

East Kent Hospitals University NHS Foundation Trust Kent & Canterbury Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Requires improvement



Minor injuries unit

Requires improvement



Medical care

Requires improvement



Surgery

Requires improvement



Critical care

Good



Services for children and young people

Good



End of life care

Requires improvement



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

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

EKUFT serves a population of approximately 759,000 and employs approximately 6,779 whole time equivalent staff.

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

Following our last inspection of the Trust in March 2014 when we found many of the services provided to be inadequate, EKUFT was placed into special measures by the Foundation Trust regulator Monitor. This announced inspection was undertaken to monitor and assess what progress the Trust had made in addressing our concerns.

We carried out an announced inspection of EKUFT between 13-17 July 2015. We also undertook unannounced visits the following week on 29 July 2015.

At this inspection although we found the hospital overall to require improvement we noted there had been improvements made in the majority of services we inspected.

Our key findings were as follows:

We saw areas of outstanding practice including:

- The Nurse leadership in outpatients was outstanding with staff inspired to provide a good service to patients. The main outpatient's matron provided knowledgeable and inspirational support to staff whilst working hard to maintain and improve the service.

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

Importantly, the trust must:

- The trust must review its nursing establishments to ensure that numbers of registered nurses meets national guidance, and the needs of patients at all times, including throughout the night.
- The trust must review the medical establishments to ensure that the numbers of doctors is sufficient to meet the needs of patients at all times, including through the night and at weekends.
- The trust must clarify name and service provided in the ECC and provided protocols for the ambulance service about what patients can be admitted.
- The trust must review its arrangements to ensure they can be assured that medicines and intravenous fluids are stored safely and securely.
- The trust must review its arrangements for ensuring that resuscitation equipment is available and ready for use at all time.
- The trust must ensure that training for staff on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards is available for staff providing care to patients a cognitive impairment.
- The trust must ensure that suitable arrangements are made for patients with mental health issues whilst awaiting assessment.

In addition the trust should:

Summary of findings

- The trust should review its medical bed capacity to ensure that the majority of patients are cared for in the correct speciality bed for the duration of their hospital admission. It should also review its arrangements for the management of patients outlying in non-speciality beds to ensure the quality and safety of their care is not compromised.
- The trust should review the processes in place that provide assurance that equipment shared between patients is clean and ready for use.
- The trust should review the pharmacy service and how staff shortages are impacting on patient's timely discharge.
- The trust should review its care planning arrangements for summarising and recording the individual needs of patients when individual risks have been identified.
- The trust should review pain management tools to assist patients living with a disability or dementia.
- The trust should ensure that all confidential patient records are fit for purpose and securely stored in clinical areas to minimise the risk of unauthorised access.
- The trust should consider the support available to people living with learning disabilities is provided when they are patients, and to its staff to ensure they can meet individual needs.
- Continue to improve referral to treatment times across all specialities to ensure that patients are treated in an acceptable timeframe following referral to the service.
- Consider how the environment in which surgical services are provided would be suitably maintained.
- Improve theatre utilisation.
- Ensure that staff are afforded the opportunity to have their performance formally reviewed.
- Ensure staff in surgical areas complete all the required mandatory training.
- Ensure that patient risk assessments were completed and acted upon.
- The trust should consider standardising inotropic infusions to avoid the risk of potential drug errors when staff engage in cross site working.
- The trust should continue to improve Referral to Treatment times across all specialities to ensure that patients are treated in an acceptable timeframe following referral to the service.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Minor injuries unit

Requires improvement



Rating

Why have we given this rating?

There had been no never events or serious incidents reported in the last year.

Cleanliness, infection control and hygiene were meeting the standards expected.

The environment was well laid out and organised within the department, however the reception area did not always maintain patients privacy and dignity and nursing staff relied upon reception staff to pick up if a patient's condition warranted speedier attention.

Stocks of equipment and medicines were maintained appropriately with evidence of good stock rotation and assurance that equipment to be used on multiple patients was clean, well maintained or serviced. Medication was stored safely and dispensed in line with trust policies and patient group directives (PGDs).

Records were held on a computer programme widely used in the NHS. Processes were in place to safeguard patients and staff were well versed with safeguarding and deprivation of liberty standards. Mandatory training rates were good and staffing levels were adequate to cover the unit. Staff were suitably qualified to assess patient risks.

Staff had access to training and development and were well supported to carry out their duties. Staff underwent annual appraisal and had their competencies checked regularly.

The unit used National Institute for Health and Care Excellence (NICE) guidance and there was evidence of local audits being undertaken to monitor quality and patients' outcomes.

Systems were in place to provide patients with pain relief which was offered, where necessary, to patients on arrival at the unit and regularly during the duration of their stay.

Food and drinks were available and could be bought when needed.

Staff understood the principles of the Mental Capacity Act 2005 and understood their responsibilities in relation to obtaining consent from patients. Patients were cared for with privacy and dignity with doors and curtains closed. Whilst we

Summary of findings

saw only four patients being treated and cared for this was done in a professional and courteous manner. The six patients we spoke with were very happy with their care. Whilst there was no information readily available about expected waiting times staff would go out into the reception area and tell people waiting if there was to be a delay.

Interpreting services were available and there were no complaints about the service since its opening. Staff we spoke with felt they were well-led at departmental level and had regular contact with the matron. Staff were kept up to date via regular meetings and regular practitioner nurse meetings. Patients were cared for with privacy and dignity with doors and curtains closed. However, privacy and dignity was compromised in the reception area as patients could be overheard telling reception staff about their personal and health details.

Signposting to the MIU was still a concern as signs directed people to an A&E department.

Whilst we saw only six patients being treated and cared for this was done in a professional and courteous manner. We spoke with four patients who told us they were very happy with their care.

There had been no never events or serious incidents reported and there had been no incidents reported in the first month of the unit being open.

Cleanliness, infection control and hygiene were meeting the standards expected.

The environment was well laid out and organised within the department, however the reception area did not always maintain patients privacy and dignity and nursing staff relied upon reception staff to pick up if a patient's condition warranted speedier attention.

Stocks of equipment and medicines were maintained appropriately with evidence of good stock rotation and assurance that equipment to be used on multiple patients was clean, well maintained or serviced. Medication was stored safely and dispensed in line with trust policies and patient group directives (PGDs). Records were held on a computer programme widely used in the NHS. Processes were in place to safeguard patients and staff were well versed with safeguarding and deprivation of liberty standards. Mandatory training

Summary of findings

rates were good and staffing levels were adequate to cover the unit. Staff were suitably qualified to assess patient risks. Staff had access to training and development and were well supported to carry out their duties. Staff underwent annual appraisal. People had their competencies checked regularly. The unit used National Institute for Health and Care Excellence (NICE) guidance and there was evidence of local audits being undertaken to monitor quality and patients' outcomes. Systems were in place to provide patients with pain relief which was offered to patients on arrival at the unit and regularly during the duration of their stay. Food and drinks were available and could be bought when needed. Staff understood the principles of the Mental Capacity Act 2005 and understood their responsibilities in relation to obtaining consent from patients. Patients were cared for with privacy and dignity with doors and curtains closed. Whilst we saw only one patient being treated and cared for this was done in a professional and courteous manner. The two patients we spoke with were very happy with their care. Whilst there was no information readily available about expected waiting times staff would go out into the reception area and tell people waiting if there was to be a delay. Interpreting services were available and there were no complaints about the service since its opening. Staff we spoke with felt they were well-led at departmental level and had regular contact with the matron. Staff were kept up to date via regular meetings and regular practitioner nurse meetings. There was evidence of good team work and staff told us they loved working on the unit. Staff were engaged in developing their service.

Medical care

Requires improvement



Overall, we found medical care services at KCH required improvement in some aspects of patient safety. This is because we identified some concerns in relation to the environment, medical staffing, nursing staffing, especially at night, arrangements to identify and support patients whose condition is deteriorating, the storage and management of medicines, the management of confidential records and shortfalls in infection control procedures. We found that there were good systems to report and investigate safety incidents.

Summary of findings

We found that treatment generally followed current guidance, but care assessments did not always consider or record the full range of people's needs and care plans did not reflect individualised care. We found that there were arrangements to ensure that staff were competent and confident to look after patients. However, medical staff were not always able to access adequate educational support to promote their professional development.

Patients were cared for by a multi-disciplinary team working in a co-ordinated way and generally had access to some services seven days a week.

However, services such as speech and language therapy and physiotherapy services were not available at weekends.

Patients received adequate food and drink and were generally supported appropriately when they had problems. Consent was obtained and recorded in line with relevant guidance and legislation and where patients lacked capacity to make decisions for themselves, staff acted in accordance with their obligations under the Mental Capacity Act.

We judged the caring aspects of medical care services were good. Patients and their relatives were positive about their experience of care and the kindness afforded them. We observed compassionate care that promoted patients' privacy and dignity. Patients were involved in their care and treatment and were given the right amount of information to support their decision making and patients could get the emotional support they needed.

We judged that the responsiveness of medical care services required improvement. This was because there was insufficient bed capacity to meet the needs of patients. This resulted in almost half patients being moved at least once during their hospital stay. There were large numbers of patients in non-speciality beds and this had negative implications for their safe care and treatment. We also found that the discharge of patients was not managed in a timely manner especially at weekends.

We judged that service was well led. There was an appropriate system of governance in medical care services. There were arrangements to monitor performance, and quality and risk issues which were

Summary of findings

escalated to the trust board when necessary. Key messages were disseminated to staff. Staff acknowledged the steps that had been taken within the organisation to improve, processes and systems of accountability and could discuss the trust philosophy. Individual wards had developed their own strategies which staff understood. We observed a caring and positive ethos. Staff reported that although the culture was improving, they did not always feel actively empowered or engaged as improvement seen as being reactive and focussed on short term issues.

There were examples of collaborative working with the voluntary sector and where patient representatives had been involved in developing and monitoring services.

Surgery

Requires improvement



The environment in which surgical services were provided was not always suitably maintained. Storage of intravenous fluids was not sufficiently safe.

Referral-to-treatment times were not always met.

Theatre utilisation was not always maximised.

Staff were not always afforded the opportunity to have their performance formally reviewed. A number of staff had not completed all the required mandatory training, which supported the delivery of safe patient treatment and care. There was a lack of understanding regarding Deprivation of Liberty Safeguards.

Patient risk assessments were not always undertaken and acted upon.

There were safe and effective arrangements in place for reporting adverse events and for learning from these. Staffing arrangements in surgical areas were managed to ensure sufficient numbers of skilled and knowledgeable staff were on duty during day and night hours.

Consent was sought from patients prior to treatment and care delivery. Consultants led on patient care and there was access to specialist staff for advice and guidance.

Procedures were in place to continuously monitor patient safety and surgical practices. Patient treatment and care was generally delivered in

Summary of findings

accordance with professional guidance. Surgical outcomes were in the main good and results were communicated through the governance arrangements to the trust board.

Patients commented positively with regard to the level of information provided and their involvement in decision making. Most patients were satisfied with the treatment and care provided by doctors, nurses and other staff.

Surgical staff spoke positively about their departmental leadership and felt respected and valued. Staff were aware of the trust's values and direction of improvement. Staff reported having opportunities to develop their skills and expertise, and were supported by suitably skilled leaders. Staff were encouraged to be innovative and share ideas. The governance arrangements supported effective communication between staff and the trust board. Risks were identified and continuously reviewed. The trust board was informed and updated with regard to service delivery and performance. The views of the patients were sought in respect to improving and developing services.

Critical care

Good



Patients were cared for in a clean and safe environment and staff showed good awareness of reducing the risk of infection. On the day of our inspection staff were very busy but we witnessed a well-co-ordinated team and a good standard of patient care and safety.

We found the care delivered in the unit reflected best practice and national guidance. There were systems in place to measure patient outcomes and the quality of the service provided. Care needs were risk assessed and the unit could demonstrate a track record of delivering harm free care.

Appropriate measures in place to ensure that patients were protected from the risk of acquiring hospital acquired infections, and staff were observed to follow trust infection control guidance. Staff had access to PPE (Personal Protective Equipment) and was observed using it in line with trust policy.

The unit could demonstrate delivering care that reflected national guidance and took into account

Summary of findings

the latest research. The care delivered was assessed by continuously audited to ensure a high standard and outcomes that were in line with the England average when compared to other critical care units. Patient had their dignity respected and their human rights protected whilst in the unit. Appropriate systems were in place to report and action safeguarding and DoLS (Deprivation of Liberty) concerns. We saw evidence that demonstrate that patients and their loved ones had their individual preferences taken into account when planning care and where possible, were involved in planning their care.

Patients and relatives spoke positively about their experience of care and treatment. Staff showed good communication practices and used this to ensure patients with complex needs received timely and expert treatment. There was a positive drive to increase the use of the Confusion Assessment Method for the ICU (CAM-ICU) for patients at risk of delirium.

Medical records were fit for purpose, kept confidential and stored appropriately. There were systems in place to ensure the safe storage, handling and administration of medication.

There was evidence that staff implemented learning from incidents and that training for staff helped them to continually improve patient care. The conversations we had with staff and the data we reviewed demonstrated a healthy culture in the department towards incident reporting. Regular Mortality and Morbidity (M&M) meetings were in place to monitor mortality on the unit.

We found sufficient numbers of skilled staff who had the appropriate skills needed to care for critically ill patients. The unit had a robust competency bases induction and ongoing learning and development programme for all staff.

Patients were looked after by a multi-disciplinary team that included appropriate consultant input. Leadership and educational support on the unit was found to be strong. Feedback received from staff about their line managers and culture in the unit was very positive and complimentary.

Summary of findings

There was an appropriate major incident plan in place. Staff were able to tell inspectors of their roles and processes to follow should a major incident occur.

