about how staff ensure that the patient is involved in their care.
- One patient that we spoke with had been in the unit for a short time. The responses given to us about care received were very positive; the patient felt that the nurses always said what they planned to do.
- We observed one nurse gently encouraging the patient to drink more, being aware of the patient comfort and wishes.
- We saw that relatives were welcomed into the unit and sat beside the patient's bed, and we saw a staff member engaging with both the patient and their relative in answering a question they had asked. When we spoke with the staff member they were able to articulate the care planned and how they would meet the patient's needs.
- All relatives spoke highly of the unit and felt care was excellent and would recommend it to others.

Critical care

Patient understanding and involvement

- We spoke with a relative whose family member had been admitted to the unit following deterioration in their condition. The relative was able to talk with staff regarding the patients care and what was best for them.

Emotional support

- Staff that we spoke with and observed interacting with both their patients and relatives demonstrated that they empathised with them. We saw staff spending time talking to their patients who were sedated and ventilated, explaining what they were doing and why.
- Another initiative that we were told about was the use of patient diaries; the purpose of the diaries was to allow patients to understand what had happened to them during their stay in the CCU. All of the bed spaces had a board to display pictures, patient information.
- There were also clocks and calendars, from patient feedback previously about not knowing the date or time the unit now ensured that patient could remain orientated to the time and date. We also saw that there were communication tools available to use with patients.
- There is also a sitting room / waiting area for visitors; which is also a shortcut to get from the level two/three facilities area. We were told that if the family had to be seen in private often a member of staff is asked to wait outside the door to stop people from entering. There are no overnight facilities on the unit for relatives to stay over, but we were told there are facilities elsewhere in the trust.

Are critical care services responsive?

Good

Maintaining flow through the department

- 273 out of the 578 admissions to the unit were planned post-operative admissions.
- Staff we spoke with felt that a major issue was related to an increase in medical admissions coming from the ward and increasingly acute care / CDU area, as the Emergency Care Centre is still seen by the local population as an A&E.
- We were told that there was an interest by senior medical staff to look at pre –operative assessment and risk ratification. This was to ensure that patients were being treated on the appropriate site for their medical needs.

Meeting the needs of all people

- We were told that staff could contact the Practice Development Nurse for people with learning disabilities for advice or support.

Discharge and handover to other wards

- There was a standardised discharge document that was completed by the critical care unit prior to discharge to the ward. There was a nursing discharge summary as well as a medical discharge summary; we did not see them in use during our visit.

Complaints handling (for this service)

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint then they would speak to the nurse in charge. If this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). This process was outlined in leaflets 'talk to us' available in the relatives waiting area.
- On the display board outside of the unit was information about a complaint that had been received, the process of how it had been dealt with and what had been learnt for future action. There was also a word cloud of compliments that had been received about the unit.

Are critical care services well-led?

Good

Vision and strategy for this service

- There was concern expressed about the trusts proposal to relocate emergency surgery to the Kent and Canterbury site. The concerns were about the expansion of the CCU, with already limited space and how medical and nursing staff would be allocated to cover the proposed changes.

Critical care

Governance, risk management and quality measurement

- The critical care unit has frameworks for monitoring the quality of its service. The unit sits within the division of surgery. The department holds monthly surgical governance meetings.
- There is a critical care steering group that meets on a monthly across all three sites: there is a video-link option available.
- We saw from the minutes of the senior nurse meeting that complaints, incidents, audits and quality improvement projects were discussed.
- However, a known risk to patient safety out-of-hours hadn't been effectively addressed. Minutes of nursing staff meetings in the ITU in October and November 2013 highlighted that there was no formal escalation plan for lone nurses to follow if patients were at risk or if patients' actions compromised the safety of the lone working nurse.
- The risk was assessed as low, despite the fact that if two nurses, one from each of the HDU and ICU are assisting one patient, the other seven acutely unwell patients in their care are unmonitored for that period.
- A dashboard was presented so that all levels of staff understood what 'good looks like' for the service and what they were aspiring to be able to provide.

Leadership of service

- The CCU sits within the surgical division. There was a designated clinical lead consultant; there is evidence of strong unit leadership.
- The unit also has a strong nursing leadership, with an identified matron, but there is also a nurse consultant who works across all three critical care units and is a link and resource for all the units.
- There are regular meetings between the nurse consultant and matrons from all three critical care units across the trust. They meet to analyse issues, and ensure that staff receive feedback and are kept informed.

Culture within the service

- There is a friendly environment, cohesion in the nursing team working between the CCU and HDU. From comments we have seen feedback at the senior nurse meeting October/November 2013 from band five staff said "When it's very busy the whole team pulls together really well".
- When we spoke with matron they were able to describe in detail her role and that of the nursing team in how the critical care unit was organised. This included the daily management of the unit, allocation, initiating care, responding to emergencies.
- The matron told us the initiative that they were leading with the introduction of the NICE (CG 83) guidelines for critical care follow up and rehabilitation.
- There are twice yearly band five study days where staff have the opportunity to meet and raise any issues or concerns.
- Issues raised are feedback to the senior nurse meeting. In the minutes of the senior nurse meeting feedback from the band five study day had raised a concern about when the unit is exceptionally short of staff, at weekends or nights, or when there is a challenging patient.

Innovation, improvement and sustainability

- The unit had made improvements re avoiding device related pressure sores and had introduced new practice for securing nasogastric tubes and endotracheal tubes.
- We were told that both band six and seven nurses have regular meetings every two months, they have designated links or leads that include; infection control, tissue viability, manual handling, equipment and end of life.

Services for children and young people

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

Information about the service

The East Kent NHS Foundation Trust provides care and treatment for children across its three sites.

At the Kent and Canterbury Hospital in Canterbury, the child health team has a Children's Assessment Centre which included a range of facilities to support the care of children and their families.

This includes the Dolphin ward ambulatory unit, a day surgery area, and child development services including community paediatricians, speech and language therapists, physiotherapists and occupational therapists.

The facilities also include a gym, a multi- sensory room and parents' resource area.

Children are also seen in other areas of the hospital such as the Emergency Care Centre (ECC), main theatres and outpatients.

The ECC can see children requiring emergency care between 9am and 4pm Monday to Friday. Outside these hours and at weekends children are expected to be taken to A&E departments at William Harvey Hospital, Ashford, or Queen Elizabeth The Queen Mother Hospital, Margate. We saw children access this service and be treated outside the times intended.

The Urgent Care Centre offered a twenty four hour, seven day a week service to treat children for minor injuries such as broken bones.

Summary of findings

The Children's Assessment Centre provided a safe environment to care and treat children. There were suitable numbers of appropriately trained nursing staff and the skill mix reflected current guidelines. In general parents were happy with the care and support and said that the facilities were very good. But they raised concerns about the distances they had to travel between the three hospitals and that not all the children's staff were appropriately trained in the emergency care of children.

The service well-led at a local level, but there was no one at board level with overall responsibility for ensuring the voice of the child was heard. Across the trust we found that risk management and clinical governance relating to the care of children was not managed well. We did not find any monitoring of the service to ensure that key performance indicators were being met. Staff did not audit their practice against national standards.

Areas identified as serious concerns had not been addressed for long periods of time. The environments where children were seen and treated had not been risk assessed to make sure that it was a safe and suitable place to treat children. The general environment in outpatients was not child friendly.

Services for children and young people

Are services for children and young people safe?

Requires improvement

Incidents

- Across the hospital we found there was limited understanding of managing risks to children outside of the main children's wards.
- Staff had not received training in specifically managing the risks to children and did not show any understanding in managing the specialist risks associated with caring for children.
- We looked at the clinical governance arrangements for reporting risk and found that the Child Health Risk Register did not identify any individual hospital site but documented general risks to child health across the trust. There were no identifiable risks to child health relating to the services offered at the hospital on the risk register.
- We reviewed the past three months of incident reports relating to child health and found that staff were reporting incidents relating to children where ever the child was being treated for example outpatients, the day surgery unit and the Children's Assessment Centre.
- We reviewed the trust's incident log relating to child health and found that of the 59 incidents reported eight related to the care given at the hospital. Three related to outpatients, one clerical, one injury to staff, one injury to patient and two related to breaches of confidentiality.
- The managers we spoke with told us that there was good reporting of incidents. They told us that incidents were quickly investigated and the reports feedback and presented at clinical governance meetings
- They told us that the reports from all paediatric incidents from the child health division were seen by their governance team however other incidents involving children seen by other divisions were not included
- We spoke with front line nursing staff who told us that there were no concerns with reporting areas of concern, incidents or errors.
- Staff we spoke with on the day surgery unit had a good understanding of assessing and monitoring risk, taking action where concerns were identified.
- Staff had identified that children attending outpatient's clinics for dermatology and haemophilia clinics were not receiving child appropriate care. They had taken action to move these clinics into the Child Assessment centre where there were staff trained in looking after children.
- We saw minutes of clinical governance meetings and memos to staff on the outcomes of various investigations. However frontline staff told us they did not often receive direct feedback following reporting of any incident.
- There was no evidence of effective learning from incidents. The meeting minutes and newsletters contained action plans and lessons learned but we did not see evidence that these were translated into a change in practice.
- We looked at three investigations following serious injury and found that the action plans included having a standard operating procedure for child health which remained outstanding for several months. Another had actions relating to the safe management of patient notes that had been outstanding for over 18 months.
- We spoke with a nurse practitioner and a parent attending the ECC with their child. The child was x-rayed with the results interpreted by the nurse practitioner who told us had some training in interpreting x-rays. The child's parent told us that previously the child had been admitted with a broken bone that had not been immediately diagnosed. No system had been put in place to check x-rays to ensure the correct diagnosis had been reached.
- This demonstrated that although there were arrangements in place for reporting safety incidents and allegations of abuse, which were in line with national guidance there was a lack of department and trust wide learning from events.

Safety thermometer

- The NHS Safety Thermometer does not relate particularly to the safe care of children as it refers to pressure area care, falls, urine infection and embolism rates.
- We asked how the trust monitored safety and performance in the Child Health Division and we were given a copy of the past 10 months paediatric balanced scorecard.
- This information was not broken down into ward or unit level but provided assurance that across the division

appraisal and sickness rates were within expectations. However the information did not give assurance on the quality of care given across the all of the services which offer care and treatment to children
- The trust did not have a system in place which measured the quality of care offered to children. We found there was no bench marking of the service against national standards or key performance indicators.