Services for children and young people

Good



Kent and Canterbury hospital (KCH) children's assessment unit (CAU) staff understood their responsibilities to raise concerns and report incidents and were fully supported by the trust when they did so. The children's and young people's service had systems in place to ensure that incidents were reported and investigated appropriately. Children and young people's safety performance showed a good track record and steady improvements. Processes were in place for lessons to be learned and these were communicated widely to support improvement in other areas as well as services that were directly affected. The trust was using the Kent safeguarding children's board procedures; but had not produced a trust safeguarding children policy. Staff worked effectively with others to implement protection plans. There was active and appropriate engagement in local safeguarding procedures and effective working with other relevant organisations. The children's assessment unit (CAU) had been designed and built with children in mind. The ward areas provided a safe environment for children and families which were effective for cleaning and maintenance. Staffing levels and skill mix were planned, implemented and reviewed to keep children and young people safe at all times. Risks to children and young people were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies. Staff recognised and responded appropriately to changes in risks to children and young people who use services. Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations.

Summary of findings

Feedback from children, young people and their families who use the service was consistently positive about the way staff at CAU treated people. The Dolphin ward friends and family test (FFT) results were consistently favourable. There was a strong, visible person-centred culture. Staff we spoke with were motivated and inspired to offer care that was kind, and promoted children, young people and their families' dignity. Relationships between staff patients and their families were caring and supportive. Staff took patients and their families' personal, cultural, and social needs into account. Patients and their families were active partners in their care. Staff were fully committed to working in partnership with children, young people and their families. Staff always empowered patients and their families to have a voice and to realise their potential. Patients' preferences and needs were always reflected in how care was delivered. Children, young people and their families' social needs were highly valued and embedded in their care and treatment. Patients' needs were met through the way services at the CAU were organised and delivered. Children and young people's services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services provided. The needs of different children and young people were taken into account when planning and delivering services. Patients care and treatment was coordinated with other services and other providers. Reasonable adjustments were made and actions were taken to remove barriers when children and their carers found it hard to use or access services. The values for children and young people's services had been developed with elements such as compassion, dignity and equality. However, there was no long-term vision or strategy in place for children and young people's services. The trust had conducted a recent strategic review of children and young people's services, and concluded that the proposed strategy of children and young people's

Summary of findings

services operating from one site was not viable. At the time of our inspection there was no decision pending on what the vision or strategy would be for children and young people's services.

Children and young people's staff were unaware of the trust's strategic goals for children and young people's services as the trust had not made a final decision about the future strategy for the service. The board and other levels of governance within the organization had undergone changes in the past 12 months. The chief nurse and director of quality had been instated as the children and young people's services lead. The service's structures, processes and systems of accountability were set out and understood by staff.

There was an effective process in place to identify, understand, monitor and address current and future risks. Performance issues were escalated to the relevant committees and the board through clear structures and processes. Clinical and internal audit processes were in place.

The leadership was knowledgeable about quality issues and understood what the challenges to children and young people's services were, and was taking action to address them. However, face to face monitoring at KCH CAU was a challenge due to the matron being based in Maidstone.

Leaders at every level prioritised safe, high quality, compassionate care and promoted equality and diversity. The culture change programme encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.

There was evidence that the leadership had introduced processes that would actively shape the culture through effective engagement with staff, people who use services and their representatives and stakeholders. Senior leaders encouraged a culture of collective responsibility between teams and services. But, these processes were not embedded.

The children's and young people's service was proactively engaging with and involving all staff to ensure that the voices of staff were heard and acted on. The leadership actively promoted staff empowerment to drive improvement and a culture

Summary of findings

where the benefit of raising concerns was valued. Safe innovation was being supported and staff had objectives focused on improving the culture of the trust.

End of life care

Requires improvement



The trust's specialist palliative care team demonstrated a high level of specialist knowledge. The team provided individualised advice and support for patients with complex symptoms and supported staff on the wards across the hospital. We found reduced resources for the team and concerns regarding sustainability of the service. The planned improvements could not be implemented on current resources.

There remained a lack of Trust Board direction for end of life care with a non-unified approach across the various wards and departments. There was limited end of life care training and use of the trust resource pack was patchy and not kept up to date. Wards struggled with staffing levels and there were no extra staff in place to support end of life care. All staff we spoke with, both clinical and non-clinical, demonstrated a very high level of care, pride and attention to detail in the provision of a good quality service for patients identified as end of life. Patients and families we spoke with described good quality care from staff. The trust worked with the East Kent regional strategy in line with evidence based practice and guidance.

Outpatients and diagnostic imaging

Good



The Outpatient department was well led and had improved since implementing an outpatient improvement strategy. Despite the strategy being relatively new, through structured audit and review the department was able to evidence improvements in health records management, call centre management, Referral to Treatment processes, increased opening hours, clinic capacity and improved patient experience.

Although there was still improvement required in referral to treatment pathways the outpatients department and trust demonstrated a commitment to continuing to improve the service long term. As a part of the strategy the trust had pulled its outpatient services from fifteen locations to six. We inspected five of these locations during our visit. Managers and staff working in the department understood the strategy and there was a real sense

Summary of findings

that staff were proud of the improvements that had been made. Progress with the strategy was monitored during weekly strategy meetings with the senior team and fed down to department staff through staff meetings and bulletins.

Evidence based assessment, care and treatment was delivered in line with National Institute for Health and Care Excellence (NICE) guidelines by appropriately trained and qualified staff.

A multi-disciplinary team approach was evident across all the services provided from the outpatients and diagnostic imaging department. We observed a shared responsibility for care and treatment delivery. Staff were trained and assessed as competent before using new equipment or performing aspects of their roles.

We saw caring and compassionate care delivered by all staff working at outpatients and diagnostic imaging department. We observed throughout the outpatients department that staff treated patients, relatives and visitors in a respectful manner.

Nurse management and nursing care was particularly good. Nurses were well informed, competent and went the extra mile to improve patient's journey through their department. Nurses and receptionists followed a 'Meet and Greet' protocol to ensure that patients received a consistently high level of communication and service from staff in the department.

Kent & Canterbury Hospital

Detailed findings

Services we looked at

Minor Injuries Unit; Medical care (including older people's care); Surgery; Critical care; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

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Background to Kent & Canterbury Hospital

The Kent and Canterbury Hospital (K&C) is one of five hospitals that form part of East Kent University Hospitals NHS Foundation Trust (EKUFT). EKUFT became a Foundation Trust in 2009. Foundation trusts are still part of the NHS but they are able to provide and manage their services to meet the needs and priorities of the local community, as they are free from central Government control. However they are still accountable to Parliament and have to comply with a framework of national standards.

EKUFT provides local services primarily for the people living in Kent. The Trust serves a population of approximately 759,000 and employs approximately 6,779 whole time equivalent staff.

The Kent and Canterbury Hospital is a 287 bedded acute hospital providing a range of elective and emergency services including an Emergency Care Centre (ECC). This

hospital provides a central base for many specialist services in East Kent such as renal, vascular, interventional radiology, urology, dermatology, neurology and haemophilia services

Following our last inspection of the Trust in March 2014 when we found many of the services provided to be inadequate, EKUFT was placed into special measures by the regulator Monitor. This announced inspection was undertaken to monitor and assess what progress the Trust had made in addressing our concerns.

We carried out an announced inspection of EKUFT between 13- 17 July 2015. We also undertook unannounced visits the following week on 29 July 2015.

At this inspection although we found the hospital overall to require improvement we noted there had been improvements made in the majority of services we inspected.

Our inspection team

Our inspection team was led by:

Chair: Ted Baker, Deputy Chief Inspector of Hospitals, CQC

Head of Hospital Inspections: Alan Thorne, CQC

The hospital was visited by a team of 50 people including CQC inspectors, analysts and a variety of specialists.

There were consultants in emergency medicine, medical care, surgery, haematology, cardiology and palliative care

medicine; an anaesthetist, and junior doctors. The team also included midwives, nurses with backgrounds in surgery, medicine, paediatrics, critical care and palliative care, board-level experience, a student nurse and two experts by experience. Experts by experience are people who use hospital services, or have relatives who have used hospital care, and have first-hand experience of using acute care services.

Detailed findings

How we carried out this inspection

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

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

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

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology

- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning groups, NHS Trust Development Authority, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospital, including doctors, nurses, allied health professionals, administration and other staff. We also interviewed senior members of staff at the hospital.

Facts and data about Kent & Canterbury Hospital

Context

The Kent and Canterbury Hospital (K&C) is one of five hospitals operated by East Kent University Hospitals NHS Foundation Trust (EKUFT) and is located in Margate, Kent.

East Kent Hospitals University NHS Foundation Trust provides acute healthcare services to Dover; Canterbury; Thanet; Shepway and Ashford.

- 2013 data indicates that deprivation in the areas of Dover; Canterbury; Shepway and Ashford is significantly better than the England average while that for Thanet is significantly worse than the England average.
- The proportion of Black, Asian and Minority Ethnic (BAME) residents is less than half than the England average of 14.6%. For example in the 2011 census the proportion of residents who classed themselves as white British in Dover was 96.5%.
- Child deprivation in Dover, Thanet and Shepway is significantly worse than the England average

- Violent crime significantly worse across the region than the England average.
- Adult health and lifestyle is the same or slightly better than the England average apart from Dover where there is a higher prevalence of smoking.
- The life expectancy for men and women in Thanet is worse than the England average but is the same or better in the other areas.

Activity

- Across the Trust there are approximately 1,190 beds with 1,047 general and acute and 59 day beds. There are 53 maternity with 4 day beds. Critical care has 27 beds.
- The Trust employs Staff: 6,778 staff of which 872 are medical staff, 2,148 nursing and midwifery and 3,758 other staff.
- In 2014/2015 there were approximately 93,509 admissions with 137,664 elective day case admissions.
- There were approximately 727,216 outpatients seen and 204,685 attendances at the emergency departments.

Detailed findings

Key intelligence indicators across the Trust

Safety

- Rates of Clostridium difficile and MSSA bacteraemia are less than those for England
- There have been 8 cases of healthcare attributable MRSA bacteraemia infections.
- Medical staffing skill mix across all staff grades are equal to England Average.
- Bank and agency staff usage higher than the national average.
- 71 Serious incidents were reported to have occurred between June 2014 and May 2015.
- 60 of these occurred in ward areas, labour ward and delivery and accident and emergency.
- There appears to have been a steady decline in the prevalence rate of Pressure Ulcers, and despite a rise at the end of last year, the rate has continued to fall into 2015
- The rate of falls with harm has fluctuated over the year but has seen a rise since Jan 2015.
- The rate of catheterised urinary tract infections has also fluctuated and seen a rise since Feb 2015.
- There is no evidence of elevated risks from the Hospital Standardised Mortality Ratio indicators.

Effective

- The trust performed the same as other trusts for the Effective questions in the A&E Survey.
- Unplanned re-attendance rate to A&E within seven days has remained around twice the 5% standard and above the England average for over two years.
- SSNAP (July 13 - Sep14): Queen Elizabeth the Queen Mother Hospital is rated C
- MINAP (2013/14): Care of patients with nSTEMI
- Recorded scores less than the England average for nSTEMI patients seen by a cardiologist or a member of team
- Recorded scores higher than the England average for nSTEMI patients admitted to cardiac unit or ward
- Recorded scores less than the England average for nSTEMI patients that were referred for/had angiography during admission including angiography planned after discharge
- In the Heart Failure Audit 2012/13 the hospital performed badly in both the clinical practice in England (in-hospital care) and clinical practice in England discharge sections.

Caring

- Mixed results in cancer patient experience survey; • Trust scored below the England average for Patient-Led Assessments of the Care in the sections of Cleanliness, Food and Facilities.
- CQC In-patient survey results “about the same” as other trusts.
- Slight increase in the number complaints in 2013/14 compared to 2012/13
- The Trusts score in the Family and Friends Test was below the England average between December 2013 to November 2014.
- CQC assessed the Trust against 96 indicators and found there was a risk in three and an elevated risk in a further six indicators.

Responsive

- The top three causes for delayed transfers of care across the Trust included waiting for further NHS non acute care, patient or family choice and awaiting residential home placement or availability.
- The Trust's bed occupancy rate is above that of the 85% standard after which the quality of care provided begins to fall.
- Average Length of Stay (ALoS) at Trust-level for both elective and emergency admissions is generally lower than that of England
- For elective admissions ALoS for the specialities with the highest number of admissions is less than that for England for that speciality.
- For Non-elective admissions ALoS for two of the three specialities (urology and vascular surgery) with the highest number of admissions is greater than that of England for the speciality.
- Although maternity bed occupancy fell in Q4 2014/15 the rate has been consistently worse than the England average.

Well-led

- Sickness absence rates for the trust are always below that for England.
- Trust was worse than expected for the Clinical Supervision and Feedback sections of the GMC (General Medical Council) national training Scheme.
- The Trust performed badly in the NHS Staff survey as a large majority of the indicators in the staff survey were negative.

Detailed findings

Inspection history

- The Kent and Canterbury Hospital has previously been inspected by CQC in 2011, 2012, 2013. This is the second comprehensive inspection of the QEQM.
- Following the last comprehensive inspection undertaken in March 2014 The Trust was put into 'Special Measures' by Monitor, the Foundation Trust regulator as the core services inspected were assessed as 'inadequate'.

Our ratings for this hospital







Our ratings for this hospital are:

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

Notes

Due to the small size of the maternity and gynaecology service at this hospital the relevant reports have been incorporated into the report for the William Harvey Hospital.