Cleanliness, infection control and hygiene

- We inspected the Children's Assessment Centre and day surgical unit and found they were new, clinical environments purpose built to meet the needs of children and their parents.
- We saw the equipment was new and appropriate for child use.
- The equipment was visibly clean with documentation available to support it was checked regularly to make sure it was safe to use.
- The Children's Assessment Centre and day surgical unit were clean and tidy with cleaning schedules in place. This demonstrated that infection control was prioritised and children were cared for in a clean environment.
- In other areas where children were seen cleanliness was not kept to the same standard. For example the outpatients area was visibly not clean.
- We spoke with outpatient staff who told us there were concerns with the general cleanliness of the department and gave examples where bathroom supplies were not replaced during the day.
- According to the documentation the department was regularly cleaned and there were no issues with cleanliness or infection control. We found that the cleaning schedules and audits were not an accurate reflection on the state of cleanliness and infection control in the outpatient department.

Environment and equipment

- We found the Children's Assessment Centre was a new purpose built unit that provided a safe and suitable clinical environment in which to see and treat children.
- On the day of our inspection there were no children using the facilities, which included a gym and sensory room.
- We saw there was a good range of equipment, with age appropriate play facilities available to help relax and divert anxious children.
- We inspected the day surgery theatres and found that the theatres were new, light and bright.
- The day surgery theatres were situated next to the children's day unit and had designated paediatric recovery bays.
- In the main theatres there was seating available for parents to enable them to wait for their child outside the recovery bays. The two designated paediatric bays were well equipped and child friendly.
- The outpatient environment where children were seen and treated had not been risk-assessed to make sure that they were safe and suitable places to treat children. The general environment in outpatients was not child-friendly.
- We saw there were basic arrangements in place to deal with foreseeable emergencies. We were shown contingency plans for child health which referred mainly to maternity services and relied heavily on the goodwill of staff. There were no child specific contingency plans in place.

Records

- During our inspection there were no children being treated in the Children's Assessment Centre and few children in the receiving care in the rest of the hospital.
- We did not have the opportunity to review medical or nursing records in this hospital. However we reviewed the documentation available and spoke with staff.
- We saw there was documentation available to support staff in caring for looked after children including consent, pre-operative assessment and information for parents/carers.
- We were told that the Children's Assessment Centre did not use standardised care plans but kept individual hand written notes.
- We found that the nursing, medical and therapy staff were all keeping their own separate records and not writing in one care record as recommended in the Lord Laming report (2009) or in accordance with the Nursing and Midwifery Council guidance.

Mental Capacity Act, Consent and Deprivation of Liberty Safeguarding

- We were told that the executive lead for safeguarding children in the trust was the Chief Nurse, Director of Quality and Operations. Although the safeguarding lead met with her, they did not attend any of the safeguarding meetings.

- There were child protection policies and procedures available on the trust intranet, which referred to best practice and local safeguarding protocols. However there were areas where practice could be improved such as flagging vulnerable children when they accessed the ECC or the A&E departments.
- Frontline staff told us that the trust dealt with a lot of looked after children but we did not see any guidance on ensuring these vulnerable children were kept safe or any flags in place. For example safeguarding checklists or protocols on the action to take when vulnerable children missed outpatient appointments.
- The safeguarding leads told us they monitored staff child protection training across the trust. The safeguarding leads were unable to provide assurance that all staff caring for children across the hospital had completed the appropriate level of child protection training.
- We were told that child protection formed part of the mandatory training for all staff; however, we couldn't verify the number of staff who had completed the appropriate level of child protection training in the ECC or theatres. Mandatory safeguarding training was at level one. Those working with children are required to be trained to level three.
- The nominated leads could not provide assurance that all staff working with children were appropriately trained to level three.
- The safeguarding children's leads told us that they worked closely with the local safeguarding boards and ensured that any learning from serious case reviews and safeguarding investigations were disseminated through the trust.
- We looked at minutes from the children's safeguarding and multi-disciplinary safeguarding meeting, which demonstrated that local and national child protection issues were discussed within the child health team.
- There was a lack of medical input in these meetings; although medical staff were invited they often did not attend.

Mandatory training

- We spoke with senior managers from the areas where children were seen and treated. Not all managers were able to tell us how up to date their staff were with mandatory training, supervision or appraisals. We were told how the records were kept centrally and were not easy to access.
- On the day surgery unit we spoke with staff who told us they had undertaken safeguarding and basic life support training but did not have any child specific training or qualification.
- We spoke with the senior nursing staff in the day surgery unit who were passionate about giving the right care and support to children. They told us that they would like to have more paediatric input with trained paediatric nurses on duty.
- The staff we spoke with were aware of the need to provide a safe, pleasant experience for children undergoing surgery.
- In the day surgery theatres we spoke with the theatre staff who told us that the hospital held paediatric lists with dedicated theatre staff who were trained in the care of children.
- We were told that the anaesthetists who looked after the children during surgery or when scans were done under general anaesthetic were all experienced in the care of children.
- However, we found that none of the staff had appropriate paediatric life support training although we were told that two staff members were booked on a paediatric training day in the future.
- In the main hospital theatres we spoke with staff in the recovery area. They told us that although they were not trained in looking after children the anaesthetist had an interest in the care of children and much experience in paediatric care.
- Staff told us they had undertaken basic paediatric life support training, they had not undertaken intermediate or advanced paediatric life support training to be able to recognise and respond appropriately when a child became suddenly and acutely unwell.
- We found that in areas outside of the Children's Assessment Centre children were seen and treated by staff who did not have paediatric qualifications and who were not trained in appropriate paediatric emergency care.

Management of deteriorating patients

- The trust used a paediatric early warning score systems (PEWS) to ensure the safety and wellbeing of children.
- We were told that PEWS was used across the trust in all wards and departments where children were cared for. This minimised the potential for confusion and promoted consistent record keeping.

- However, we had concerns that an audit conducted in February 2013 showed that completion of the tool was variable. A further audit was due to be undertaken in March 2014 to monitor if the situation had improved.
- We spoke with staff on the day surgical ward who told us that if following surgery or assessment the general health of a child deteriorated, the child would be transferred. They told us that they would be transferred to one of the other two hospitals in the trust with inpatient beds or to an outside specialist trust. We were told there was good communication between front line staff and gave us examples of escalating concerns about a child's health to the medical staff and told us this was well managed.
- However, the trust had few policies procedures or protocols available to support staff in caring for children such as the management of the deteriorating child.
- There were no standard operating procedures in place for the guidance of staff and to promote consistency and good practice.
- Paediatric resuscitation or emergency care was variable as not all staff caring for children had received the appropriate level of resuscitation training.
- Staff on the day surgery unit had not undertaken appropriate life support training to care for children appropriately should an emergency occur. Staff had undertaken basic life support training for adults and not specialist children's intermediate life support training. In an emergency, children were at risk from inappropriate care as staff were not appropriately trained.
- We spoke with the trust's resuscitation lead who could not provide assurance that all staff including doctors and consultants caring for children across the trust had current life support training appropriate to their role and specialty.
- On both the main theatres and the day surgery theatres we found that there was appropriate resuscitation equipment available specifically for children, which were kept readily to hand by the paediatric recovery bay.
- We saw that the paediatric resuscitation trolleys were well equipped with systems in place to check daily that items were in place and dated.
- Outpatients did not have child appropriate resuscitation equipment available. This meant that in an emergency staff would not have the necessary equipment to deal with the emergency readily to hand.

Nursing staffing

- Staff told us that there was little continuity of staffing as staff were rotated without an apparent plan. They told us that the rota did not appear to take into consideration staff qualifications, their experience or expertise. This meant that the needs of children were not considered when staff were scheduled for duty.
- The Children's Assessment Centre had specialist children's nurses to support children and their parents/carers while they attended the unit.
- The staff included therapists such as physiotherapists, occupational therapists and speech and language therapists.
- We looked at staffing rotas across the unit and found that the staffing levels were consistent and reflected current professional advice.
- Staffing was not consistent in all areas where children were seen or treated in the hospital.
- In the ECC and outpatients departments there were not always specialist children's nurses available when children were being seen and treated.
- Staff told us that when they were aware that children were being seen and treated in areas outside of the Children's Assessment Unit such as dermatology and haemophilia clinics, they had made arrangements for these clinics the be held inside of the paediatric areas, where they could be supported by trained children's nurses.
- The ECC saw children requiring emergency care between 9:00am and 4:00pm Monday to Friday. Outside these hours and at weekends children requiring emergency care were taken to the A&E departments at William Harvey Hospital, Ashford, or Queen Elizabeth the Queen Mother Hospital, Margate.

Medical staffing

- There are no specialist paediatric surgeons at the trust. Paediatric surgery is provided by surgeons with general paediatric training.
- We spoke with paediatric consultants and the anaesthetists working with children in the Children's Assessment Centre and day surgical unit. They told us that they had concerns regarding the safety of children in the trust.

Services for children and young people

- This mainly concerned the low number of middle grade doctors available, the geography of the three hospitals in the trust and the logistical problems of ensuring the right doctor was at the right hospital to respond to the care needs of the child when required.

Are services for children and young people effective?

Requires improvement 

Use of national guidelines

- We looked at the policies and procedures that were available for staff and found that there was little guidance on the trust's intranet relating to the safe care of children or referencing national guidelines or best practice.
- Policies, procedures and protocols are guidance for staff to enable them to provide safe, evidenced based care and treatment to children.
- Staff were aware of where the policies were kept and showed us the trust's on-line policies, procedures and protocols.
- There was only one standard operating procedure for an assessment unit, there was no overarching children's strategy or information about what key performance indicators were used to monitor the outcomes for child care.
- The trust had various actions plans which discussed implementing standard operating procedures however these had been outstanding for several months.
- There were few key documents available on the intranet and no reference to National Institute for Care Excellence quality standards and other best practice guidelines for staff.
- We saw that staff had developed local protocols to assist them in providing care for children.
- We spoke with senior staff who told us that it was sometimes difficult to standardise policies and procedures across the three hospital sites as there was a disparity between the techniques used by the various consultants and differences of medical opinions. They gave examples of the techniques used for tonsillectomy, anaesthetic techniques and the anaesthetist's views on having staff in the anaesthetic rooms.
- We did not see that there was a forum where these issues could be constructively discussed and resolved.
- There was no system in place to monitor that medical and nursing staff abided by best practice guidelines and national standards as the trust did not provide basic policies, procedures and standard operating procedures that documented the standards expected
- This impacted on the care of children because there were no systems in place to monitor if care was being delivered in line with national standards and best practice guidelines.