Minor injuries unit

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

Information about the service

The Minor Injuries Unit (the unit) was part of the emergency care services provided by the East Kent University Hospitals NHS Foundation Trust. Their other services were located on three sites: William Harvey Hospital in Ashford, Queen Elizabeth The Queen Mother Hospital in Margate and the minor injuries unit at Buckland Hospital, Dover. These three sites are reported on in separate reports. However, services at all sites were managed by the urgent and long term conditions directorate.

The unit at the Kent and Canterbury hospital treated people with minor injuries requiring urgent care and was nurse led with no medical cover.

It treats patients who have sustained a minor injury. Patients with more serious health problems must access other services such as their doctor, or for more serious illness or injury, the Accident and Emergency department at the William Harvey Hospital.

The ECC was situated next to the unit which was very similar to some medical assessment units. However, ECC took very sick patients that would normally go to an accident and emergency department. For the purposes of this report the ECC will be reported via the medical services domain report.

The unit was part of the emergency care services provided by the East Kent University Hospitals NHS Foundation Trust. Their other services were located on three sites: William Harvey Hospital in Ashford, Queen Elizabeth The Queen Mother Hospital in Margate and the minor injuries

unit at Buckland Hospital, Dover. These three sites are reported on in separate reports. However, services at all sites were managed by the urgent and long term conditions directorate.

The unit saw both adults and children with approximately 25% of all attendances being from children under 16. The unit had admission criteria which were followed by the ambulance services. Patients also self-presented to the unit. Patients who did not meet the unit's admission criteria but required emergency care were usually transported to the William Harvey hospital.

We spoke with six patients, four relatives and four staff, including senior managers, nurses and ambulance staff. We observed care and treatment and looked at two treatment records. We also reviewed some of the trust's own quality monitoring information and data.

Minor injuries unit

Summary of findings

There had been no never events or serious incidents reported in the last year.

Cleanliness, infection control and hygiene were meeting the standards expected.

The environment was well laid out and organised within the department, however the reception area did not always maintain patients privacy and dignity and nursing staff relied upon reception staff to pick up if a patient's condition warranted speedier attention.

Stocks of equipment and medicines were maintained appropriately with evidence of good stock rotation and assurance that equipment to be used on multiple patients was clean, well maintained or serviced. Medication was stored safely and dispensed in line with trust policies and patient group directives (PGDs).

Records were held on a computer programme widely used in the NHS. Processes were in place to safeguard patients and staff were well versed with safeguarding and deprivation of liberty standards.

Staff had access to training and development and were well supported to carry out their duties. Staff underwent annual appraisal and had their competencies checked regularly.

The unit used National Institute for Health and Care Excellence (NICE) guidance and there was evidence of local audits being undertaken to monitor quality and patients' outcomes.

Systems were in place to provide patients with pain relief which was offered, where necessary, to patients on arrival at the unit and regularly during the duration of their stay.

Food and drinks were available and could be bought when needed.

Staff understood the principles of the Mental Capacity Act 2005 and understood their responsibilities in relation to obtaining consent from patients. Patients were cared for with privacy and dignity with doors and curtains closed. Whilst we saw only four patients being treated and cared for this was done in a professional and courteous manner. The six patients we spoke with

were very happy with their care. Whilst there was no information readily available about expected waiting times staff would go out into the reception area and tell people waiting if there was to be a delay.

Interpreting services were available and there were no complaints about the service since its opening. Staff we spoke with felt they were well-led at departmental level and had regular contact with the matron. Staff were kept up to date via regular meetings and regular practitioner nurse meetings.

Patients were cared for with privacy and dignity with doors and curtains closed. However, privacy and dignity was compromised in the reception area as patients could be overheard telling reception staff about their personal and health details.

Signposting to the MIU was still a concern as signs directed people to an A&E department.

Whilst we saw only six patients being treated and cared for this was done in a professional and courteous manner. We spoke with four patients who told us they were very happy with their care.

Minor injuries unit

Are minor injuries unit services safe?

Requires improvement



There had been no never events or serious incidents reported in the last year.

Cleanliness, infection control and hygiene were meeting the standards expected.

The environment was well laid out and organised within the department, however the reception area did not maintain patients privacy and dignity and nursing staff relied upon reception staff to pick up if a patient's condition warranted speedier attention.

Stocks of equipment and medicines were maintained appropriately with evidence of good stock rotation and assurance that equipment to be used on multiple patients was clean, well maintained or serviced. Medication was stored safely and dispensed in line with trust policies and patient group directives (PGDs). PGDs are written instructions for the supply and administration of medicines to specific groups of patients without having to be seen by a doctor or dentist.

Records were held on a computer programme widely used in the NHS. Processes were in place to safeguard patients and staff were well versed with safeguarding and deprivation of liberty standards.

Mandatory training rates were good and staffing levels were adequate to cover the unit. Staff were suitably qualified to assess patient risks.

We rated the safety of the unit as requiring improvement.

Incidents

- There had been no never events or serious incidents reported and staff were not aware of any serious incidents on the unit.
- There were 25 incidents reported from January 2015 to May 2015. Three of these incidents related to a delay in patients with a mental health problem waiting to see the mental health crisis team. Other incidents related to patients attending with pressure sores.
- Staff were encouraged to report incidents if they saw anything that concerned them.

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient and any other relevant person within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has or may have occurred.
- The reception area did not maintain patients' privacy and dignity and nursing staff relied upon reception staff to pick up if a patient's condition warranted speedier attention.
- We found that staff were aware of the process to report incidents and would complete incident reports using the trust's electronic incident reporting system. However, the unit had no incidents to report from February 2015.
- Staff on the unit told us they had access to the trust magazine 'Risk Wise' which included learning from incidents. An example from an incident was included in the autumn 2014 edition where there was a missed case of sepsis in a patient with diabetes. The root cause analysis showed that blood cultures and arterial gases should have been taken earlier. The learning for staff was that documenting observations and decisions should be clearer in the patient notes and an improvement plan in the management of sepsis was underway.
- All staff we spoke with were aware of the duty of candour and could explain how the process worked. However, staff still needed to attend the training for this area.

Cleanliness, infection control and hygiene

- In the Care Quality Commission's (CQC) national A&E survey, 96% patients described the emergency departments as being clean.
- The department reported there were no incidents of MRSA (methicillin resistant staphylococcus aureus) or clostridium difficile (C diff) in the last twelve months.
- Alcohol gel was available for use on admission to the unit and personal protective equipment such as gloves and aprons were available.
- Nursing staff followed bare below the elbows policy.

Minor injuries unit

- There was a decontamination policy for toys posted on the walls in the unit for staff to follow.

Environment and equipment

- Security arrangements were adequate. In the CQC's national A&E survey, 96% of patients said they did not feel threatened in the A&E departments.
- There was a mental health crisis room as part of the waiting area in the reception. This meant patients and relatives waiting to be seen by an ENP could identify those patients who had a mental health condition. The room was not safe in that there was only one exit and the room was not ligature proof.
- However, there was also a room used for the out of hours GP service in the reception area which had previously been used as a triage room. We understood this room would be converted back to a triage room once the GP service had ceased in September 2015 and would address the issue of patients being triaged by the reception staff.
- There were five cubicles for use in the minor's area with one cubicle dedicated to seeing and treating children. There was also a small play area in this cubicle with toys for the children to play with. However, we saw this cubicle being used to treat adult patients. Which meant this area was not always the most appropriate area to treat adults and this cubicle may not be available for children when needed.
- We checked a range of equipment such as resuscitation trolleys, defibrillators and trolleys. Most were in order and checked regularly however, some equipment had not been signed as cleaned.

Medicines

- PGDs were available and processes were in place for the management of these.
- Medication was stored safely and dispensed in line with trust policies.
- However, there was an old British National Formulary (BNF) in use in the resuscitation room. This meant that drugs being administered may not be the most up to date and effective.

- BNF is a pharmaceutical reference book containing information and advice on prescribing and medicines available on the NHS. These include dosages and side effects of specific medicines currently being used.
- In the CQC's national A&E survey, 94% of patients said the purpose of new medicines was explained before they left the department. However, only 46% of patients said they were told about the possible side effects of those prescribed new medicines whilst in the department.
- Medications for patients to take home were in good supply which meant they could be discharged in a timely manner.
- There was a trust policy for the management of medical gases and a matron from the William Harvey hospital would attend the medical gases committee which reported to the drugs and therapeutics committee on a three monthly basis. Feedback to staff would be given from these meetings.

Records

- Staff audited one another's records on a monthly basis to ensure they were fully completed and up to date.
- We were told an electronic system had been purchased for the unit to use an electronic patient's records system but this was not yet in operation.
- A spot inspection by the children's safeguarding and child protection liaison team demonstrated 39 sets of notes were looked at and seven of these had no risk assessment. This meant that not all patients care had been fully assessed and patients may have needed more in depth planning.

Safeguarding

- There were safeguarding posters on walls in the unit for staff and patients to read.
- We spoke with a member of staff from the children's and young people liaison team. A member of the team would visit all emergency departments and minor injuries units every day to review and document every child attendance to ensure there were no safeguarding or child protection issues for each attendance.

Minor injuries unit

- Processes were in place for the identification and management of adults and children at risk from abuse. Staff understood their responsibilities and were aware of safeguarding policies and procedures. All staff had adult and children safeguarding Level 3 training.

Mandatory training

- Data provided by the trust showed nursing staff across all A&E sites completed most mandatory training using e-learning. We did not see this evidence across individual sites. Compliance with mandatory training for the department was as follows:
 - Fire training 76%
 - Moving and handling training 95%
 - Health and Safety training 64%
 - Infection control prevention 85%
 - Equality and Diversity 89%
 - Safeguarding 77%
 - Information governance 63%.

Assessing and responding to patient risk

- A see and treat model was used with patients being seen in time order rather than a traditional triage system.
- We observed the receptionist greeting patients and taking their personal details. However, the receptionist also took clinical details such as: location of pain, severity of pain and then decided where the most appropriate place would be to send the patient. For example: they would decide whether the patient needed to be seen by either a GP, a nurse in the minor injuries area or in the emergency care centre.
- We were told this was called 'signposting' but in practice this was a reception led triage. We heard the receptionist saying, 'this looks like a urology patient, she needs ECC, she is crying in pain'.
- We observed paediatric early warning scores (PEWS) being initiated for a child attending the unit. This meant that children attending the unit were being assessed using a national warning score tool so that any deterioration in their condition would be picked up and acted upon in a timely manner.
- Mental health patients were risk assessed using the SMART tool and their condition graded as red, amber,

yellow or green. This then stipulated what actions would be taken next. For example if a patient had been assessed as an amber risk they would have a nurse allocated to them for supervision purposes.

- The mental health liaison team would see all patients in a small room in the waiting area. There were concerns with long waiting times to see the mental health liaison team and some patients would often have to stay overnight on the clinical decision unit in order to be seen by the team.
- There was a senior consultant in ECC available to give advice if this was needed.

Nursing staffing

- The unit was nurse led with no medical cover; it was staffed by nurse practitioners (ENPs) who were qualified nurses with extra training. One practitioner was a trained paramedic with additional training. Staff covered the unit from 9am to 7pm Monday to Friday and 10am to 6 pm at the weekend.
- Still waiting for actual numbers
- If there were shortfalls of staff due to annual leave or sickness, staff from the minor injuries unit in Kent would cover. The unit did not use agency staff.

Major incident awareness and training

- Due to the closeness of the channel tunnel, M20 and Dungeness nuclear power station, the trust's major incident procedure was being reviewed and training to support the procedures were in place. However, there was no major incident training for paediatrics.
- 85% of staff in the department had attended major incident training. There had been no major incident exercise for 18 months.
- Staff on the unit had watched a video on major incident procedures.

Minor injuries unit

Are minor injuries unit services effective? (for example, treatment is effective)

Requires improvement



The unit used National Institute for Health and Care Excellence (NICE) guidance and there was evidence of local audits being undertaken to monitor quality and patients' outcomes.

Systems were in place to provide patients with pain relief which was offered to patients on arrival at the unit, where necessary, and regularly during the duration of their stay.

Food and drinks were available and could be bought from the local shop inside the reception area.

Staff had access to training and development and were well supported to carry out their duties. Staff underwent annual appraisal. People had their competencies checked regularly.

Staff understood the principles of the Mental Capacity Act 2005 and understood their responsibilities in relation to taking consent from patients.

Evidence-based care and treatment

- There was a range of care pathways which complied with the National Institute for Health and Care Excellence (NICE) and the College of Emergency Medicine's (CEM) clinical standards for emergency departments.
- Staff could access the trust's electronic system to store and access evidence based pathways. In addition, nursing staff had their own PGDs which they updated regularly and were signed off by a consultant working at the William Harvey emergency department.
- Staff used a SMART tool to assess the health of patients being treated on the unit.
- However, we saw a folder being used with out of date information about pathways of care and a paediatric information folder with out of date guidelines dating back to 1996. This may mean that staff may not be using the most up to date information to treat their patients.

Pain relief

- In the CQC's national A&E survey, 77% of patients said staff did all they could to help control their pain. However, 44% of patients had to wait a long time for pain relief
- Staff explained to people to ask for pain relief if needed and used pain scoring tools to measure patients' pain.
- We saw no evidence of pain assessments for the people who were in the unit at the time of our inspection.
- We saw three children in the waiting room waiting for over one hour to be assessed. One had a head injury and so would not be getting their pain assessed in a timely manner.
- We spoke with a patient who had taken a fall and was waiting to be transferred to the William Harvey hospital for an operation. She told us she had been given pain relief when she first attended the unit and had been asked again whether she needed further analgesia. She was very happy with the pain relief she had been given.
- The pain management policy was in draft and was being developed in conjunction with the trust's medication policy.