Outcomes for the department

- We saw that the child health division had participated in most of the clinical audits they were eligible for.
- We saw limited evidence that the results of these audits had been fed back to staff and were being used to improve outcomes for children.
- We saw details of three audits undertaken in 2013 but not a planned programme of audits undertaken at a local level across children's services to monitor the quality of care provided.
- There had been no auditing of key performance indicators or monitoring of compliance against national standards such as the British Association of Paediatric Surgeons Standards for Children's Surgery.
- The hospital could not demonstrate that there was a systematic process in place for implementing and monitoring best practice guidelines and standards or the impact on the care and treatment of children.
- At a local level in the Children's Assessment Centre and in other areas in the hospital where children were seen and treated the safety and effectiveness of the treatment offered to children was not monitored or assessed.
- We did not see evidence of regular programmes monitoring such as audits of medical and nursing records on a regular basis to ensure they contained all the required information on consent and adhered to best practice in record keeping.

Care plans and pathway

- We found that the services for children were provided at all three of the trust's hospitals.
- However because of the limited service offered at the hospital, children and their parents often had to travel between the three hospitals to access the right care from the right service. For example a child may access emergency care at one hospital, be assessed at another, have the surgery at another with follow up somewhere else.

Services for children and young people

- Parents and clinicians raised concerns about the distances they had to travel to access and provide the care.
- On the day of our inspection there were few children present in the hospital receiving treatment. However we spoke with staff and the children and families that were available and followed the pathway the child would take if they were undergoing surgery at the hospital, both in the day surgery unit and in the main theatres.
- Although there were no specialist children's nurses available in the day surgery unit or in theatre, staff were trying to meet the needs of children having surgery.
- We were told that the anaesthetist had met the child and their family previously and the preadmission process was undertaken by a general nurse rather than a trained children's nurse.
- On the day of surgery the child was admitted then collected from the ward by theatre staff. The child was able to wear their own clothes to theatre and walk there with their parents. One parent accompanied them into the anaesthetic room where they stayed with them until they were anaesthetised.
- Staff told us that if small children were distressed they anaesthetised them sitting on their parent's lap.
- Parents were then escorted back to the ward or there was a waiting room where they could stay if they wished. A nurse from the day surgery unit collected the child with their parents from theatre and took them back to their bed.
- This demonstrated that the needs of the child and their parents were taken into consideration when a child received surgical treatment at the hospital.
- In the outpatients department we observed the care that was given and inspected the general environment as staff were very busy with little time to talk with us.
- Staff told us that there were very few children seen in the general outpatients department. We saw that children were seen in the Urology and Ear, Nose and throat clinics with audiometry.
- We saw there was documentation available to support staff in caring for looked after children including information about consent, pre-operative assessment and information for parents/carers.
- We were told that the Children's Assessment Centre did not use standardised care plans but kept individual hand written notes.
- We saw that the Child Health Directorate was aware of the risks of transition for adolescents between child and adult services and there were pathways in place for certain conditions. This meant that where children were being treated for conditions which would continue into adulthood there were arrangements in place to ensure continuity of care.

Multidisciplinary team working

- The service for children and young people offered at the hospital included child development services such as community paediatricians, speech and language therapists, physiotherapists and occupational therapists.
- Parents we spoke with told us that it was very useful being able to access all these services in one place.
- We spoke with senior staff who told us that the care for children with complex conditions was shared with other specialist hospitals.
- They told us that there was good joint working and coordinated care. They gave examples of the care for children with cancer which was shared with the Royal Marsden Hospital who offered a specialist oncology service for children. The team from the Royal Marsden sent specialist consultants to the trust and offered some training for staff in caring for children with cancer.

Seven day services

- The hospital did not offer a seven day inpatient child health service. The Children's Assessment Centre operated a day surgery unit which was not open through the night or at weekends.
- Children who required emergency care could be seen between 9 am and 4 pm Monday to Friday in the ECC.
- Outside these hours and at weekends children who needed emergency care had to travel to A&E departments at the William Harvey Hospital in Ashford or the Queen Elizabeth the Queen Mother Hospital in Margate.
- The ECC offered a seven day service for minor injuries such as broken bones.

Are services for children and young people caring?

Good

Compassionate care

- In order to assess if the hospital offered a caring service to children and their parents we spoke with medical,

nursing and ancillary staff. We reviewed available documentation, looked at feedback information provided to us before and during the inspection, reviewed information about concerns, complaints and incidents and spoke with the parents and children that were available.

- On the day surgery unit we spoke with staff that were very aware of parents concerns when a child was admitted for surgery. They told us about the steps they took to reassure the parents and provide compassionate care for their children. They told us how parents were encouraged to visit and spend time with their child and how they could relieve some of the parent's anxiety by enabling them to accompany the child to theatre and back.
- We saw how the design of the building facilitated staff in providing compassionate care through simple arrangements such as providing seating outside of theatre while parents waited for their child and providing them with areas to sit and relax and meet other parents for support if needed.
- In the limited interactions we were able to observe on the day of our inspection we saw that staff were courteous in all their dealings with parents and friendly when talking with the children.
- We observed the care being given in the day surgery unit, in the ECC and in the outpatients department. We saw that staff responded appropriately to the needs of the children and provided reassurance to their parents.
- We found that the general environment in the Children's Assessment Unit and Day Surgery Unit protected the dignity of children through providing individual bays with screening and side rooms that could be used for private conversations if needed.
- The children and families we spoke with in the day surgery unit, in the ECC and in the outpatients department told us they were happy with the care provided at the hospital. They told us that the staff were kind and caring.
- We reviewed the past three month's complaints information relating to the child health division and noted that of the six formal complaints none related to the care given at the hospital.
- We saw in the records of incidents that occurred in the trust over the past three months none indicated there was a problem with staff attitudes at the hospital.

Patient understanding and involvement

- We spoke with parents and their children attending the outpatients. They told us that the doctors and nurses were very kind and they did not have any concerns about the care and treatment they received.
- One parent told us that "we haven't had to wait too long at all" and told us they regularly attended the hospital with their children and never had any concerns.
- The parents we spoke with told us they felt staff involved them in decision making. One parent told us "they are always kind and considerate and keep us informed what's going on".
- We spoke with staff on the unit and asked about information sharing with parents. We found that staff had limited awareness of their duty of candour. They told us they would share information about serious incidents with a child's family but there were no policies or guidance for staff or supporting information or leaflets for parents about this issue.
- We saw there were a range of information leaflets available for parents to access about the various services the hospital had to offer and information about various conditions.
- There were information boards available in the Children's Assessment Centre, which contained much useful information for parents about how to access help and support both in the hospital and local community.
- Although over 5% of the local population were from diverse ethnic groups we found that information leaflets were not readily available in other languages or formats. We spoke with staff who told us the leaflets could be translated if required but this did not meet the immediate needs of patients and their families attending the hospital.

Emotional support

- We found that parents and children were supported emotionally while their child received care and treatment at the hospital. For example we saw that on the Children's Assessment Centre and wherever children were seen and treated in the hospital, parents were encouraged and supported to stay with their child.
- There were arrangements in place to care for parents should a child die in the hospital. This included individualised bereavement boxes. The staff we spoke with were aware of the special support and care that bereaved parents might need and felt able to provide this when needed.

Services for children and young people

- There were initiatives in place to encourage the children to enjoy their hospital experience such as certificates for being a 'Star patient'. These actions demonstrated that staff were aware of the need to support children and their parents emotionally while they were in hospital and had put in place practical means of helping them.

Are services for children and young people responsive?

Good

Maintaining flow through the department

- On the day of our inspection at the hospital there were few children receiving care or attending for outpatient appointments. In order to assess if the hospital offered a responsive service to children and their parents we spoke with medical, nursing and ancillary staff. We spoke with senior managers and staff with safeguarding responsibilities.
- We reviewed available documentation, looked at feedback information provided to us before and during the inspection, reviewed information about concerns, complaints and incidents and spoke with the parents and children that were available.
- From the information available there were no issues with providing children with a safe and timely discharge from hospital services.
- The Children's Assessment Unit did not use the trust's paediatric procedure care pathway which included a discharge checklist as the unit used individual hand written nursing, medical and therapy notes. However the parents we spoke with did not raise any concerns about the discharge of their child from the day surgery unit or from the Emergency Care Centre.
- We saw that there were appropriate arrangements in place to transfer children who had difficulty in breathing and needed artificial ventilation to another specialist service from outside of the area. We were told that the staff were supported with link consultants and training.
- The safeguarding team told us of the strong working relationship they had with the local authorities to manage child protection in the local area. They told us they attended the local authority safeguarding committees and worked closely with community teams to ensure the safety of vulnerable children and their families. However there was no evidence that the hospital had systems in place to alert staff when vulnerable children accessed their services such as the ECC or outpatients.

Meeting the needs of all children

- The trust website had mechanisms in place that enabled patients to give feedback on the care they received. This included a link to the NHS Choices website and a patient questionnaire. There were no specific initiatives in place to seek the views of children on the service they received.
- We saw children and their families were supported to make choices with information leaflets that were readily available on the hospital and various conditions.
- Senior staff told us that the biggest risks were the children and adolescent mental health service and looked after children. However, neither of these two risks identified by senior staff were on the paediatric risk register.
- Across the trust staff told us that there was an issue with children accessing mental health services in the area. The NHS provider of community psychiatric care for children and young people had changed and staff told us the service provision had deteriorated. Children with mental health problems were admitted through the A&E department where they were held awaiting a mental health referral and admission.
- Children with mental health problems were at risk from delay in therapeutic interventions and from receiving inappropriate care from untrained staff. One child had waited up to 48 hours for a mental health assessment and admission to an appropriate mental health facility. This meant that children and young people with mental health problems were often kept in inappropriate locations such as the ECC or had to be transferred to another general hospital location while awaiting specialist help or support in the community.
- The staff told us that meeting the needs of looked after children in the local area were a challenge. We had concerns that strategies had not been put in place to address their particular needs, for example, monitoring their attendance at outpatient clinics with a procedure to follow if they did not attend.

- There was not a clear pathway of care or policies and procedures to guide staff in caring for these vulnerable children. The trust did not have a policy on the actions to take when a looked after child did not attend outpatient appointments.
- Staff guidance on looked after children was limited to information about the different types of legal guardian and information on obtaining valid consent.
- We did not speak with nursing or clinical staff in outpatients department as the unit was exceptionally busy and staff could not be released to speak with us. However we did speak with patients, volunteers and ancillary staff who told us that the outpatient department unit was very busy and not particularly child friendly.
- We found that the service offered in the main outpatients department did not always make reasonable adjustments to meet and support the needs of children. Such as providing a suitable environment for children to wait in and with limited distraction facilities such as toys.