Nutrition and hydration

- There was a water fountain in the waiting area for people to access whilst waiting to be seen and a tea trolley was used to offer people food and drinks if necessary.
- Staff told us they were unable to take breaks as the unit was too busy.

Patient outcomes

- Nurses undertook their own audits and shared these with the emergency nurse practitioners (ENP) forum when they met every two to three months. They were carrying out an audit on eye care where they were auditing one another's practice.
- According to the trust data in April 2015 the unplanned re-attendance rate to the unit within seven days of discharge was 9.5% which was above the England average of 5%; this may mean patients may not be getting the best possible care at their first attendance.

Competent staff

- Nurses were trained in using PDGs which were regularly audited and updated.

Minor injuries unit

- All staff had their appraisals booked but clinical supervision didn't take place formally. However staff felt well supported and able to discuss clinical issues openly with colleagues and managers.
- All staff were immediate life support (ILS) trained and staff were either paediatric life support (PILS) trained or were booked to do the training.
- Staff kept up to date via an ENP forum where they met with the other ENPs working at the other hospital sites.
- Staff had attended some specific paediatric training such as paediatric scenario sessions and band five staff also had access to an unwell adult's course.
- No staff had received dementia training. However, the trust had a dementia strategy and could access the dementia link person if needed.

Multidisciplinary working

- The trust had worked with the South East Coast Ambulance Service NHS Foundation Trust in developing criteria for the types of conditions for patients being brought to the unit for treatment. There was clear guidance on the types of conditions that the unit could care for. For example: the unit could take patients with abrasions, eye injuries, foreign bodies, head injuries with no loss of consciousness, limb injuries where there was no gross deformity and stings and bites.
- There was also criteria for what the unit could not treat such as: head injuries with loss of consciousness, penetrating injuries and patients who were under the influence of drugs or alcohol.
- Staff reported good links with the other emergency departments.

Seven-day services

- The unit was open seven days a week, 24 hours a day and the unit had access to on-site x-ray facilities.

Access to information

- Clinical guidelines and policies were available via the trust intranet. We found that some guidance on the intranet was in need of updating however we were informed that this process was underway throughout the trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were confident with the consent process and could explain how consent to treatment was obtained. They accepted implied consent as the patient agreeing to a procedure.
- Staff were aware of the Mental Capacity Act and the Deprivation of Liberty Standards (DoLS).

Are minor injuries unit services caring?

Good



Patients were cared for with privacy and dignity with doors and curtains closed. However, privacy and dignity was compromised in the reception areas as patients could be overheard telling reception staff about their personal and health details.

Whilst we saw only seven patients being treated and cared for this was done in a professional and courteous manner. We spoke with eight patients who told us they were very happy with their care.

Compassionate care

- The results of the CQC's national A&E survey disclosed the majority of patients (80%) said they had enough privacy and dignity when discussing their health problem with the receptionist. 91% of patients said they were acknowledged by staff and staff did not talk in front of them as if they were not there. 67% of patients felt reassured by staff if they were distressed while in the department.
- The trust scored worse than the England average in the NHS Friends and Family Test for the last 15 months (52%) although this was starting to improve.
- We saw good communication with patients.
- Privacy and dignity was compromised at reception as patients could be overheard telling reception staff about their personal and health details.
- Spare clothes were made available for a child who had vomited.
- Two parents complained to us about waiting for their children to be seen and not knowing what was happening.

Minor injuries unit

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved in their care. In the CQC's national A&E survey: 78% of patients said they were involved as much as they wanted to be in decisions about their care and treatment.
- 80% of patients felt their doctor or nurse explained their condition and treatment in a way they understood and 86% of patients told us they felt the doctor or nurse listened to what they said. 74% of patients said they had enough opportunity to talk to a doctor if they wanted to.

Emotional support

- In the CQC's national A&E survey, 71% patients said the doctor or nurse discussed their anxieties or fears they had about their condition or treatment. Good response from parents with injured child well looked after great care.
- Excellent care was observed.

Are minor injuries unit services responsive to people's needs? (for example, to feedback?)

Requires improvement



Signposting to the MIU was still a concern as signs directed people to an A&E department. There was no information readily available about expected waiting times, however staff would inform people waiting if there was to be a delay.

There was no information readily available about expected waiting times, however staff would inform people waiting if there was to be a delay.

Interpreting services were available and there were no complaints about the service since its opening.

Service planning and delivery to meet the needs of local people

- Managers were aware of the type of patients who attended the department and had the necessary equipment and trained staff to manage such situations.
- Due to the way in which emergency care was provided at the Kent and Canterbury hospital meant that some

patients attended the MIU inappropriately. Additionally, some patients were unhappy that the MIU was not a full A&E department. Road signs still signposted patients to an A&E department.

Meeting people's individual needs

- There was no information readily available or visible to patients about expected waiting times. This meant that patients did not know how long they could expect to be in the department and could be stressful not knowing how long it would be before they would be treated.
- The trust had access to interpreting services for people whose first language was not English. Staff told us that in an emergency situation they may use a family member in the very first instance, but would try to access an interpreter as quickly as possible. The trust could also access telephone interpreters if necessary. The 'Big word' was available 24 hours a day
- The staff had access to a dementia matron and could contact her if they needed advice or guidance.
- The staff we spoke with about patients living with dementia, or a learning disability all told us that they would treat patients as individuals but would try to find out about them in order to make a decision about whether they needed any extra support such as to be seated in a private area. Staff told us that whenever possible, people with dementia or a learning disability would be seen as quickly as possible in order to minimise distress for the patient.
- The unit had mixed adult and child cubicles and we saw adult patients being treated in the children's cubicle.
- There was minimal child friendly décor which was not conducive for children to be treated.
- On one occasion reception staff walked one patient to majors leaving the reception empty resulting in patients having to wait longer to be seen or directed to the appropriate professional.

Access and flow

- Trust overall minors performance was 98.2%. The trust did not provide data specifically for the unit as this was part of the ECC. We observed long waits in the reception area and reception staff being extremely busy. This led to the telephone ringing for long periods of time without being answered. The majority of calls would ask

Minor injuries unit

whether specific patients could be directed to the unit. The reception staff would then make a decision whether patients should attend the unit or another emergency department.

- We were told there were long waits for patients with a mental health problem to see the mental health liaison service. The mental health liaison team were available Monday to Friday between 8am and 10pm.
- There was no paediatric support out of hours which meant children would be treated by staff not trained to look after children.
- 1,400 patients were seen in the unit since it opened. Sign posting to the new unit was clear and the trust's website had been updated to ensure people knew about the new unit and that it was a minor injuries unit and not an A&E department.
- No patients had to wait for more than 15 minutes to be seen by a nurse practitioner.
- At times between 55 to 59 patients were seen over a 10 hour shift. We were told this made them feel as if they were overstretched. This often led to staff having no breaks in order to meet their targets.

Learning from complaints and concerns

- There was information about how to raise concerns about the unit or the trust as a whole on display in the department and there were leaflets available for patients to take away with them.
- Staff were able to describe to us the action they would take if a patient or relative complained to them.
- No complaints had been received in the last six months and there were no complaints at the time of the inspection.

Are minor injuries unit services well-led?

Requires improvement



Staff we spoke with felt they were well-led at departmental level and could access the matron easily. Staff were kept up to date via regular meetings and regular practitioner nurse meetings.

There was evidence of good team work. Staff were engaged in developing their service. There were good links with the emergency care centre (ECC) who would provide medical assistance if needed.

There was no strategy for the emergency department, this was being developed and in draft format. There were no plans for shared paediatric rotas and no plans for shared paediatric governance at this time. This meant that services for children in the department may be compromised

Staff told us they felt supported by their seniors. However, there had been no management response to safety issues identified in the reception area.

Vision and strategy for this service

- There was no strategy for the emergency department, this was being developed and in draft format. However, the urgent and long term conditions directorate was contributing to the trust's 'Developing our Future' five to ten year strategy. There was a vision for children's services in the department. However there were no plans for shared paediatric rotas and no plans for shared paediatric governance at this time. This meant that services for children in the department may be compromised.
- Staff we spoke with were aware of the future plans for the whole emergency care departments. They were aware of the increasing number of patients accessing the accident and emergency departments. Work was underway to look at how increased demand could be managed to meet the needs of the population.

Governance, risk management and quality measurement

- Monthly meetings were held to review incidents, complaints, progress on audit activity and other safety issues. This was attended by senior clinicians and managers.
- The divisional risk register detailed the risks associated with poor patient flow, increased activity, delays in the department and staffing levels. These risks mirrored what staff and managers told us.
- There were 12 risks on the division's risk register. They detailed the risks associated with poor patient flow, increased activity, delays and staffing levels within the department. Other risks included the lack of policy and guidance for managing children when they attend the department and the effective management of patients with sepsis. These risks mirrored what staff and managers told us. There were actions to address these risks with dates attached for completion.

Minor injuries unit

- The minor injuries unit at Kent and Canterbury hospital and the minor injuries unit at Buckland were managed by the same matron and as such all governance processes were the same for both units.
- Staff from both units would meet every three months where they would review governance arrangements and share learning from complaints and incidents.

Leadership of service

- Staff told us they felt supported by their seniors. However, there had been no management response to safety issues identified in the reception area.
- Staff told us that they had no concerns with their line managers and felt that they could raise concerns and be confident that they would be resolved whenever possible.
- Staff we spoke with felt they were well-led at departmental and trust level.
- We found the nursing leadership in the department to be good. During our inspection we found that the senior matron would visit every week and was easily accessible over the phone if needed.

Culture within the service

- Staff told us that there was an open and supportive culture within the department. They told us that morale in the department was good and staff worked together as a team.

- Staff felt supported and were supportive of each other. We saw and were told that staff had very good professional relationships.

Public engagement

- Signage still directs patients to an A&E department as well as a minor injuries unit.
- Reception staff received a high number of phone calls asking if they should come to the MIU. We heard reception staff telling them to go to another hospital, the emergency centre or to the unit itself. This meant people were still confused as to where they should go in an emergency.
- The department used the Friends and Family Test to capture patients' feedback and comments cards were handed out to patients as they arrived in the department.







Staff engagement

- Staff were updated by the matron every week and there were regular meetings with the matron to keep staff engaged.

Innovation, improvement and sustainability

- The trust was looking in to the sustainability of the service and how the unit fitted in alongside the emergency centre and clinical decision unit to ensure that services were delivered to patients in the right place, at the right time.

Medical care (including older people's care)

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

Information about the service

Kent and Canterbury Hospital (KCH) is an acute hospital with 326 beds providing a range of medical care services. These include cardiology, gastroenterology, respiratory medicine, medical oncology, general medicine, nephrology, stroke and specialist rehabilitation services. The hospital also provides services to elderly patients. There is also an 18 bedded Clinical Decision Unit (Medical CDU) and Medical Assessment Unit (MAU) described by the trust as an Emergency Care Centre (ECC).

In the period July 2013/14, the last for which figures were available, the trust admitted 7,970 patients to medical care services. At the Kent and Canterbury there were 3370 admissions in the same period. Of these 49% were emergency admissions, 48% day case and 3% elective. General medicine was the speciality for the majority of admissions at 48%. Admissions to geriatric medicine accounted for 18%.

In the period April 2014/15 the ECC had 46,933 attendances, with an average attendance of 903 per week.

We inspected the medical CDU, ECC, general and speciality medicine wards (Clarke, Kingston, Invicta, Mount McMaster, Endoscopy), acute neurology unit (Harvey, Treble), frailty wards (Hambledown) and Cathedral Day Unit.

We spoke with about 17 patients including their family members and carers, 53 staff members including nurses, doctors, consultants, senior managers, therapists, and support staff. We observed interactions between patients

and staff, considered the environment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences. We reviewed other documentation from stakeholders and performance information from the trust and KCH.

Medical care (including older people's care)

Summary of findings

Overall, we found medical care services at KCH required improvement in some aspects of patient safety. This is because we identified some concerns in relation to the environment, medical staffing, nursing staffing, especially at night, arrangements to identify and support patients whose condition is deteriorating, the storage and management of medicines, the management of confidential records and shortfalls in infection control procedures. We found that there were good systems to report and investigate safety incidents.

We found that treatment generally followed current guidance, but care assessments did not always consider or record the full range of people's needs and care plans did not reflect individualised care

We found that there were arrangements to ensure that staff were competent and confident to look after patients. However, medical staff were not always able to access adequate educational support to promote their professional development.

Patients were cared for by a multi-disciplinary team working in a co-ordinated way and generally had access to some services seven days a week. However, services such as speech and language therapy and physiotherapy services were not available at weekends.

Patients received adequate food and drink and were generally supported appropriately when they had problems. Consent was obtained and recorded in line with relevant guidance and legislation and where patients lacked capacity to make decisions for themselves, staff acted in accordance with their obligations under the Mental Capacity Act.

We judged the caring aspects of medical care services were good. Patients and their relatives were positive about their experience of care and the kindness afforded them. We observed compassionate care that promoted patients' privacy and dignity. Patients were involved in their care and treatment and were given the right amount of information to support their decision making and patients could get the emotional support they needed.

We judged that the responsiveness of medical care services required improvement. This was because there was insufficient bed capacity to meet the needs of patients. This resulted in almost half patients being moved at least once during their hospital stay. There were large numbers of patients in non-speciality beds and this had negative implications for their safe care and treatment. We also found that the discharge of patients was not managed in a timely manner especially at weekends.

We judged that service was well led. There was an appropriate system of governance in medical care services. There were arrangements to monitor performance, and quality and risk issues which were escalated to the trust board when necessary. Key messages were disseminated to staff. Staff acknowledged the steps that had been taken within the organisation to improve, processes and systems of accountability and could discuss the trust philosophy. Individual wards had developed their own strategies which staff understood. We observed a caring and positive ethos. Staff reported that although the culture was improving, they did not always feel actively empowered or engaged as improvement seen as being reactive and focussed on short term issues.