Environment

- The Children's Assessment Centre was a new purpose built unit that provided a safe and suitable clinical environment in which to see and treat children. The facilities included a gym and sensory room. We saw there was a good range of equipment, with age appropriate play facilities available to help relax and divert anxious children.
- Feedback from the parents we spoke with in the hospital indicated that the facilities were very much appreciated although one parent queried why the same standards weren't in place at each of the trust's hospitals when the other services were more heavily used.
- We inspected the day surgery theatres and found that the theatres were new, light and bright. They were situated next to the children's day unit and had designated paediatric recovery bays.
- In the main theatres there was seating available for parents to enable them to wait for their child outside the recovery bays. The two designated paediatric bays were well equipped and child friendly.
- However staff told us that the journey to and from the ward was not child friendly. Where the child left the paediatric areas which were light, bright with child appropriate decoration the corridor then became cold, bleak and austere as it joined the main hospital corridor. Staff told us they were aware of this and were taking ideas forward to improve the child's journey.
- We found the day surgery and theatres had made adjustments to provide a suitable environment to treat children such as dedicated bays which were child friendly.
- We found that in other areas where children were seen and treated the general environment was not suitable for children. For example the main outpatients did not have an area that was child friendly or had been risk assessed as a safe place for children to wait before their appointments.
- Outpatients did not provide an appropriate environment to see and treat children.

Communication with GPs and other departments within the trust

- Staff told us of difficulties in providing GP's with discharge letters in a timely fashion. They gave examples of GP's waiting four to five weeks to receive information about their patients. The doctors we spoke with also raised this as a concern and told us this was due to the new service design which was not staffed adequately.
- Staff told us that a GP clinic and an emergency dental service that operated out of the Emergency Care Centre. This enabled patients to have immediate access to other services should their condition require it.

Complaints handling (for this service)

- We spoke with senior managers and staff on the day surgical unit, theatres and the ECC. We were told that staff were encouraged to resolve all complaints at ward level. This meant staff could act quickly to intervene, address any issue quickly, which demonstrated that staff were proactive in dealing with concerns.
- We saw that the trust had in place a leaflet titled 'Talk to us'. This was available in all areas throughout the hospital and on the trust's website.
- Parents we spoke with were aware that the hospital had a complaints process but told us they had never had occasion to use it.
- We spoke with senior staff who explained the complaints process and how it fed into the hospital's

clinical governance processes. On a monthly basis the individual complaints were reviewed and the statistical information fed into the quarterly report to the trust board.

- We saw that the trust continuously monitored the complaints information it received however the reports did not provide assurance that the complaints had been handled in a timely way or that that there had been any action taken as a response.

Are services for children and young people well-led?

Vision and strategy for this service

- The trust did not have documented strategic objectives for the care and treatment of children. The frontline staff we spoke with were unaware of the trust's vision and values regarding the provision of care for children.
- We spoke with senior managers with responsibilities for child health. We had concerns that the responsibilities for senior staff with the remit for overseeing child health did not encompass the care and treatment of all children in the hospital wherever they received care.
- The trust did not demonstrate that they had a vision and strategy in place for children's health service that was known and shared across the workforce and the population it served.

Governance, risk management and quality measurement

- There was a clinical governance structure in place to monitor data from various sources such as patient safety incident reports, complaints, health and safety incidents, inquests, claims and clinical audits to build a picture of safety performance. We saw that monthly meetings took place where this information was reviewed and then fed into quarterly Board meetings.
- Several of the actions had been outstanding for long lengths of time. For example updating policies, guidelines and developing standard operating protocols for child health had been outstanding for many months. This meant that although there was a governance structure in place the delay in implementing agreed actions put children and staff at risk.
- We spoke with staff across the hospital and we were told that there was an issue with managers being ineffective and not managing various staffing problems. For example we were told about the outpatients area where the lack of management structure meant that issues like the cleanliness was not managed appropriately.
- Front line staff told us about the areas they were concerned about and we saw that many of these issues were documented on the Child Health Risk Register and in action plans.
- However, we saw that little action had been taken to address these concerns. For example in January 2010 staff raised a concern that the emergency care pathway did not meet the national service framework for children in A&E. The trust had set a target date for meeting the framework of July 2014. This meant that for over four years the emergency care pathway did not meet national best practice standards.
- Other items on the risk register had been outstanding since 2009 such as funding for a named doctor for child protection. We saw that in 2012 the trust had concerns that there was insufficient middle grade medical covering paediatrics however this was removed from the risk register in September 2013 without being resolved.
- We found that many of the issues the staff raised as risks and concerns were either not on the trust's risk register or had been removed without being resolved. During our inspection we identified there were still concerns with the level of middle grade medical cover and this risk was added to the register again.
- We also raised concerns about the safe care and treatment of children in areas outside of the main children's wards which was added to the risk register during the inspection.
- These issues did not give us confidence that the risks to children across the hospital were appropriately assessed, monitored and managed.
- We saw evidence that where clinicians had raised concerns about the care of children in the trust little action had been taken. Serious risks to children had been brought to the chief executives attention in 2011 and at this inspection we were concerned to note that the same issues remained outstanding.
- Clinicians told us that there were good paediatric skills across the trust but peoples skills were not communicated or used. They told us staff felt disenfranchised with the reporting process and they felt

that the children's service was not well led. In particular they told us that because the operational cover was spread over the three different sites it lost its effectiveness.

- The trust told us how they were taking action to address staff concerns. We saw that the trust conducted an engagement survey in 2013 which involved all staff across the trust. The results from this survey indicated that there remained issues the trust needed to address. The survey indicated that the child health division scored low on 'I am able to make improvements in my area of work' and 'I would recommend my organisation as a place to work'. We saw that the action plan prioritised developing the administration team to expand and consolidate their knowledge.
- The trust was concerned about the engagement of their staff but queried if the action plan to develop the administrative team's knowledge would address the concerns of the child health division to recommend the organisation as a place to work.
- Staff told us that children's services were poorly managed, and that there was no standardisation and much was down to the individual consultants. This led to inconsistencies with the emergency management of children. They told us the overwhelming impression was the trust did not want to look after children who required surgery and there had been no investment in the service.

Leadership of service

- The National Service Framework for Children states that all trusts should have a named individual with responsibilities for the planning and delivering services for children. The responsibility for implementing the standard should sit in the trust's clinical governance framework for which the chief executive is responsible to the board.
- The trust did not have a named non-executive director with overall responsibilities for the care of children and young people within the trust. This meant that there was not a senior person at board level who understood the key risks associated with providing a paediatric service and had the responsibility for ensuring the child's voice was heard and their rights and issues were considered and promoted.
- The proposed reconfiguration of surgery placed children at risk from multiple transfers to receive appropriate care. We did not see an impact assessment relating to this issue and the senior medical staff we spoke to had concerns about the effect of its implementation on children's care.
- There are no specialist paediatric surgeons at the trust which puts child safety at risk.
- We heard that board members undertook 'Walk Arounds' on the wards and departments. We did not see reports or action plans following their visits and staff told us that they rarely saw senior members of the trust.

Culture within the service

- We spoke with senior managers who had responsibilities for different aspects of child care across the trust. We found that the management of the care of children and young people across the trust was not coordinated. For example the care and treatment of children outside of the Children's Assessment Centre did not come under the Child Health Division.
- We spoke with senior nursing staff who told us that they felt well supported by the trust's divisional leads. They told us that their managers were visible and accessible. We found that senior staff worked hard in a complex environment to manage the needs of children over the three different sites
- However, managers told us that the culture in the hospital was not fair as the medical staff were treated differently than other staff.

Innovation, improvement and sustainability

- We found that staff from the Child Assessment Centre were aware that the care and treatment of children in other areas of the hospital could be improved and had taken action to address some of the anomalies. For example staff had moved some of the outpatient clinics that saw and treated children into the Children's Assessment Centre. This meant that children who attended these clinics were now seen by staff with qualifications and expertise in caring for children.
- Senior managers told us that their managers had an open door policy and they were always made welcome if they wanted to raise a concern or raise an issue. They told us of regular meetings with their line managers such as the Matron's Forum and quarterly senior nurses meetings. They told us about the staff listening days and the Executive Briefs which were another means of communication.

End of life care

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

Information about the service

The Kent and Canterbury Hospital had a specialist palliative care (SPC) team, led by a nurse consultant in palliative care medicine. We saw evidence that systems were in place for the referral of end of life (EOL) patients to the SPC team for assessment and review. This ensured that patients received appropriate care and support with up-to-date holistic symptom control advice for adults with advanced, progressive and incurable illness in their last year of life. The SPC team supported and provided evidence-based advice to other health and social care professionals, and ward staff told us that they were highly regarded across the trust. We saw evidence that urgent referrals were seen on the same day, however this service was Monday to Friday, 9-5pm only, with telephone advice available from the local hospice outside of these hours.

We visited Brabourne, Treble, Invicta, Kent and Clark Wards, Clinical Decision Unit (CDU) ,the Chemotherapy Day unit, bereavement office, hospital mortuary and hospital chapel. We reviewed the medical records of six patients at the end of life and eight medical records of patients who had died in the past six months, observed the care provided by medical and nursing staff on the wards, and spoke with three patients receiving end of life care and their relatives. We also spoke with members of the hospital's SPC team, ward staff, relatives' support officers (RSOs), chaplain and mortuary staff. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

Summary of findings

The trust's specialist palliative care (SPC) team showed a high level of specialist knowledge and across the trust provided advice on up-to-date holistic symptom control for patients. Patients and relatives spoke positively about the care they received. Staff showed a good understanding of the issues they needed to consider in order to maintain people's dignity in the later stages of their lives. Patients and families were involved in decisions about their care.

Since the trust had stopped using the Liverpool Care Pathway, nursing staff had found it harder to identify which patients on wards were receiving end of life care and treatment. As a result, care planning for patients who hadn't been supported by the trust's SPC team was ad-hoc and inconsistent. Also vulnerable adults were being put at risk as Mental Capacity Act assessments were not always completed. This inconsistent approach highlighted the lack of an end of life care champion at board level who could steer the end of life care strategy throughout the trust.

End of life care

Are end of life care services safe?