There were examples of collaborative working with the voluntary sector and where patient representatives had been involved in developing and monitoring services.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



Overall we found medical care services at KCH required improvement in some aspects of patient safety.

This was because we found that there were insufficient doctors and registered nurses on duty, particularly at night, to meet the needs of patients. There were insufficient systems to ensure that resuscitation equipment was maintained ready for use. Medicines, including controlled drugs, were not always stored safely according to The Misuse of Drugs Regulations 2001 and The Nursing and Midwifery Council's "Standards for Medicines Management." There was inconsistency in the quality of record keeping and confidential patient records were not always kept securely.

There was a positive culture of incident reporting. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and were supported when they did so. There were robust arrangements for investigating safety incidents and monitoring the implementation of action points following an incident. There was a range of suitable forums for staff to receive feedback and learning. Rates of harm free care as monitored by the national Safety Thermometer programme showed a harm free care rate of 94.3% which is slightly better than the England average of 94%.

We found that measures for the prevention and control of infection met national guidance, but systems for providing assurance around cleaning and hand washing were not always followed. The clinical environment appeared clean but on some wards shower and bathroom facilities were not sufficient or maintained appropriately to meet patients' needs. There was sufficient equipment that was properly checked and maintained to meet patients' needs and staff were competent to use it. Staff were aware of their role in relation to safeguarding children and adults living in vulnerable circumstances and acted according to local policies when abuse was suspected. Mandatory training helped ensure nearly all staff had current knowledge and

skills in key safety areas. However, compliance with mandatory training overall for the medical division was 62.9 % for medical staff, 79.8% for nursing staff which was worse than the trust's target of 85%.

Staff were using the Vital Pac wireless system to record information directly into patient records, however there appeared to be issues with the number of Vital Pac's being available for staff on the wards, issues with the system going down and staff having to resort to paper resort and staff not being aware of when to report problems when the system has not uploaded. This meant patients were at risk of not having their observations taken and monitored regularly and patients who were deteriorating were at risk of not receiving a speedy response and having their care re-assessed.

Incidents

Trust policy stated that incidents should be reported through a commercial software system enabling incident reports to be submitted from wards and departments. All staff we spoke with across medical care services at The Kent and Canterbury Hospital (KCH) told us there was an evolving culture of encouraging the reporting of incidents. They knew how to use the system and could confidently demonstrate its use to us.

There were no "Never Events" reported by the trust in medical care services in the period May 2014 to April 2015. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The trust reported 20 serious incidents for the medical care services between May 2014 and April 2015 out of 24 for the trust. This represented 83% of all incidents. Of the incidents in medical care services, 60% were in general medicine and 20% were in geriatric medicine. This correlates with the areas of most admissions. The most common serious incident reported was pressure ulcers grade three and four, (10) and slips trips and falls (7).

In medical care services at KCH, including the ECC, safety incidents were categorised as one death, no severe incidents and 88 of incidents moderate harm, of which 28% were in stroke. There were also 572 low and no harm incidents reported which indicates a good reporting culture within the service.

Medical care (including older people's care)

Staff we spoke with at all levels were aware that falls and pressure ulcers were the most common incidents. A nurse we spoke with described how they had reported and incident where a patient who was receiving one to one care fell because they were not supervised. Following feedback, changes had been made to ensure that the patient was observed at all times.

We saw examples of the "Risk Wise" pamphlet that was circulated by the trust on a quarterly basis. Staff described how this had significantly increased awareness of incidents and associated change of practice within the wider trust community as opposed to just their own areas of responsibility.

Morbidity and Mortality meetings were held as a trust-wide forum. We saw minutes that showed medical care services were involved in these meetings and that medical patients and their management were reviewed and lessons learned.

Duty of Candour

The trust reports that 59 members of staff at the KCH have currently undertaken duty of candour training as part of their root cause analysis (RCA) training. We saw that their RCA documentation included prompts regarding duty of candour. This encouraged staff to detail the actions been taken to support patients and or relatives. We asked staff about their understanding of the new regulations concerning duty of candour. Most were able to describe the concept and understood the organisation's responsibility for transparency and openness. However, we were told that not all had received training in the regulations or fully understood the statutory process to be followed.

Safety thermometer

Medical care services at East Kent Hospitals University Foundation Trust participated in the national safety thermometer scheme. The NHS Safety Thermometer is an improvement tool to measure patient "harms" and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections. Ward managers collected monthly data as part of the NHS Safety Thermometer scheme. Key safety information such as days since the last fall, incidence of pressure

damage or avoidable infection was displayed at the majority of ward entrances in a format that was easily understandable to patients and their families. On the Invicta ward we saw that safety thermometer data was displayed but some of it was out of date. On Kingston and Harvey ward the safety thermometer data showed positive results with Harvey ward having no ward attributed pressure ulcers in last year. When we asked about the actions that had been taken to improve, we were informed of initiatives that had been introduced to reduce patients' risk of falls.

Safety thermometer data was incorporated into the clinical quality and patient report which was reported to the trust board. In May 2015 92.3% of inpatients were deemed 'harm free' which is worse than reported in April 2015 at 94.3% and slightly worse than the England average (94%).

The trust reported that the rate of falls per 1000 patient bed days was 5.4 which places the trust in line with the England average.

Of the 160 patient falls recorded for the trust in April 2015 (185 in March 2015), four incidents were graded as moderate, no incidents were graded as severe or death. There were 94 falls resulting in no injury and 65 in low harm. Kingston Stroke Unit reported nine falls and Harbledown reported six falls.

For the period year to end of March 2015 the trust reported greater than 25% reduction in all avoidable heel ulcers, significant reductions in avoidable heel ulcers by 77% and the total number of acquired heel ulcers by 31%. This demonstrates that initiatives to reduce pressure ulcers were having a positive impact across the trust.

Cleanliness, infection control and hygiene

Overall, we found that the Department of Health's "Code of Practice on the prevention and control of infections and related guidance" was complied with in medical care services.

Clostridium difficile (C Diff) and Meticillin-resistant staphylococcus aureas (MRSA) for the trust were within expected statistical limits and below the organisation's targets.

Medical care (including older people's care)

Throughout our visit we generally found the wards and specialist medical units were clean and tidy. We observed support staff cleaning throughout the day and undertaking this in a methodical and unobtrusive way.

There was a visual guide to indicate which group was responsible for cleaning equipment. We saw this displayed on some wards. However, there was no evidence of cleaning checklists in all patient toilets or bathrooms.

Most of the equipment we examined such as commodes, vital sign monitors, wheelchairs, toilet rising seats were visibly clean but the evidence of a standard green label to indicate it had been cleaned was not universally used on all wards. Supplies of these labels were seen on the wards but not consistently completed for example, on McMaster/Mount and Kingston wards. Ward managers told us that it was trust policy to use this system to indicate that equipment shared between patients were easily identifiable as ready for use. When we spoke to staff they told us they were aware of the system and could offer no explanation as to why the stickers were not used. This meant that there was no robust assurance process in place to demonstrate equipment was clean and safe to use.

The trust operated an infection control score card which performance information against a range of infection control indicators. These included hand hygiene compliance, adherence to the high impact interventions known to reduce infections and cleanliness audits. We saw the audit reports of individual wards during our visit. Some wards had display boards with key infection prevention and control messages and the performance score card for their ward. For example on Harbledown the weekly commode audits showing the latest audit had achieved 90%.

A member of the cleaning team explained and showed us how any deficiencies identified as part of the audit were communicated to them, and confirmed that remedial action was checked. We saw results of ward audits and action plans to address shortfalls. This meant that cleaning standards were audited and the results monitored.

Adequate hand washing facilities and hand gel were available for use at the entrance to the wards/clinical areas and within the wards. However, at the entrance to

McMaster/Mount there was no hand gel under the signage for visitors or staff. There was prominent signage reminding people of the importance of hand washing at the entrances to wards and within the toilet and bathroom areas. We observed that staff generally washed their hands in line with the World Health Organisations guidance "Five moments of Hand Hygiene." We saw that there were monthly infection control audits. These included an audit of hand hygiene.

Adequate supplies of personal protective equipment (PPE) were available and we saw staff using this appropriately when delivering care. We noted that all staff adhered to the "bare below the elbows" guidance in the clinical areas.

Side rooms were used to care for patients where a potential infection risk was identified. This could be to protect other patients from the risk or the spread of infection, or to protect patients from infection where they had reduced immunity to infection. Signs were in place at the entrance to side rooms which were being used for isolating patients, giving clear information on the precautions to be taken when entering the room. On Invicta ward a staff member described to us the protective hygiene and hand washing procedures for a patient isolated for methicillin-sensitive staphylococcus aureus (MRSA). In the CDU the nursing staff thought that a patient was being isolated on clinical grounds but there was no signage to alert staff to the patient's condition this showed that arrangements for patient isolation were inconsistently applied.

We saw that clinical and domestic waste was appropriately segregated and that there were arrangements for the separation and handling of high risk used linen. We observed that staff complied with these arrangements. However, on Harbledown ward we observed a patient with blood stained sheets that had not been changed in a timely manner, but this was dealt with immediately when raised with staff.

We found items of hand washing equipment, hand gel and hand wipes stored inappropriately in the sluice room. On Harbledown ward we found that the sluice was cluttered with commodes and other equipment. This meant that staff were not able to easily access equipment as required.

Medical care (including older people's care)

We observed that sharps management generally complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw that sharps containers were used appropriately and that they were dated and signed when brought into use. However, we found that in the majority of clinical areas they were not closed appropriately following use.

Infection and Prevention Control training formed part of the mandatory training programme that was updated yearly. In the first quarter of 2015 the training rates were across the division averaged 72% with a range of 74% - 93% within departments. This programme of training would ensure most people had completed training by year-end achieving trust target of 85%.

In the Endoscopy department we saw that there were effective decontamination procedures for cleaning endoscopes after use, with supporting audits to maintain standards.

We saw on some wards that action plans developed to address issues identified in the trust annual infection control audit were displayed. On other wards this information was held in the ward manager's office. It was unclear from the action plans if the actions had been met or were still work in progress. The Harbledown ward was in special measures for infection control. We saw that an action plan had been put in place in January 2015 and that it had been reviewed in April and June 2015. We found that there had been no changes in the audit results recorded between the reviews.

Patients that we spoke with were generally complimentary about the cleanliness of the hospital.

Environment and equipment

All the areas we visited during the inspection were clean and tidy. Some wards presented challenges regarding limited storage space by nature of their layout. We saw that staff had been vigilant in reducing clutter in the ward corridors, thereby avoiding trip hazards so that people were kept safe. On Kingston ward we found that there was limited storage space and equipment was stored in the corridor.

The trust had recently established an equipment library and throughout our inspection staff were complimentary about this service and the support they received when requesting equipment. The equipment library was open

Monday to Friday 9.00 am to 5.00 pm with out of hour's service available. Staff described that out of hours requests took longer as porters were required to deliver items to wards, but the service was generally reliable. On Invicta ward staff told us that they were able to get specialist equipment, for example beds from the store within an hour.

We found that each clinical area had resuscitation equipment stored on resuscitation trolleys readily available and located in a central position. The trust policy identified the systems to ensure it was checked daily, fully stocked and ready for use. This included the recording of daily checks. We checked trolleys on all clinical areas that we visited and found that there were omissions on the majority of records. In the CDU we found that there were 48 days between April and July 2015 where there were gaps in the daily recording of checks. We identified that the main omissions occurred at weekends and the ward managers told us this was often due to staffing shortages or agency staff not knowing who was responsible for the checks.

When we asked about audit activity we were told that the trust resuscitation officer undertook monthly audits of resuscitation equipment, but staff were unclear of what actions were required or had been taken as feedback from the audits was not made available to them. This meant that learning from audits was not communicated and it was not clear if the resuscitation equipment was complete and ready for use in the event of an emergency.

We found documentation to support that the majority of equipment for example, hoists, slings and the clinical monitoring system, had been tested and were maintained to the appropriate standard across the medical division.

Staff told us that Electrical Medical Equipment (EME) was well maintained centrally by the EME department. They said that it was very unusual for them not to be unable to access equipment when it was needed. We saw that all EME had a registration label affixed which meant that the department were aware of its existence and that it was maintained and serviced in accordance with manufacturer's recommendations. We also saw that Portable Appliance Testing (PAT) labels were attached to electrical systems showing that it had been inspected and was safe to use. For example, on Invicta ward we saw that the blood and gas machine tests were up to date.

Medical care (including older people's care)

We spoke with staff who explained the systems they followed when they encountered environmental problems or maintenance issues. They described the system and reported that generally it worked well with more minor issues, but bigger issues often remained unresolved.

On Invicta ward, oxygen had been leaking for about a month and on McMaster/Mount splash backs on sinks were badly stained. We saw that this had been reported several times in the last few months but no action had been taken.

We looked at fire-fighting equipment throughout the wards and medical speciality units. We noted that there was a system of fire risk assessments and equipment was labelled confirming that it had been maintained and tested.

Records were available to demonstrate that an average of 73% of staff in medical care services had completed training in both health and safety and fire safety training.

Medicines

We observed that medicines were administered by appropriately trained staff following the Nursing and Midwifery Council's "Standards for Medicines Management." Nursing staff were aware of the policies on the administration of controlled drugs.

We saw there were adequate resources such as up to date British National Formulaires and IV treatment guide that staff could reference when they needed to. In the ECC we found the copy of the "Royal College of Paediatric and Children's Health (RCPH) medicines for children" was out of date.

We found that in the majority of wards, CDU and ECC medicines were stored securely in locked cupboards, rooms and medicine trolleys and the keys to drug cupboards were held by appropriate staff.

Patients own drugs were kept in a 'green bag' and stored in bedside lockers to ensure that they were not mislaid or mixed with other patients medicines. We saw on CDU that drawers were not locked. This meant that not all medicines were being stored safely.

We saw that when applicable medicines were stored in dedicated medicines fridges. We saw records showing daily checks were undertaken.

Controlled drugs were stored correctly. In CDU we found that there were four gaps in the witness signature for June 2015. This shows that the legal requirements for the management of controlled drugs were not being met.

We observed a nurse and doctor check a controlled drug which was signed and witnessed in the CD register.

We found there were gaps in the daily checks of emergency drugs held in the CDU, ECC and on Invicta ward. This showed that trust policy was not consistently followed with the risk that discrepancies in stock levels may not be promptly detected.

We consistently found intravenous fluids stored in rooms that were unlocked at the time of the inspection throughout the medical wards. We found that the clinical treatment room on Invicta ward, McMaster/Mount wards were left unlocked and unattended which meant the area was accessible to unauthorised persons.

We observed medicines rounds in progress and saw staff checked the identity of patients prior to administering their medicines. We observed them talking to patients about how they liked to take their medicines during administration. One patient on Harvey ward told us that they "don't always have two nurses to give medicines (CD's) and that I have to wait to get another nurse. They are due at 2pm but have waited until 6pm. The drugs charts are sent away and this adds to the delay".

Pharmacists visited ward areas and the CDU and ECC daily to carry out medicines reconciliation and check for medicines to take away (TTA). Staff reported that this system worked well but frequently charts were taken to pharmacy. This resulted in delays in obtaining TTA's particularly at the weekend and if there were CD medications prescribed. This meant there was a risk of a patient missing a dose of medicine if their chart had been taken to pharmacy and delays to patient discharge as they were frequently waiting for their medicines.

Staff on the wards told us that they had no named pharmacists and used saw communication diaries so that pharmacists could readily access the wards immediate requirements which helped to ensure that the wards maintained their stock level.

Medical care (including older people's care)

Discharge from the CDU were minimised as the CDU held labelled packs of take home medicines. The CDU also kept a stock of prescriptions (FP10's) so doctors could write a prescription for a patient to take to their community pharmacy.

There was a medicines safety group within the clinical governance structure. This group monitored the medicines risk register. When medicine safety issues were identified, alerts and emails were sent to the relevant areas. . This was instrumental in raising awareness and ensuring key messages were received. We saw from minutes of meetings that all pharmacy related incidents were reported and reviewed at the Pharmacy Senior Governance Team meeting.

Records

Medical care services had integrated patient records shared by doctors, nurses and other healthcare professionals. This meant that all professionals involved in a patient's care could see the full record. We looked at 14 sets of nursing records and found that these were generally compliant with guidance issued by the General Medical Council and the Nursing and Midwifery Council, the professional regulatory bodies for doctors and nurses. However, many were disorganised and difficult to navigate. It was evident there was no procedure for maintaining patient records to a trust standard wards and departments adopted different formats

Patient's records were readily accessible to those who needed them.

We saw that medical records were not always stored securely and that unauthorised access was possible. On Invicta, Hambledown, Treble, Kingston wards and the CDU records were generally stored in open notes trolleys, in pigeon holes or on shelves in ward areas to which the public had access. Staff told us this was normal practice. On Invicta and Kingston wards computer screens were facing patient bays so patient data was clearly visible. This demonstrates that confidential patient records and information was not always kept securely.

We looked at 14 sets of records and found many examples of patient notes that were not consistently completed. For example, we saw nursing assessments, repositioning charts, food charts and personal care round records were not completed on every occasion. On Harbledown and Invicta wards we saw that in nine

records no nursing assessments had been completed. Some forms had been badly photocopied and were difficult to read. On Treble ward we saw that a patient transferred from WHH did not have a new risk assessment completed. A further patient had a grade two pressure sore which staff not aware and another had a dressing on leg from a biopsy taken. There was no care plan to state when dressing should be changed. The dressing had been on a week.

In the CDU we looked at eight sets of medical notes. We found that these were clearly documented, with appropriate action plans, a post take ward-round proforma and a safety checklist completed. We saw that where a patient was at a high risk of falls, a full risk assessment had been completed. However, in the ECC we found that five sets of records had no pain scores recorded.

We saw that a nationally recognised quality tool for the recording of information known as Situation, Background, Assessment, Recommendation (SBAR) was being used. The information is used to assist in the safe transfer of patients; ensuring specific information is available in a set format. When we checked records we saw that SBARs had not always been fully completed for patients. This meant that staff receiving the patient might have to make additional enquiries about the patient in order to ensure appropriate care was given.

An average of 65% of staff across the medical division had received Information Governance training. The trust target was 85%.

Other records we requested in ward areas, such as duty rotas and safety information that were relevant to the running of the service could usually be produced without delay either in paper or electronic formats.

Appropriate arrangements were in place for the management of confidential waste.

Safeguarding

The Adult Safeguarding team had been renamed the "People At Risk Team" (PART). We heard how they supported doctors, therapists and matrons across each of the three main hospital sites in all matters relating to

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safeguarding and the protection of people's human rights. We heard that they worked closely with the specialist dementia, nutrition and tissue viability teams to improve the quality of care for patients.

A trust-wide Harm Prevention Group had been established with clinical specialist members to identify and target key clinical issues highlighted in investigations, complaints and local intelligence that affect safeguarding.

Staff had access to an adult safeguarding policy and the PART team were available to provide advice and guidance when required. Staff told us that this team were very supportive in giving advice and assisting them when concerns were raised or information was required.

Safeguarding information, including contact numbers and the trust lead were kept on the wards and staff were aware of how to access this.

Safeguarding training was mandatory for staff and different levels of training were provided according to the job role. The training records indicated that an average of 65% of staff had attended safeguarding training on the medical directorate. This was below the trust target of 85% but following this trajectory would ensure most people had completed training by year-end. One member of staff told us that they had completed safeguarding training via e-learning.

Staff were able to identify the potential signs of abuse and the process for raising concerns and making a referral. We were given examples of concerns they had identified and referrals made. Staff told us that they generally received feedback on the outcome of referrals. In the CDU we saw that where nursing staff had safeguarding concerns that there were detailed safeguarding information recorded and that the local social services department had been contacted.

Generally patients we spoke with told us they felt safe in the hospital. However, on Harvey Ward one patient told us that "You do feel a bit unsafe, and it was like being in the middle of an asylum" and another told us that they felt "mostly safe as it was a bit better than it was."

Mandatory training

Staff were aware of the mandatory training they were required to undertake.

The mandatory training programme covered awareness sessions in areas such as fire safety, manual handling, infection control, falls preventions, safeguarding children and young people.

Ward managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed, or refreshed.

All mandatory training for staff was provided through electronic learning. Some staff reported they had experienced difficulty accessing the training due to incompatibility of the IT system. The introduction of a new training application had helped to address this issue. Drop in e-learning clinics were also available for staff who wished to complete their training with face to face support.

On Harvey ward two computers had not been working since June 2015/1 It had been reported several times. This resulted in staff's mandatory training not being completed. Staff also told us that they hadn't been able to get the time back when they had completed their mandatory training in their own time.

Compliance with mandatory training over all for the medical division was 62.9 % for medical staff, 79.8% for nursing staff and 87% for allied health professionals worse than the trust target of 85%. There was no evidence to support that staff in medical services had received training in the safeguarding adults.

Assessing and responding to patient risk

We found that patients clinical observations such as pulse and temperature were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' We watched observations being taken and noted that the technique used would ensure an accurate result.

Patient observations were recorded electronically using a system known as Vital Pac. A scoring system known as a national early warning score (NEWS) system was used to identify patients whose condition was at risk of deteriorating. We saw that where NEWS scores indicated patients may be deteriorating nurses had mostly requested medical reviews. The electronic system allowed early warning scores to be automatically calculated.

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We saw a demonstration of this equipment and saw that staff members had unique logins to ensure professional accountability. Temporary staff were allocated logins. We observed staff using the electronic wireless system to record information directly into the patient's medical records. This meant that recording errors from illegible writing or incorrectly completed charts were virtually eliminated. Staff showed us how the system could be interrogated to show charts and graphs over time, which enabled clinicians to monitor a person's health. The system was accessible from any computer terminal in the trust. The system also had built in alerts if readings were outside expected parameters, enabling speedy response and re-assessment of care.

Staff informed us that there were only seven electronic monitoring units available on Harbledown ward which was not enough for all the staff which resulted in patients' observation being missed or inputted to the system late.

In the CDU staff advised us that the WIFI was working but they had to resort to paper records two months ago to record patients' observations.

On Harbledown we saw that a patient's observations which triggered a NEWS score of five overnight had not been up loaded onto the electronic system, had not been documented in medical or nursing notes and had not been reported to the doctor. We found that staff were unclear when to report NEWS scores.

We saw that patients were risk assessed in key safety areas using nationally validated tools. For example we saw that patients were assessed using the Waterlow score which identified the risk of falls and pressure damage. We noted that when risks were identified it was documented but relevant care plans which included control measures were not always generated. We checked a sample of six patient records on three wards and found no evidence to support that relevant care plans had been formulated. For example with falls, we found very few examples where care plans had been generated as a result of the risk assessment and the "SLIP" care bundle had not been fully implemented.

We saw that when risk assessments were reviewed and repeated they were not always within appropriate and recommended timescales.

On some wards risks were communicated to staff using symbols displayed on a whiteboard above each patient's bed, although this was not used uniformly on all medical wards. This enabled staff to quickly identify which patients had specialist needs.

Nursing staffing

Levels of nursing staffing was acknowledged as a major risk area. Common with many trusts, EKHUFT experienced difficulties in recruiting appropriately qualified and experienced nurses. The trust had been proactive in meeting this challenge and had recruited from overseas and employed large numbers of overseas trained staff.

Nursing establishments had been reviewed in 2014 using the nationally recognised "Safer Nursing Care Tool" which had led to investment in additional nursing posts. During our visit the ward areas were in the data collecting phase of a further review using this tool and were collecting information on acuity and staff numbers for future analysis. The divisional management team assured us that they would act on the data to ensure that nursing numbers could meet demand.

The numbers of staff vacancies across the medical services varied and some areas such as Harvey ward reported that they had no vacant posts. Other areas like Treble ward reported that they had five WTE band 5 nurse vacancies which increased their reliance on agency staff. On Invicta the matron's post was vacant and recruitment taking place. The staff reported no issues with staff shortages.

The numbers of staff planned and actually on duty were displayed at some ward entrances in line with guidance contained in the Department of Health document "Hard Choices".

The National Institute of Health and Care Excellence (NICE) has recommended minimum registered nurse patient ratio in its guidance "Safe staffing for nursing in adult inpatient wards in acute hospitals." Whilst the medical wards generally met the ratio of one registered nurse to eight patients during the day, we found staff vacancy rates made this difficult to achieve on some wards.

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Kingston ward was staffed for 22 patients, but used as overflow/winter pressure ward for 27 beds. The sister reported they were allocated extra staff, but with had been unable to increase staff numbers due to recruitment process and existing vacancies.

Kingston ward also experienced difficulty getting agency nursing to cover but staff reported that this had not impacted on patient care. Auditing the quality data since having more beds open had not revealed any increase in complaints and the safety thermometer data was stable despite no increases in staff numbers. However, staff sickness levels on the ward were higher 8.46% compared to the trust average of trust 3.5%. This meant they were operating at lower than optimum staffing levels.

The trust provided data regarding the levels of agency nursing staff used by each speciality and ward. We were able to see from this that there were areas with a heavy reliance on agency nursing staffing. For example, for the period January 2015 to April, 2015 cancer and oncology services reported an average of 20% reliance on agency staffing with endoscopy services at 12%. In March 2015 this was 23.4%

Staffing turnover for nursing staff appears to have increased year on year especially on the elderly care ward with current rates recorded at 18.6% and for general medical nursing at 17.5%.

When agency staff were used we found there were no robust arrangements for ward based staff to be assured of the competency of staff working for agencies. The trust had quality standards as part of its contracting framework with NHS Professionals which would ensure competency but there were no systems for this to be checked at the commencement of an assignment. Staff expressed concerns over the variability in skills and competencies of agency nurses.

During our inspection patients told us that staff worked extremely hard to ensure their comfort and reported excellent care and they felt looked after but there were not always enough nurses on duty particularly at night. One person told us that "the staff are nice and look after you" another person told us "some of the staff are better than others but generally they are good".

Adequate arrangements for nursing staff handover were in place and staff told us that all staff had the opportunity to ask questions and clarify plans and that relevant information regarding the care and management of patients on the ward was clearly communicated.

Medical staffing

Consultants represented 32% medical workforce in line with England average of 33%. Middle career doctors represented 6% in line with an England average of 6%; Registrars 43% which is more than the England average of 39% and Junior doctors 19% against an England average of 22%. This means there were fewer consultants and junior grade doctors than the England average whilst the proportion of middle career doctors and registrars exceeds that of England.

Medical staff WTE establishment figures for medical staff as at April 2015 demonstrated that there was a shortfall of approximately 8.5% doctors in post. This equated to 21 at consultant or equivalent level and 56 at other medical grades. For example, in endoscopy there were currently four WTE consultant/ doctor posts vacant across the trust.

Medical staff advised us that at night there were only three doctors covering the hospital, CDU and ECC. This included all admissions and ward patients. The junior doctors mainly examined new patients and the registrar supervised the whole hospital and managed emergency situations.