Requires Improvement

Incidents

- We saw evidence that the hospital had responded to a National Patient Safety Agency rapid response report relating to syringe drivers. It stated that all syringe drivers had to be replaced by December 2014 because of the reporting of a fatal error. In a timely manner the trust sourced new McKinley T34 syringes which arrived in February 2014. We saw that these were being used across the trust.
- We learned that a full training programme was set up, but attendance from wards was poor. Subsequent online training was introduced and SPC nurses supported individual nurses on the ward when a patient required drug therapy (often controlled drugs) through a syringe driver.
- Staff we spoke to on Brabourne ward were able to explain in detail the incident reporting mechanism, 'Incident reporting system'. The most recent serious untoward incident described led to a full root cause analysis with the learning's from the event being sent back to both the medical and oncology teams to be discussed at monthly staff meetings.
- All staff we spoke to stated that they would report incidents to ensure that services could be improved and similar incidents would not happen in the future.

Medicines

- We reviewed eight patients' medical records and saw end of life care medication was appropriately prescribed as per hospital end of life policy. We saw three patients had received support from the SPC team, the medication was clearly documented and regular reviews to support patient's changing clinical needs.
- On Clark ward we observed one patient who required pain management. We saw that the medication was written up promptly as per end of life protocol and the medication was provided quickly when the patient asked. Patients not referred to the SPC had the appropriate medication prescribed and delivered but the documentation in the medical records was not as detailed as the SPC team daily notes.
- We were told that the site co-ordinator would support staff with any problems out of hours to ensure the safe usage of the syringe driver. In four of the eight sets of medical records we saw patients that required syringe drivers had them in place and were receiving appropriate medication.

Records

- We reviewed the medical records of eight patients and found the do not attempt resuscitation (DNA CPR) form was at the front of the medical records allowing easy access in an emergency; all decisions were recorded on a standard form with a solid red border around the edges.
- Six of the eight forms were not signed by a senior health professional.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- On reviewing the medical records of eight patients we found that four patients that were described as lacking capacity to make decisions did not have the necessary Mental Capacity Act (2005) assessments in place showing that procedures was not being followed.

Management of deteriorating patients

- The Liverpool Care Pathway (LPC) had been used in the past to support patients at the end of life. After guidance from the Department of Health (October 2013) the trust had stopped using it. The SPC nurse consultant undertook an audit in October 2013 and found no patients on the LCP because clinicians had stopped using it before the hospital phased it out.
- From our discussions with staff and our review of medical records, it was clear that there was confusion and a lack of clarity around what had replaced the LCP.
- We reviewed eight sets of medical records of patients who had died between November 2013 and March 2014.In all of the medical records we found, except for three patients who were under the SPC team, care was very ad-hoc and did not follow a structured approach.
- However, the patients under the SPC team had a clear approach to end of life care with regular reviews and advanced care planning.
- We asked frontline staff we if they knew what had replaced the LCP. We found a variety of responses from nursing staff but the majority did not know what had replaced the LCP, which meant that although guidance had been put in place it was not descriptive enough.
- We observed posters on hospital notice boards communicating the trust's response to the removal of

End of life care

the LCP as 'End of life care – getting it right' quality standards, in which it was stated that "the trust expects all staff to continue to maintain the principles of palliative and end of life care".

- The SPC nurse consultant explained that end of life referrals have escalated and their work is about complex symptom control in the last 72 hours. They do not support patients that do not have symptoms.
- The SPC nurse specialist told us that they believed end of life care was the responsibility of every nurse and clinician, but anyone who has concerns can refer to the SPC team. Their role is to support consultants and junior doctors and support nurses on the ward with one to one discussions.

Are end of life care services effective?

Requires Improvement

Use of National Guidelines

- We saw that the trust had followed the manual for cancer services (2004) which reflected the recommendations of the National Institute of Health and Care Excellence's (NICE) guidance for Improving supportive and palliative care for adults with cancer (2004) guidance, and had a specialist palliative care (SPC) team in place that was demonstrating a high level of specialist knowledge.
- We saw evidence that the SPC team supported and provided evidence-based advice to other health and social care professionals by undertaking training, however since the LCP had been withdrawn there was confusion as to what was to be used in its place.
- The SPC team had an operational work plan in place, which demonstrated an integrated and equitable approach to SPC provision across the trust's three sites, and the challenges the team faced to support the whole of the end of life pathway.
- We saw further evidence that the team had an integrated approach to EOL care as demonstrated through the 2012 peer review process and the successful launch of an EOL board. The national End of life care strategy (2008) aimed to improve EOL care for all.

Care plans and pathway

- On visiting wards and departments in the hospital, an overall impression was that staff did not recognise those patients who were at the end of their lives. On discussion with ward staff, it was clear that, because patients were no longer on the LCP, staff found it difficult to say who was receiving EOL care.
- EOL care across the hospital was a developing service. Many of the wards we visited were providing it for patients and their relatives. On Invicta Ward, the ward manager described a situation that had occurred with one of their EOL patients. The SPC team and Multi-disciplinary team (MDT) with the relative undertook a best interest's decision and the patient received hospice care. This was a good example of proactive EOL care planning having taken place with family involvement and the whole MDT.
- On Marlowe Ward a pilot was undertaken called the Assessment, Management Best Practice, Engagement, and Recovery uncertain care bundles (known as AMBER) between September and October 2013. However, due to a lack of a clinical coordinator this pilot had not been continued.
- On treble Ward we reviewed the medical records of two patients receiving EOL care, both records had the appropriate decision making including referral to the SPC team. One patient had an "end of life conversation" proforma which was completed well, documenting the conversation with the family and the wishes and preferences of the patient. A DNA CPR was correctly completed and was clearly positioned at the front of the notes. The second patient had just been referred to the SPC team and the SPC clinical nurse specialist was on the ward to review the patient.
- On Invicta Ward we reviewed the medical records of a patient receiving EOL care. We saw clear evidence of the appropriate decision making regarding EOL care/ escalation, resuscitation and discussions with the family. Staff had consulted and used guidelines on EOL diabetes care. However we did note that the patient had not been referred to or discussed with the SPC team and the patient had been on the EOL pathway for four days.
- Across the trust an e-learning module was available on EOL care but we were told that this was difficult to access and, in talking to staff; we did not find many who had undertaken the module or knew about the module, which was not mandatory. We therefore concluded that gaps existed across the EOL pathway because of the lack of training of the staff delivering the care

- The SPC team had undertaken an audit across the trust of EOL documentation at the end of 2013; all of the 58 patient records audited had DNA CPR forms in place, but 13 of the forms had no discussion with patient, relative or carer documented about DNA CPR status.
- Our findings in association with the SPC findings showed that DNA CPR forms did not always provide evidence that procedure had been followed; this indicated that more work was required in this area. Completing these forms ensured that appropriate decisions were made about the care of these patients.
- We were told that the chaplaincy office's activity was audited, which required the chaplain to complete a visiting record sheet after each consultation. This gave evidence of the type of consultation undertaken, but no indication of the quality and effectiveness of the service the chaplaincy provided. When visiting a ward, staff told us that they received a good response from the chaplaincy office.
- We spoke with staff in the mortuary about the arrangements for transporting patients to the mortuary. We were told that porters had received training to ensure that they were able to carry out the necessary procedures in the mortuary at weekends and overnight. This meant that delays in the system would be prevented because night and weekend porters had been trained to ensure a streamlined consistent service was in place.
- The bereavement team carried out the administration of a deceased patient's documents and belongings, providing practical advice and signposting relatives to support services such as funeral directors. The office was open limited hours, Monday to Friday. The office was situated in the trust management buildings close to the main hospital. Signs were in place to direct relatives.
- The RSO aimed to produce death certificates within 24 hours, but this could be extended if the doctor was on nights and not returning to the hospital for two days. We were told that there was no training given in this role but support was available from the chaplain if needed.
- The RSO worked closely and effectively with the coroner's office and helped advise junior doctors of the correct procedures after a death
- During the inspection, we were unclear how the service of relatives' support and the patient advice and liaison service came together and operated to cover peaks and troughs, sickness and annual leave. There was a lack of clarity in line management, objectives and support to the staff to prevent situations occurring that could leave both relatives and staff vulnerable.

Multidisciplinary team working

- We saw evidence in patients' medical records that MDT discussions were taking place around patients towards the end of life in areas including the intensive therapy unit (ITU), Treble and Invicta Wards and the SPC team.
- On visiting ITU, we observed that practices were in place, following national guidance, for the withdrawal of life-sustaining critical care treatment. The process could only begin after discussion had taken place with the relatives, patient and the MDT.
- The protocol gave direction to the medical team around the prescribing of medication and the removal of certain active treatments. After this process was completed, patients were transferred to wards where a referral to the SPC team would be made. All decisions made by the MDT had to be documented. With this system in place, continuity in care could be maintained and active treatment removed in a safe environment.
- As part of the national peer review, which was a national quality assurance programme, an MDT had been set up for the SPC team .This was a specialist multi professional team that made decisions together about how someone was to be cared for during the course of their EOL care. The team would consist of core members, such as the medical palliative care consultant, CNS and other associate members.
- We saw that the SPC MDT took place across the trust on a Tuesday morning each week to discuss how best to meet the palliative needs of patients with cancer and non-cancer referred to the SPC team. Patients' management plans were reviewed and any changes noted in the patients' medical records on the wards. This meant that EOL patients were benefitting from a multi professional approach to their palliative care needs, so that the best care possible is delivered.
- Brabourne Ward has open access to the specialist palliative care team. A palliative care nurse choses to work on the ward one day a week to maintain her skills. The ward manager told us that they have an open and honest approach to EOL care and undertake good conversations with patients and families around disease progression.

End of life care

- Between Monday and Thursday an extra staff member is on duty as the ward has multi-disciplinary meetings and ward rounds on these days and staff become involved in these.

Seven day services

- Patients could be referred to the SPC team via telephone or the hospital management system, Monday to Friday 9am–5pm. Families could ask to see the team via the ward staff. Out of hours and at the weekend, the local hospice would give advice and support.

Are end of life care services caring?

Good

Compassionate care

- Out of hours, the site co-ordinator will support frontline staff with bereaved families to ensure that relatives receive supported care at all times.
- On Brabourne ward open visiting hours allow families to stay with their relatives on EOL care. All patients are nursed in single rooms so privacy and dignity are in place. Families will be offered comfort drinks by the staff and as on Treble ward will be given a bereavement booklet before leaving the ward.
- We were told that after a patient has passed away the proper procedures around caring for the deceased will be followed and when all procedures are completed the deceased will be taken to the mortuary. Throughout the process staff explained the importance of respecting the deceased person.
- On visiting Clark ward we were able to talk to a patient receiving EOL care and their three relatives. We were told that the care they had received from the SPC clinical nurse specialist, nursing and medical staff was "very responsive and caring". We were told that if they require anything such as medication, they receive this very promptly after asking.
- On the clinical decision unit, we observed the chaplain carrying out a very caring interaction with a patient.
- Staff on Invicta Ward told us about how patients' wishes are met even after the patient has passed away. One member of staff told us of an example where the patient and family had requested the family dress the patient. The ward supported this request, and the wishes of the deceased were met.

Patient understanding and involvement

- We spoke to a patient who told us that they felt involved in their care. The patient felt that they had received very good care on the ward and had been fully involved in discussions about resuscitation and ceiling of care. The patient told us that they wished not to be resuscitated in the event of an arrest or to return to ITU. This meant that patients were being involved in decisions about their care.
- The SPC nurse consultant explained that with the introduction of "the EOL conversation record" which was completed by a medical consultant or registrar will prompt conversations with patients and relatives and ensure that they are involved in decisions about their care. We saw a completed form on Treble Ward, which gave a detailed picture of the conversation undertaken with the relative and any concerns.
- The nurse in chemotherapy outpatients unit described an incident where the family needed to become more involved in the care of their relative. The nursing staff supported the family to undertake elements of the patient's care. The family were involved in delivering care until the patient passed away.

Are end of life care services responsive?

Requires Improvement

Access

- We spoke with members of the specialist palliative care (SPC) team about their role. They told us they provided wards and departments across the hospital with up-to-date holistic symptom control advice for patients in their last year of life, whatever the diagnosis.
- At present, their case load was 40% non-cancer and 60% cancer with two clinical nurse specialists covering each site. We were told by one staff member that this had led to inevitable pressure on the team in spread themselves across the hospital to assess many EOL patients, but most patients were referred to the SPC team in the last 48 or 72 hours of life.
- We reviewed five sets of medical records of patients referred to the SPC team. We saw the patients had been visited on the same day because they were classified as urgent. The clinical nurse specialist told us non-urgent

referrals were seen within 24 hours and they encouraged the wards to make referrals to them before 3.30pm on a Friday afternoon so that patients could be reviewed before the weekend.

Discharge arrangements

- Patients under the SPC team who wished to return to their home, hospice or care home were put on the fast-track discharge pathway.
- We saw detailed evidence of the 'MDT Activity checklist summary pathway' which was developed in November 2011 to support staff in the necessary processes that needed to be completed for the safe discharge of EOL patients. Nursing staff on Treble ward told us that during the discharge process the ward contact the District Nurse and confirm that the patient is on a fast track discharge pathway and a specialist interest meeting will be arranged in order that urgent EOL care can be delivered in the community. This will ensure that processes are in place to ensure continuity in care is maintained.
- We were told discharge checklists were available for all staff to access and were part of the hospital's discharge policy. We were told that patients would only be discharged home or to a nursing home once suitable community packages of care had been put in place.
- Staff on Kent ward told us that it would aid the discharge process if social services were more involved in the process. At present social services get involved only 72 hours before discharge.
- Access to community packages of care varied, but the average time taken to arrange such a package was four to five days with delays often occurring due to the many people involved in the process.
- The SPC team aimed to achieve 100% of patients dying in their preferred location. Since July 2013 the SPC team have been coding "preferred place of death". The SPC nurse consultant told us that 75% of patients' preferred place of death was achieved.

Meeting the needs of all people

- We reviewed the EOL board minutes and saw that the SPC team had highlighted that conversations with patients and families was not always being documented, and we confirmed this when we reviewed medical records across the wards we visited.
- To respond to this, the SPC team had developed a proforma, "a record of end of life conversation", to gather the preferences and wishes of EOL patients irrespective of whether they had been referred to the palliative team or not. The proforma had to be completed by a medical consultant.
- On visiting Kent ward, we found that staff were aware of "the end of life conversation form" but they told us they had not used it yet.
- The SPC nurse consultant told us that the EOL board had organised a debate with healthcare professional to allow people to raise concerns and reinforce the use of the form to ensure patient's wishes and preferences are documented. The debate was scheduled to take place on 20 March. The SPC team will audit the forms in April 2014.
- We learned from the RSO that no multi faith rooms are available at the hospital. We were told that the chapel can be used by any faith. We found that the team were not looking forward or laterally at the multi ethnic needs before and after death.

Facilities for relatives

- A significant project was initiated and led by the nurse consultant, as a response to relative's needs, for a private space in the hospital, to maintain their dignity when upset and distressed.
- Plans are now underway to build a relatives area at the hospital so relatives will have a relaxing area whilst staying with their relatives.
- Visiting the wards we found that there were no allocated relatives rooms, relatives and families were taken to offices or staff rooms when they were upset or anxious.

Communication with GPs and other departments within the trust

- We were told by the SPC team, and saw evidence to support this in the SPC annual report, that they were developing an electronic record system to be implemented and linked to GPs. This would support a more robust activity and monitoring system, and real-time interventions. At present, the SPC and medical staff needed permission to access GP records, which meant consistencies in care might be lost.

Records

- We reviewed eight sets of medical records to establish if the appropriate documentation was in place that demonstrated that well managed care was delivered to EOL patients.

End of life care

- The SPC team had undertaken an audit of 58 forms across the trust of end of life documentation in 2013. 13 of the forms had no discussion documented with patient/relative/carer about DNA CPR status.

Are end of life care services well-led?

Requires Improvement

We reviewed minutes from the past nine months' end of life board meetings. Attendees included a multi professional team including senior nurses from palliative, renal, critical care and stroke services, the hospice lead and the trust medical risk and governance lead.

The group was supporting the implementation of palliative and supportive care practices and over the past nine months it had been actively involved in the development of the EOL pathway by initiating the "record of end of life conversation" and offering best practice advice.

Other initiatives included the "caring conversations, end of life care-getting it right' campaign which highlighted quality standard in end of life care, an 'amber care bundles' pilot on the renal ward and panel discussions with Junior Doctors.

Reviewing the documentation that the specialist palliative care (SPC) team submitted to us demonstrated that it was well led with an excellent knowledge base. We found the team to be very patient centred and responsive to the palliative care needs of both the patients and relatives who were experiencing EOL care.

Throughout the inspection, staff across the hospitals spoke very highly of the SPC team and the work they undertook led by the nurse consultant.

Nurses we spoke to on the wards felt comfortable about accessing hospice support during the evening if EOL patients developed complex management issues. Ward staff told us that the intensive therapy unit (ITU) outreach service was available to support them during the night.

Leadership of service

- There is no obvious (strategic) trust wide leadership, documented strategic direction and support for end of life care.
- The lack of trust Board direction is observed in a non-unified approach to EOL Care across the wards and departments. Therefore, although individual staff are committed, the result is an ad-hoc reactive response to unplanned EOL events.
- This can be observed through different approaches to and methods of recording in medical records, different hospital/ward/dept. forms being used or obsolete forms still in use.
- We spoke to staff about leadership across the SPC team. They told us that they felt supported by the SPC nurse consultant who was both "supportive and approachable". They felt that they worked as a team and that they were kept informed about what was happening within the team.
- They said they could access counselling services through occupational health. Good team spirit and good support across the team were evident, resulting in an engaged and committed team.

Patient experiences and staff involvement and engagement

- Work in progress included a project to obtain feedback from bereaved families, because at present it was only bereaved families who had been though ITU who were asked about their experiences, and the EOL board wished to introduce a way of extending this to all bereaved relatives across the trust.
- The team had introduced electronic palliative care records that allowed all healthcare professionals timely access to patients' records, and enabled safe and consistent care to be delivered at all times.
- Finally, we saw that integrated working with the Pilgrim's hospice has been enhanced by good leadership from the nurse consultant, which meant that patients benefitted from streamlined pathways of care across both the hospital and the community.

Outpatients

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

Information about the service

The outpatient services (OPD) at the Kent & Canterbury hospital is located on the ground floor with two main outpatient areas. Outpatient areas share one reception area which is located on the entrance to the department.

The trust offers outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up are required. The hospital offer clinics, general surgery, respiratory, neurology, diabetes and endocrine, gastroenterology, women's health, urology, cardiology, Ear, Nose and Throat (ENT), colorectal, joints, and urology.

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

Summary of findings

All the patients we spoke with told us that the staff in outpatients were polite and caring. The department was led by a manager and matron who were respected and liked by their staff. We did, however, receive multiple patient complaints about cancelled follow-up appointments. Some clinics were very busy and staff routinely overbooked patients because the number of appointment slots did not always reflect patients' needs. Patients could therefore experience long waiting times. Also follow-up letters were not always being sent to GPs promptly. We found that staff were collecting data on waiting times and overbooked clinics, but they felt unable to make improvements.

Some areas of outpatients were not cleaned to the required standard. Cleaning audits had failed to identify issues within the department. Patients and staff had been put at risk as two fire escapes were unsuitable for people with limited mobility. The department did not have enough storage and equipment and stock were crammed into small cupboards or left in the corridors, at times blocking fire exits.

Outpatients

Are outpatients services safe?

Inadequate

Incidents

- Staff in the OPD used an online reporting tool to record any accidents, incidents or near misses that occurred. We saw that staff had used the reporting system for a variety of incidents which included misfiled patient records, late starting clinics, and patient falls.
- The OPD manager told us that they would feed back any learning from incidents and accidents to staff. However, one staff nurse that we spoke with told us that they had never received feedback from any incidents they had reported and another told us that they had received an email outlining the investigation outcomes; however this did not happen consistently. They said that Health and Safety department were particularly good at responding; however, the senior managers were not as prompt.