We heard at the doctor's focus group that there were concerns about medical staffing at night with one registrar and two junior doctors covering all of medicine and the ECC. We were told if there was a medical emergency (for example, a cardiac arrest) on one of the wards then all three doctors could be called to this and leave the ECC without any medical cover. These concerns had been raised with consultants but there was uncertainty if it had been officially reported on the incident reporting system.

There was a consultant presence in the ECC during the day and an on call physician with appropriate skills available on call at other times.

Doctors reported that there were gaps in the medical rota due to medical staff shortages resulted in them often having to stay over time, or not being able to spend time

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with patients or talk to carers. It also affected their training as they often missed teaching sessions. We also heard many examples from junior doctors who were unable to secure annual leave due to pressures caused by low staffing levels.

Doctors reported that a large number of locums were used by the stroke team and in the ECC, and that there were requests daily for urgent cover for the ECC. One doctor reported that a patient had waited for three days for a chest drain as there was nobody competent to carry out the procedure. As a result the patient deteriorated.

One doctor told us that they felt care was compromised as they were so busy and described one shift where they had examined 12 patients and had four resuscitation calls. This resulted in a patient waiting three hours to be told blood results.

We were told that there were no middle grade cardiologist and that there was a general lack of cardiology support available during out of hours across the trust. There was an out of hours cardiology service but only for advice.

The endoscopy department operated a consultant led out of hours on call service across the three hospital sites.

Major incident awareness and training

The trust had recently reviewed and revised the Major Incident and Business Continuity Plan. The policy and associated plan was available on the intranet and in hard copy throughout the hospital. We saw signs displayed in prominent positions in wards and specialist medical areas directing staff to the location of this plan in their area of work. Some staff knew what actions were expected of them, while others felt that they could refer all issues to a senior person. We heard how staff had been introduced to this plan at ward meetings with a supporting video presentation.

We were advised that only the ward manager in the CDU had major incidents training and that none of the doctors in the ECC had attended the training.

Live exercises to test the plan were scheduled later in the year to coincide with when the majority of staff training has been completed.

Requires improvement



We rated the effectiveness of medical care services as requiring improvement.

Staff were well supported with access to training, clinical supervision and development. Junior doctors told us they felt well supported by the senior medical staff and had access to regular training, although pressures of work and lack of staffing often meant they were unable to attend or participate.

Evidence based guidance was used across a range of conditions. There was a programme of national and local audits regarding clinical practice in place. The KCH was performing in line with other trusts in achieving good outcomes for patients with strokes.

We found the majority of policy documents were evidence based and readily accessible on the intranet and in hard copy. However, not all policies were in date and there was no control to provide assurance that those in use were current and this presented the risk that staff may have used out of date policies to guide them in the care and treatment of patients.

The pain management policy was in a draft and was being developed in conjunction with the trust's medication policy. Patients did not consistently receive timely pain relief and we saw records that showed patients had not had their pain assessed. There were no specialist tools in place for assessing pain in patients living with dementia or with a learning disability.

We saw that patients' nutritional needs were assessed with scores recorded and risks identified. However, the use of plans to manage these risks was not always evident in patient records. This meant that patients were at risk that their nutritional needs may not be met.

There was access to designated mental health nurses but this was often problematic especially out of hours. This meant that patients with a mental health problem experienced long delays to be seen by the mental health team under the care of staff with none or limited mental health experience.

Weekend medical cover was provided by a "Hot" and "Cold" team. The "Hot" team provided cover for new

Are medical care services effective?

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admissions and sick patients with the “Cold” system attending to ward patients and discharges. However there was no access to therapy staff, dieticians or speech and language therapists (SALT) at weekends, together with limited access to pharmacy services during the weekend, this greatly impeded patient discharge

Patients were asked for verbal consent to be treated and we heard doctors and nurses explaining the care and treatment they were receiving. We spoke with staff about the Mental Capacity Act 2005 and deprivation of liberty Standards (DoLS). Staff understood the basic principles of the Act and could explain how the principles worked in practice. However, there was no evidence to support that staff had received training in the Mental Capacity Act 2005 or DoLS.

Evidence-based care and treatment

The medical division used a combination of National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines to guide the treatment they provided. The division had a system for evaluating new guidance from NICE and learned societies and for disseminating this to clinicians.

There was a divisional audit programme for 2015/2016 which saw. Eleven audits were carried over from the 14/14 programme and there was a total of 62 audits, 22 of which were national audits. This showed that the trust were engaged in the audit of effectiveness of care.

We observed effective pathways of care across the medical division in the clinical decisions unit (CDU), the coronary care unit (CCU) and the cardiac catheter laboratory.

Best practice guidelines were implemented in the stroke unit.

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

Clinical policies and guidance was available on the organisation's intranet system. Staff could locate policies when requested. We reviewed policy guidance and policies and judged they were compliant with current guidance and best practice. We noted all local guidance that we reviewed carried a review date that was in the future. However, we found examples of operational and

clinical policies which had been printed out on wards and were out of date. For example, on the Cathedral Day Unit we found that the policies that were printed off were not the latest edition and dated due for review in 2013. The policies available on the intranet were updated but there was no warning to staff that printed copies might not be the most current or evidence of a watermark stating “Not controlled if printed”. This meant that although policy documents were readily available and evidence-based, there was not control to provide assurance that those in use were current and presented the risk that staff may have used out of date policies to guide them in the care and treatment of patients.

During the period June 2013 to May 2014 standardised relative risk to re-admission for medical care services at KCH was broadly in line with national expectations. However, in general medicine where the majority of activity occurred, the relative risk worse than the national expectation at 111.

We saw that key clinical guidelines, for example the anti-microbial prescribing guidelines, were available to junior doctors. This meant that that current guidance was available for staff to reference.

The in-patient heart failure service was established two years ago. This recognised the trust was not achieving a good standard of care for heart failure patients according to audit data from the Enhanced Quality Programme. There is one heart failure nurse based on each site, providing outreach services to all wards caring for patients with heart failure. Patients were referred to them via the patient centre or by mobile phone contact. The nurses also visited the CDU and medical wards daily to pick up referrals to ensure that no patients are missed. A programme of information had been developed by this team to ensure that patients understood the importance of self-monitoring, how to identify when the heart failure symptoms were worsening, coping strategies, and medication and long term issues they may encounter.

The cardiology team had developed an acute heart failure pathway that incorporated NICE guidance on Acute Heart Failure (such as the introduction of B-type natriuretic peptide testing) and were working closely with various departments to ensure the safe implementation of the pathway.

Medical care (including older people's care)

In the CDU we saw that local audits of skin care bundle (a tool to monitor consistent care for the prevention of skin ulcers) were undertaken with ten being reviewed on a weekly basis.

Pain relief

The trust's pain management policy was in a draft and was being developed in conjunction with the trust's medication policy.

Patients told us that they had received appropriate pain relief. We observed staff assessing patients' pain levels and taking appropriate actions to ensure that pain relief was administered in a timely way. However, in the ECC we observed that a patient presenting with severe pain had to wait 45 minutes before they received pain relief following being triaged. Pain scores were not recorded and the patient was not seen again for a further 30 minutes following the doctor's review. We looked at several patient records and saw that no pain score was recorded.

We saw that assessments of patients' pain were included in all routine sets of observations. We noted that as part of "intentional rounding" processes (where staff attend patients at set intervals to check a range of patient-centred issues) staff ensured that patients were comfortable and recorded this in patient records. However, we found that non-pharmacological approaches to pain relief were not routinely explored.

Staff knew how to access the specialist acute pain team when their advice was indicated. The palliative care team also provided support and advice in the pain control of those who were terminally ill.

The trust reported that using internal patient feedback mechanisms for the period April 2014 to March 2015 they had achieved 85% and above on inpatient satisfaction on pain management.

We found that there were no formalised specialised tools in place to assess pain in those with a cognitive impairment such as a learning disability or dementia, in use. Staff told us that they used a range of communication methods to assess patient levels of pain but acknowledged that the management of pain in people living with dementia had not been formalised or embedded into practice.

Nutrition and hydration

The trust scored worse than the England average for Patient Led Assessments of the Care Environment (PLACE) in the sections on food.

We observed that patients were served a choice of foods and that therapeutic diets were managed well.

In the CDU we saw that patients were offered a menu and that the food was cooked on the unit. Snack boxes were available for patients to have if they wanted something to eat outside of meal times. A variety of hot and cold drinks were available five times a day. The CDU was not meeting the required standard of having drinks available seven times a day and water at the bed side. "A Quick Guide to the Government's Healthy Eating Recommendations" 2014 states people should Drink between six to eight glasses (about 1.2 litres) of water, or other fluids, every day, to avoid dehydration.

Patients were assessed by a dietitian when screening suggested a risk of malnutrition, or if there were medical problems that compromised patients' nutrition. Dietary supplements were given to people when prescribed. On the stroke unit we saw that there were arrangements to ensure that patients who had had a stroke were assessed promptly to ensure they had a competent swallow and were not denied food or fluid unnecessarily. We saw that fluid thickeners were used as planned, and patients' received a "mashable" diet when recommended by the dietitian. We were advised that nurses would perform swallow assessments and patients would have dietary emergency regimes while awaiting SALT assessment. This showed there were systems to ensure people with compromised swallowing received appropriate food and nutrition.

Patients and relatives we spoke with were generally satisfied with the quality and range and choice of food that was offered. Food that met people's special cultural and religious needs was available such as hal-al food. However one patient commented that that had been offered the same four choices for the last four days, and that they only had the choice of two types of sandwich.

We saw that meal services times were generally calm and well managed, although not all wards offered patients the chance to wash their hands before eating. We saw that when required patients were supported to eat and drink.

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We observed that generally patients were offered sufficient quantities of fluids and had drinks left within reach and were given assistance to drink.

On the stroke unit we saw adaptive utensils and equipment such as plate guards, beakers, and special cutlery were available. This showed there was equipment to support patients' independence with food and drink.

On Harbledown the dining room was also used for activities. The ward had recently changed their visiting times so that relatives and carers were able to visit patients at meal times to assist patients with their food. Staff told us that there had been a 50% increase in relatives and carers coming in to assist their loved ones.

On Harbledown we saw patients' nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition. We saw that scores were recorded, and risks identified. However, the use of generated care plans to manage these risks were not always evident in patient records.

We saw that there were adequate arrangements to ensure food safety. For example we found that food service personnel wore suitable PPE, food fridge temperatures were checked and the temperature of food was checked before service to ensure it had reached safe temperatures.

The Harbledown ward had a food hygiene rating of five. This means that the ward had been inspected by the food standards agency and was found to have very good food hygiene practises in place.

We spoke with catering staff on the wards who told us that they were given daily lists of patients' dietary needs and any restrictions. We saw staff using these during food service. This meant that staff responsible for serving patients food were well informed about their needs.

Patient outcomes

Overall in medicine for non-elective admissions at KCH the average length of stay was 3.3 days which was better than the England average of 6.8. In general and geriatric medicine which represents the majority of the activity the average length of stay was less than the England average. For example, in general medicine it was 2.1 days compared to the national average of 6.4 days.

During the period January 2015 – May 2015 the trust reported their compliance levels against the 62 day cancer waiting time standards for tumour sites with urgent and long term conditions. Their performance levels ranged between 70.31% - 80.53% worse than the target of 85%.

During 2014/15 38 national clinical audits and three national confidential enquiries covered relevant health services that East Kent Hospitals University NHS Foundation Trust provided. During that period East Kent Hospitals University NHS Foundation Trust participated in 92% national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The trust participated in the Sentinel Stroke National Audit Programme which is an ongoing national audit that investigates and analyses the quality of care in stroke services. Hospitals are awarded a score A to E where A is the best. At KCH the stroke services achieved an E rating in April to June 2014 and improved the rating for the period July to September 2014 to a C. With 70% of trusts achieving a D rating this indicated that the hospital was achieving good outcomes for patients with strokes in line with the national average.

The hospital participated in the 2012/2013 National Heart Failure Audit and achieved markedly below the England average in clinical in patient care but slightly better in the clinical discharge category. Scores were better than the England average for one out of the seven standards audited.

The Joint Advisory Group on GI Endoscopy (JAG) ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced. Using The Endoscopy Global Ratings Scale (GRS) The KCH participates in the quality improvement system for endoscopy services to achieve and maintain accreditation. Bi- annual self-assessments and governance reports are submitted which provides the organisation with assurance that the endoscopy service is doing the right things and doing them well; thereby significantly reducing the risk of error in the delivery of services. JAG in accreditation updated in July 2015 shows that the units performance is has been assessed as

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requires improvement level 1. This means that the unit has been assessed and does not meet all of the JAG criteria. JAG accreditation is deferred to allow the unit to make improvements.

We heard at the medical focus group that there had been improvements in patient care and safety recently with the introduction of speciality wards. For example, respiratory patients were now accommodated on one ward and this was better and safer as patients were being cared for by nurses with right skills.

Competent staff

We were told that all new staff attended a corporate induction programme, supplemented by a local induction. Staff we spoke with confirmed they had received adequate induction.

Staff had the appropriate skills and training, and their competency was regularly monitored through clinical supervision and the staff appraisal process.

Throughout our inspection we observed that staff were professional and competent in their interactions with colleagues, patients and their relatives/carers.

Staff told us they participated in the appraisal process. We found documentation in ward areas and medical speciality units, together with reports on the central records system that identified current appraisal rates. The trust reported that 82% of nursing staff within the medical directorate had received an appraisal which was less than the trusts target of 85%.

Staff attended a wide range of training which was recorded on the central electronic training record.