Cleanliness, infection control and hygiene

- We observed that some of areas were not cleaned to the required standard, and that in some areas the environment was not suitable for reducing the risk of the spread of infection.
- In clinic room 41 in the OPD area C, we found that the floor tiles were cracked in places, with the floor edging strip not meeting the wall which left a gap. In the gap, and in the cracks in the floor tiles, there was visible black dirt and debris.
- The national specifications for cleanliness in the NHS (April 2007) state that; 'the complete floor including all edges, corners and main floor spaces should have a uniform shine and be visibly clean with no blood and body substances, dust, dirt, debris, spillages or scuff marks. In the same treatment room we wiped a small area of skirting board behind the domestic bin and gathered a black ball of dust three centimetres in diameter.
- We observed that in several areas of the OPD walls were stained and paintwork was chipped.
- Multiple crossed lines of stained black dust marks on one wall where a wire rack had been removed. We asked the manager when this crack had been removed from the wall. The manager told us that the crack had been removed six years previously. The national specifications for cleanliness in the NHS (April 2007) state that; 'All wall surfaces including skirting should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages'.
- In many of the OPD areas the walls and door frames were damaged and in a poor state of repair.
- The chairs in the OPD patient waiting area were different styles and colours. Some chairs had ripped fabric and many had paint scuffs on the back of the headrests. We turned over nine chairs to inspect them for cleanliness. We found that each of the nine chairs had between three and eight lumps of chewing gum stuck to the bottom of them. Four of the nine chairs also had cobwebs and visible debris hanging from them.
- These issues had been identified in an audit in February 2014, but no actions and had been identified and improvements had not been implemented.
- The chairs within the department had received a 100% audit score in the February cleaning audit. The room had been scored 100% for the low surfaces and walls.
- We were told that the OPD had one cleaner for each area. They worked from 6:30am until 9am Monday to Friday. The OPD area C cleaner would be responsible for cleaning 19 treatment rooms, the patient waiting areas, and the dirty utility. The area B cleaner had 25 treatment rooms, the patient waiting areas and dirty utility to clean.
- The manager of the area acknowledged that these areas and chair were not cleaned to a satisfactory standard. We highlighted these concerns after the cleaner had finished their shift for the day. They said that they would send someone to the department straight away. When we left the department at 4pm that afternoon neither of these issues had been dealt with.
- There was a lead for infection control in the department, and we were shown that all staff had received their mandatory annual infection control training. Nursing staff that we spoke with demonstrated a good understanding of infection control and of their roles in preventing the spread of infection.
- Clinical staff were responsible for cleaning the clinic rooms and clinical equipment between uses. We were shown checklists as evidence that this was being completed.

Environment and equipment

- We saw that two fire exits from the OPD area B and C could not be used by patients and staff with mobility

issues. Both exits required people to walk firstly down one concrete step, then across a paved area which was uneven and had paving slabs which wobbled underfoot. Having negotiated this people would then be required to walk down a further three or five steps concrete steps before reaching the fire meeting point in the car park.

- We were told that this was an ongoing issue that had been on the risk register for over a year.
- The risk register also stated that both of these fire exits were routinely being blocked by staff storing equipment in front of them. This meant that the trust was putting patients and staff at risk in the event of a fire.
- Maintenance of the building created on going issues for the OPD. We were told that the flat roof across both the OPD areas leaked. The manager told us that this had been an issue for the past six years. We were shown clinic rooms, and clean utilities where walls and ceilings were stained and water damaged. The department had areas with chipped walls and door frames. This compromised staffs ability to clean these areas to the required standard.
- The department did not have enough storage areas and equipment and stock was crammed into small cupboards or left in the corridors at times blocking fire exits. Storage cupboards had stock stored on the floor as there were not enough shelves.
- We were shown the Health and Safety risk assessments for the area. We were told by the manager that where things were considered a risk following assessment that they would be placed onto the trust's Risk Register.
- The OPD had a link person for Health and Safety who had taken on extra training and responsibility in this area. The link person attended meetings every quarter and fed any information from these meetings back to the rest of their team. We were shown the minutes from the 11 December 2013 meeting which showed that feedback from incidents were shared and discussed
- The OPD hoist was on the departments risk register. We were told that this was because the hoist legs could not fit under all of the treatment couches in the department. This meant that if a patient collapsed on one of these couches they could not be safely moved.
- We saw that on the afternoon of our inspection a new hoist had been delivered to the department for a trial period and staff were being trained on its use.
- The OPD kept a log of the work that they had reported to estates and kept track of when and how issues were resolved. We were shown the departments log book which evidenced that staff were reporting and tracking maintenance issues.
- When equipment failed staff followed guidance for decontamination and arranged for The Electronics and Medical Engineering Department to collect, repair and return the item. The manager told us that when this happened they would borrow replacement equipment from other areas of the hospital or that the department would lend them a replacement item whilst they made their repairs.
- The manager told us that when they required more equipment they would ask the division that the equipment was required for supply this. They also said that the Hospitals League Of Friends were always supportive where the department had asked for funding for equipment.

Medicines

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

Records

- In one ophthalmology treatment room there were seven sets of patient medical notes stacked on a desk unattended. The room was empty and the door open. Outside the door patients were sitting waiting for their appointments. A member of staff from the clinic told us that they routinely used the area as a central place to hold medical records so that staff could easily access the notes when they were required.
- This was a breach of a Caldicott principle that the provider was expected to apply, and the department had failed on this occasion to protect patient's confidential data.

- The manager told us that an ongoing safety issue in the OPD had been the misfiling of patient records. This meant that patient records on occasions contained the wrong patient information. This could lead to unsafe or inappropriate treatment.
- The manager told us that each time notes were misfiled these would be recorded and investigated through the incident reporting system. They told us that they shared any learning from misfiled notes in daily staff meetings.
- This issue had also been raised on the departments risk register. The sister told us that they had raised awareness of this issue with staff to ensure that Incident reporting system forms were being completed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All of the nursing staff with the exception of staff on long term sick leave had attended level 1 safeguarding training annually in line with the trust's policy.
- Staff had a good understanding of The Mental Capacity Act 2005 (MCA) and had applied its principles in an example given. They demonstrated that they had considered the least restrictive ways of caring for the patient concerned in accordance with the MCA and with Deprivation of Liberty safeguards.
- The manager told us that many patients with a learning disability came to the service from supported living environments. Most of these patients bought with them a 'Healthcare passport' document. This outlined to staff how they should be supported with their care needs.
- The manager said that where patients attended the clinics without this information the OPD would contact their carers or family for advice on ways that the department could best support them with their care.

Mandatory training

- Staff in the department had all completed mandatory training requirements and the manager was able to demonstrate this using a database of staff training.
- Staff had also completed competency assessments for the roles that they performed.
- Staff that we spoke with told us that although they were busy they felt that they were able deliver patients required care needs and support.
- 96% of staff in the OPD department had completed an annual appraisal.

Management of deteriorating patients

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

Staffing

- Nurses told us that although they were busy they felt that they were able to deliver good and safe patient care. They also said that they felt supported and listened to by their manager. We were told by the manager that staff working in the department needed a good understanding of their role and needed to be assessed for competencies in the areas that they were working.
- Where staff were absent they were therefore replaced either by staff within the department who would work extra hours or alternative shifts; or the department gave shifts to particular NHS professional staff who had been trained in the competencies required to work within the department.
- The medical cover for clinics was arranged within the divisions, who agreed on the numbers of clinics and patient appointment numbers. The divisions had provided the appointment teams with templates which showed where appointment spaces were available.
- A doctor that we spoke with told us that they were happy with the way that the OPD was run and felt that clinics ran smoothly. They told us that clinics were routinely overbooked as the templates did not match the number of patients requiring appointments.

Are outpatients services effective?

Outpatients

Not sufficient evidence to rate

Outcomes for the department

- National Institute for Health and Care Excellence (NICE) guidance for Smoking cessation had been met within the department. The OPD assessed each patient who accessed the service to establish whether they would benefit from a referral to the Smoking Cessation service.
- Staff would refer patients to the service where a need was established. In order to ensure compliance with NICE guidelines the department had made this a part of the 'meet and greet' guidance for staff and had included this in staff competency assessments.

Care plans and pathways

- Patients that we spoke with told us that they had discussed their care plans with their doctors and felt that time had been taken to ensure that the care planned for them met with their needs.

Multidisciplinary team working and working with others

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

Are outpatients services caring?

Good

Compassionate care

- We observed staff interactions with patients as being friendly and welcoming. We saw staff stopped in clinics to greet patients that they knew and ask after their well-being. We observed that patients that attended clinic regularly had built relationships with the staff that worked there.
- Staff were trained and expected to keep patients informed of waiting times and the reasons for delays. We observed this happened in all areas of the OPD during our inspection.
- All of the patients we spoke with were complimentary about the way the staff had treated them. One relative said, "They are well looked after". A patient said, "It's really good overall. The system is overstretched, but the staff are splendid".
- Patients also told us that they had been treated with dignity in the department. One patient told us, "I have always been treated with respect".
- The OPD reception was in the main lobby of the hospital. The lobby was busy with patients arriving for appointments along with visitors to the hospital. There were signs to prevent people from crowding around the desk. Reception staff told us that when patients arrived for appointments their name, date of birth, address, and telephone number were checked with them at this desk.
- The receptionist told us that as they checked patients personal information they ensured that other people stood back so that they could not be overheard. This showed that staff had considered ways to ensure that patient's personal information was protected.

Patient understanding and involvement

- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand. Patients told us that they felt included in decisions that were made about their care and that their preferences were taken into account.
- One patient said, "The doctor explained everything to me". Another patient said, "They asked me if I had any questions to ask, but they had pretty much told me everything that I needed to know".
- There were patient leaflets in each waiting area which provided patients with information about the department, how they could complain, and information on diseases and medical conditions. We saw patients reading this information. When asked, they all said that the information was in a format that they understood.
- The OPD ran a Patient User Partnership Group meeting every two months. We were shown the minutes from the last two meetings. During the meetings staff and patient representatives discussed improvements that could be made to the service. The matron told us that they had invited patients that had previously complained about aspects of the service to join this group.

Emotional support

- The OPD was a calm and well-ordered environment. We saw nurses constantly updating patients on clinic waiting times and checking that patients were

comfortable and happy. One patient told us, "The nurses have been very supportive. I am a bit of a worrier but they made me feel safe. I have been informed and consulted about everything".

- We were shown how the department had reviewed the way in which it manages patients coming into the department. The matron told us that as a result of feedback from surveys which showed that patients did not feel informed by staff about waiting times for clinics the department had reviewed procedures and staff training in this area. As a result the department had produced guidelines for staff on meeting and greeting patients into the department along with a competency assessment which all staff had completed.

Are outpatients services responsive?

Requires improvement

Key responsiveness facts and figures

- NHS England and Clinical Commissioning Groups in the responsibilities and standing rules regulations 2012 state that patients have the legal right to start their NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they wait longer.
- Patients also have the right to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected. In order to manage the demands of this legislation the trust ran a central OPD booking system which opened between 8am and 8pm.
- The 'Choose and Book' system (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic) accounted for 20% of appointments booked by the OPD.
- The trust had mostly met national targets for the two week wait target for patients with a suspected cancer. The trust's 2013 data shows over 94% compliance (national average 93%) for 10 months of the year. However, in both July and August 2013 the trust fell below the national average with 92% of patients being seen within the two week target.
- The 18-week targets had also mostly been met. In the latest data for January 2014 the trust saw 3,231 patients for their first appointments in under 18 weeks from referral to appointment. However, 359 patients were not seen within 18 weeks. This meant that 90% of patients were seen within the 18 week target.
- We received multiple complaints about the number of cancellations that patients had experienced for their follow up appointments. The trust operated under guidance that except in exceptional circumstances, clinics should not be cancelled without eight weeks' notice. However data showed that 20% of cancellations did not comply with this guidance.
- We were told that follow-up appointments were booked by the divisions. Data showed that 12% of booked outpatient's appointments in the past three months had been cancelled by the provider however data did not indicate whether these cancellations were first or follow up appointments. Trust wide data showed that in January 2014 85013 patients visited the OPD, The trust in the same month cancelled 10984 patients appointments.
- Staff in the OPD told us that where appointments needed to be cancelled it was generally the follow up appointments that were moved as these did not affect the 2 week and 18 week rule.
- Data provided by the trust showed that patients waited and average of 9 weeks for their follow up appointment. The central booking department informed the divisions weekly of patients who had not been offered a follow up appointment within the timeframe required. Medical secretaries that we spoke with confirmed that this was an ongoing issue.
- Some of the patients that we spoke with complained about the waiting times in clinics. Staff told us that this was an ongoing problem with some clinics waiting times being worse than others. We were told by both staff and doctors that the main reason for long waiting times was either the overbooking of clinics, or patient appointments taking longer than anticipated.
- Clinic templates were agreed by the division leads and medical or surgical teams. The OPD had no input on the templates that had been agreed.
- Staff completed a '30 minute wait audit'. This audit examined how long patients were kept waiting for their appointments. This data was logged monthly. We saw that most clinics had some delay.

- One February 2014 cardiology clinic saw 12 patients in total. Two patients were seen within 30 minutes, none within 31-40 minutes, two within 41-50 minutes, one within 51-60 minutes, with seven patients waiting for more than 61 minutes.
- The notes on this clinic showed that the clinic had needed to change clinic rooms as it was running two hours late, and that one patient had cancelled due to the long wait.
- Data gathered did not reflect how long patients waited once the waiting time was over 61 minutes so this data reflected the minimum time patients would have waited. Other reasons given for clinics running late in the month of February were patient transport arriving late, patients going to the wrong hospital by mistake, consultants and registrars arriving late for clinic, and consultations taking longer than expected.
- The manager told us that incident forms were completed where doctors arrived late for their clinics.

Access for all patients

- Where patients required translation services the OPD would access translation services. This could be done over the phone using the 'Big word' telephone translating system which could be accessed by staff at any time with no requirement for prior arrangement with the service. The manager told us that where patients needed a more complex consultation and where it had been identified that telephone translation was not appropriate the OPD was able to book face to face translators, although this service needed to be organised in advance.

Communication with patients and GPs

- Following appointments at the clinics General Practitioners (GP) letters were sent by the divisions' medical secretaries to inform them of what had taken place and any further action that may be needed. Medical secretaries told us that the trust expected GP letters to be processed and sent within 72 hours.
- Trust wide we found that there were inconsistencies in meeting these targets. For example, we were told that in this hospital, the ENT and ophthalmic clinics GP letters took around four to five weeks to be processed. Medical secretaries that we spoke with across the trust said that this was due to inadequate staffing levels, and a service redesign which had left some secretaries unable to meet their targets.

Environment

- The layout of the department meant that patients were weighed, their heights measured and their blood pressures taken was in a cubicle in the waiting area with a curtain for privacy. The manager told us that this room had been built specifically for this purpose. They said, "I did say at the time that the room needed a door on the front as patients could be overheard through a curtain. But I was told that we couldn't have a door". This meant that patients were being treated with a lack of confidentiality and was a dignity issue.

Complaints handling (for this service)

- Patients who attended the department where asked to fill out a questionnaire and post it into the comments box in each area. The manager looked at the comments that had been made by patients and fed back any learning or changes to the service to staff during the morning staff meeting.
- The January/February 2014 internal OPD surveys showed that patients felt that the OPD were good at treating them with dignity and respect, but needed to improve on explaining to patients what they should do if they were worried about their condition or treatment after they had left the OPD.
- The manager also collected information on patients experience in the OPD during a weekly walk the floor audit. This audit looked at ten patients from different clinics and staff interviewed them to obtain their views on the OPD and their experience of care. The manager told us that they analysed the results of this audit and where any patterns or trends were seen they would look to make service improvements.
- The manager told us that they used morning staff meetings to feed back to staff about patient questionnaire results, complaints, and audit results. They said that these were a good opportunity for staff to discuss any service improvements that could be made as a result of feedback.

Are outpatients services well-led?

Requires improvement

Vision and strategy for this service

- The manager was able to describe to us the trust's vision. Staff we spoke with felt loyalty to their

department and their department manager. They told us that their manager and matron were both good leaders. For example one staff member said, "The nursing team works well together. Our team leaders are approachable and friendly". One member of staff said, "It would be great if the Chief Executive came and introduced himself to us"

- Staff that we spoke with were aware that the OPD was going through a consultation process and could be redesigned. There was a sense from staff that these decisions were made at a higher level and that the changes would happen to them rather than them feeling a part of the process. For example, one staff member said, "we hear bits and bobs, until it happens I won't worry too much".

Governance, risk management and quality measurement

- Outpatients held a monthly clinical governance meeting and produced a monthly governance report which was used to inform the trust's Board and other stakeholders. During the meeting all areas of governance were discussed and reported on along with any learning or changes to the service. The agenda for this meeting included incident reporting, complaints, training, human resources (HR) management, Infection control, risks, health and safety, and audit results.
- The OPD used a range of methods to gather the data required to meet with the trust's governance arrangements. Incidents/accidents and near misses were reported and investigated using the online incident system. We found that all of the staff that we spoke with were aware of this reporting system and were using it. The number of incidents and their severity were reported in the department's governance report.
- The governance report also outlined staff attendance at mandatory training, staff sickness levels, and compliance with the departments audits such as the hand hygiene audit.

Leadership of service

- Health and Safety was monitored using risk assessments and with staff raising risks to the trust's risk register where appropriate. We found that the department manager had a good understanding of risk assessment and were able to describe items on the risk register to us.
- Complaints and compliments were investigated by the manager of the OPD who had reported back to staff any service improvements that had been identified. The number of complaints along with a breakdown and analysis of the complaints were included in the governance report and fed up to the board.
- The manager of the department and the Matron were able to outline the departments governance procedures, they were also able to tell us how their department performed in all areas.
- In order to help staff with stress they had been encouraged to complete self-assessments of their stress levels. Where issues had been identified the OPD manager had completed individual risk assessments. The manager also ensured that staff were aware of the contact details for the trust free and confidential counselling service. However, the manager told us that there was reluctance amongst staff to complete the stress self-assessment forms as they felt that if they were shown to be stressed that this, "would be used against them" by the trust.
- All of the staff that we spoke with were able to describe their individual roles. This was backed up by competency assessments of staff that ensured that they both understood and were able to perform their roles to a required standard.

Culture within the service

- All of the staff that we spoke with were able to describe their individual roles. This was backed up by competency assessments of staff that ensured that they both understood and were able to perform their roles to a required standard.
- Throughout our visit we saw that the department was calm and ordered. Patients told us that they were well informed and that staff were both friendly and supportive of them.

Innovation, improvement and sustainability

- We asked staff about the trust's 'Dragon's Den' initiative which had been devised to encourage staff to bring forward any ideas or initiatives that they had which they felt would improve the service. We were told that no one from the department had attended 'dragons den'.
- Staff we spoke to were aware of the issues in the OPD around overbooked clinics and waiting times for patients. Staff told us that they were often dealing with the stress that managing sometimes angry patients due to waiting times bought about. One member of staff

described this by saying, “It is stressful and frustrating, there are times when you don’t want to go out and tell them the clinic is an hour late. I once got a slow handclap which was humiliating”.

- Staff told us that these were decisions that were made and influenced outside of their department and did not therefore feel able to make changes.
- Although there was awareness amongst all staff groups about overbooked templates, and patient waiting times no improvements had been made. Staff had completed the incident reporting system forms but were unable to demonstrate that the OPD had improved on these issues.
- The central booking service was not always able to give patients appointments within the NHS England and Clinical Commissioning Groups (CCGs) regulations 2012 two and 18 week targets. They had however developed systems to ensure that divisions were kept regularly informed where they had fallen short of these targets to ensure that patients were offered the best possible alternative.
- Templates set for some clinics did not meet with patient requirements. Data which evidenced this was being collected daily by the OPD, the central booking department, and medical secretaries. We were not informed of any work being done by the trust to alleviate this problem despite a number of staff including managers and doctors raising this with us as a persistent issue.>

Outstanding practice and areas for improvement

Outstanding practice

We observed areas of good practice, including:

- The critical care unit promoted the use of patient diaries to support patients with memory loss and poor recollection.
- Patients being cared for on medical wards gave positive feedback about the care they received.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.
- Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.
- Ensure that, at a board level, there is an identified lead with the responsibility for services for children and young people.
- Ensure all staff are up to date with mandatory training.
- Protect patients by means of an effective system for reporting all incidents and never events of inappropriate or unsafe care, in line with current best practice, and demonstrate learning from this.
- Ensure that paper and electronic policies, procedures and guidance that staff refer to when providing care and treatment to patients are up to date and reflect current best practice.
- Ensure that the assessment and monitoring of patients' treatment, needs and observations are routinely documented to ensure they receive consistent and safe care and treatment.
- Ensure that the environment in which patients are cared for is well maintained and fit for purpose.
- Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are undertaken.
- Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply, and that in-depth cleaning audits take place in all areas.
- Ensure that staff in children's services audit their practice against national standards.
- Implement regular emergency drills for staff, and ensure relevant policies are up to date.
- Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.
- Ensure that procedures for documenting the involvement of patients, relatives and the multidisciplinary team in 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times. All forms must be signed by a senior health professional.
- Ensure that patients are not experiencing unnecessary waits for follow-up appointments with outpatients clinics, and when waiting in outpatients to be seen, that they are not delayed.
- Ensure there is adequate administrative support for the outpatients department.
- Assess and mitigate the risk to patients from the high number of cancelled outpatient appointments and the delay in follow-up care.

Action the hospital SHOULD take to improve

- Take all appropriate steps to inform potential service users in the local community of the remit of the Emergency Care Centre.
- Ensure appropriate signage to reflect that the hospital provides an Emergency Care Centre and not an Accident and Emergency department.
- Consider national guidance is reflected in medication policies.