We found there was a system for supporting new staff, especially those that were newly qualified when they commenced work. There was a comprehensive competency based programme which they worked through with the support of a preceptor. We saw examples of these and spoke with staff who was undertaking the programme. We noted that there were a wide range of clinical and organisational skills included in this programme requiring formal sign off. For example, in the CDU and ECC we saw that 46% of nursing staff had been trained in advanced paediatric life support (APLS)

and 63% of nursing staff had been trained in advanced life support (ALS). This indicated that staff, their managers and patients could be confident staff had the skills to carry out their jobs.

However, staff informed us there had been no specialist training in neurology which meant that the staff may not have the appropriate skills or knowledge.

On Treble ward we observed two nurses discussing the administration of chemotherapy to a patient. One of the nurses had administered chemotherapy previously but neither of the nurses had completed any competency based training. Currently there is no national guidance with regards to the education and competency training of registered nurses for the administration of chemotherapy for the treatment of "non-malignant diseases". The "Manual of Cancer Standards" published by the NHS states that "non-malignant disease" is outside the scope of the national cancer peer review measures and allows local discretion with regards to education/competency of staff. However, even though there is no national guidance it would be recommended as best practice that the lead chemotherapy nurse in the trust would develop an education and competency package for nurse's who are administering chemotherapy to patients with non-malignant disease. This would ensure the health and safety of both staff and patients.

On Kingston ward, we saw they had developed good initiatives to embed safety, effectiveness and person centred care on ward. The ward staff had three teams that took responsibility for these areas with each team meeting monthly for teaching or external presentations to ensure that they kept up to date.

We saw there was a wide range of specialist nurses, for example the dementia care team, palliative care team, safeguarding leads, diabetes care team and discharge co-ordinators who supported staff in ensuring they were delivering competent care. We noted their presence on the wards and staff told us they valued the input of these teams who were proactive at team meetings and on the wards. The diabetic nurse had developed a three day training programme 'Think Glucose' based on a NHS initiative for training and educating staff across the hospital.

In the doctors' focus groups, we were told that the opportunities for training had improved but they were

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often unable to attend due to low staffing levels. The junior doctors felt that due to workloads on the wards there was a lack of ward based on going teaching. They felt that ward based nurses needed to be more understanding of doctors training needs; they gave an example of nurses 'not letting' a registrar examine patients with juniors to use as a training opportunity, even though the patients had consented to this. They also told us that there was no opportunity for cross-site working which meant that they were not able to gain experience of working in different hospitals.

There was a robust system to ensure that nursing staff maintained current registration with the Nursing and Midwifery Council.

Nurses told us that there were opportunities for learning and development, particularly around enhanced clinical skills training in dementia and cardiac care.

Consultants we spoke with confirmed that they participated with appraisals and there were systems in operation regarding revalidation of GMC registration.

Multidisciplinary working

We found there was a strong commitment to multi-disciplinary working in medical care services. Each ward area had a multi-disciplinary team meeting on at least a weekly basis to plan the needs of patients with complex needs. We saw documentary evidence of a multi-disciplinary approach to discharge planning.

Ward and specialist medical teams had access to the full range of allied health professionals such as speech and language therapists, dietitians, tissue viability, falls co-ordinators, dementia and diabetic consultant nurses and described good, collaborative working practices. Where allied health professionals and specialist medical teams had been involved with patients they had recorded this in patient records.

Medical and nursing staff of all grades that we spoke with all described excellent working relationships between healthcare professionals. We observed that the healthcare team worked well together to provide care to patients.

Medical care services had integrated patient records shared by doctors, nurses and other healthcare professionals we saw that on the stroke unit had

integrated patient records shared with doctors, nurses and therapists. This meant that that all members of the team were aware of the input of others, and that care was well co-ordinated for patients and their relatives.

Consultants we spoke with told us they found the input of other clinical teams and specialist nurses to be very good.

Staff on the CDU told us that they could access the advice of mental health professionals and their response to referral was prompt during normal working hours. However, there were consistently pressures on the department to manage patients overnight without any mental health support. The ward manager explained that mental health services were provided by Kent and Medway NHS and Social care partnership under a service level agreement. Designated mental health nurses were providing 24 hour cover but this ceased three months ago and staff based in the hospital until 10.00 p.m. consistently are unavailable after 5.00 p.m. Staff advised us that the patient was waiting for a bed to become available in a psychiatric unit. The patient had settled and was in a side room.

Seven-day services

New medical admissions were seen every day on one of the twice daily post-admission ward rounds.

Consultants from acute and general medicine, cardiology, respiratory medicine and gastroenterology performed a daily ward round including weekends and bank holidays.

Staff reported that there was seven day availability of all diagnostic services including imaging, (excluding ultrasound) and laboratory facilities. They told us they did not encounter any problems with diagnostic services out of normal working hours.

Currently there was no access to therapy staff, dieticians or speech and language therapists (SALT) at weekends. On the stroke ward which we were advised resulted in delayed discharges. Patients presenting at the on weekend must wait until Monday for a physio therapy and occupational therapy review. The unit usually has four referrals per day but on a Monday this increased to ten or more.

Endoscopy services provided elective procedures on two Saturdays per month and one weekend in every four weeks.

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With the closure of the Celia Blakely day care unit at WHH the Cathedral Day Hospital the unit extended its working hours to 9pm Monday to Friday and opened all day on a Saturday to provide chemotherapy services.

With pharmacy services only available until midday at weekends, timely discharge was impeded at weekends for patients who were unable to obtain their discharge medication.

Access to information

Clinical staff who told us they had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for patients. We were told that patients' old notes were retrieved from the hospital archives when required without delay.

We saw there were systems to ensure the transfer of information when a patient moved between wards and these were supplemented by a verbal handover.

We saw that the patient flow team and site matrons routinely collected information throughout the day to inform the management of the hospital and the flow of patients. For example we saw that information about patients in the wrong specialty beds (outliers) was collected early each morning and was widely disseminated; we saw copies displayed in ward areas.

Consultants and junior doctors we spoke with told us they felt there was excellent communication between medical and nursing staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

We found little or no evidence from staff that they had received training in the Mental Capacity Act (MCA) or Deprivation of Liberties Safeguards (DoLS). Staff told us that they had not received this training as it was not part of mandatory training. A ward manager told us that it had become more difficult to arrange MCA and DoLS training and the earliest they had been able to book nursing staff on the training was December 2015.

Staff we spoke with was aware of the requirements of their responsibilities as sent out in the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS), although some more junior staff said they would seek assistance from managers.

We saw examples of where staff had appropriately identified that a person's liberty was being curtailed using the High Court definition of 2014. We saw that urgent DoLS authorisations were sought and approved by an appropriate member of trust staff and those standard authorisations were sought from the relevant supervising authority. We saw that consideration was given to using the least restrictive option. On Harvey ward the ward sister talked through paperwork and could show the correct measures and steps had been taken for two patients who were subject to DoLS.

We saw that there was a standard checklist in place with information regarding best interest meetings and supporting documentation for staff to use when concerns about any patient whose liberty needed addressing.

Staff told us that for patients who lacked mental capacity and presented with challenging violent behaviour that they ward could use 'Patient watch' which was provided by a security company whose role was to provide one to one observation. Staff told us this was of great assistance to them on the wards.

In the endoscopy department we spoke they told us that doctors and nurses were extremely careful in explaining the procedures before patient signed the consent to treatment forms. We saw there were arrangements for nurse-led consent which ensured that patients gave informed consent prior to their procedure.

Patients told us that staff gained their consent before care or treatment was given. One patient told us that staff always asked them before taking their blood pressure.

Are medical care services caring?

Good



We judged that the caring aspects of medical care services were good.

This was because patients and their relatives were positive about their experience of care and the kindness afforded them. We observed staff being friendly towards patients and treating them and visitors with

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understanding and patience. Treatment was provided in a respectful and dignified manner. We also saw, and patients told us, that privacy and dignity was maintained at all times.

Patients told us they were usually involved in decisions about their care and treatment and were given the right amount of information to support their decision making. Emotional support was provided by staff in their interactions with patients. Most patients were positive about their experience.

Compassionate care

The trust used the Friends and Family test (FFT) to get patients views on whether they would recommend the service to family and friends. We looked at the latest FFT scores that were available to us and during the period December 2013 to November 2014 the average response rate for individual wards ranged from 14% to 54%. Overall, these showed satisfaction with the service with the medical wards scoring 90 or more and the CDU score 89. A score above 50 is considered to be positive.

In the cancer patient experience survey results for inpatient stay for the period 2013/2014 the trust scored in the bottom 20% of trusts in relation to being given enough privacy when examined or treated, patients not feeling that they were treated as a set of symptoms and staff doing everything to control side effects of chemotherapy.

In many areas we saw that confidential patient information was displayed in the public area on large whiteboard information boards. We asked ward managers if this raised concerns regarding patient confidentiality and were informed that it was necessary for the running of the ward and was essential as they did not have the benefit of an electronic board, capable of displaying initials.

The patients who contacted us prior to the inspection, and through our various listening events, told us that the care was usually good and the staff were excellent. We heard some patient's stories where care was less than ideal, but when reported, the issues were always dealt with promptly and appropriately.

We observed that interactions between nursing staff and patients were professional, kind and friendly. For example we heard staff carefully explaining to a patient about their medication.

Patients told us the nursing staff were respectful to them and every effort was taken to ensure their privacy was protected when personal care was being given. For example we observed that curtains were drawn and when patients were receiving personal care. However, on Invicta ward we observed that patient with dementia was sitting out of bed and his blanket kept slipping, compromising their dignity. When this was brought to the attention of staff the matter was dealt with immediately.

We looked at the results of the patient led assessments of the care environment (PLACE). The trust scored 82% for privacy, dignity and wellbeing worse than a national average of 87%.

Mixed sex breaches are reported in the monthly Clinical Quality & Patient Safety Report, including those that occurred as being within the agreed scenarios. At KCH there had been four mixed sex breaches on the Kingston ward reported in April 2015 affecting 16 patients. The endoscopy department at KCH did not provide single sex recovery wards. Staff advised that they try to run single sex lists and use screens to section off areas of the recovery ward. In the CDU we observed staff tried to achieve single sex areas by segregating patients using curtains and allocating separate toilet facilities. However we saw there was a six bedded bay with access to one toilet. Staff told us that the bay was used by both male and female patients; however this was not reported as a breach which meant that reported to NHS England's monthly monitoring of Mixed-Sex Accommodation (MSA).

Understanding and involvement of patients and those close to

Patients we spoke with confirmed that they understood their treatment and care plans. They described conversations with the doctors and consultants and had been told how their illness or injury might improve or progress. Where alternative treatment options had been available, people told us that they had been given all the details of the various options and how these might affect their condition and overall health and had been able to decide which treatment to undertake.

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Patients told us that generally they were kept informed of their care plans, and were involved in developing these. Where appropriate, they told us they were given choices about the care and treatment options available.

On some of the wards relatives and carers were encouraged to visit during meal times so that they could assist their loved ones at meal times.

Access to translation services was available for patients and staff were knowledgeable about how to access this support.

In the cancer patient experience survey results for inpatient stay for the period 2013/2014 showed that the trust was in the top 20% of trusts with regard to patients being given clear written information post discharge. It was also in the top 20% for patients given enough care from health or social services, patients being given correct information and patients told who to contact post discharge

Emotional support

Patients and their relatives and supporters told us that generally the clinical staff were approachable and that they could talk to staff about their fears and anxieties.

We found that patients could access a range of specialist nurses, for example in palliative care, stroke and diabetes care. These staff offered appropriate support to patients, their families and carers in relation to their psychological needs.

In the endoscopy unit there was a discharge room which enabled staff to speak with patients and their families confidentially. However, there were not always dedicated private areas in other medical ward areas where patients and their families could go to discuss issues with medical staff or amongst themselves issues relating to care and emotional support. For example on CDU we were told by staff that very often they were required to deliver personal and difficult news in corridors.

There was a hospital chaplaincy service supported with an information booklet which was seen displayed throughout medical services. A chapel and prayer room facility was available together with rooms set aside for use by those belonging to other religions than Christian. Staff were aware of how to contact spiritual advisors to meet the spiritual needs of patients and their families.

Are medical care services responsive?

Requires improvement



We judged that the responsiveness of some medical care services as required improvement.

In the ECC patients were frequently moved to the CDU to avoid breaching the four hour national target to see, treat and discharge patients. There were no clear guidance for the South East Coast Ambulance Service on how to assess possible surgical patients.

There was insufficient bed capacity to meet the needs of patients. This resulted in almost 25% of patients being moved at least once during their hospital stay. There were large numbers of patients in non-speciality beds and occasions when doctors were difficult to contact and consultant reviews less likely to occur.

Discharge planning was not always effective. Although there were established medical pathways of care through the hospital, the discharge plans were not always realistic resulting in patients not being discharged in a timely manner especially at weekends.

Patients had their needs assessed but there was not always a supporting plan of care devised to meet their identified needs. The use of the "This is Me" document designed to obtain information to assist staff in providing care designed to meet each individual's needs was not routinely being completed, although there had been some progress to improve the care of people living with dementia, these were not yet fully embedded into practice. We also found that support for people with mental health needs was variable.

Endoscopy services were not meeting national targets and this meant that patients were not able to access services for diagnosis and treatment when they needed to. Consultants had established a triage to streamline referrals and an additional locum consultant had been engaged but the situation was slow to improve.

Complaints and concerns were managed appropriately, with learning points identified and fed back to staff.

Service planning and delivery to meet the needs of local people

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Patients were admitted to medical wards via the ECC or via their GP. The ECC provides for emergency care for medical patients but is not an A&E. However, any patients can self-present there and the medical registrar is responsible for stabilising these patients and arranging for transfer to CDU or other hospitals. Staff told us that 50% of patients were admitted to KCH via the CDU, with 50 % of patients being discharged following treatment.

The ECC was staffed by medical doctors and there was no surgical cover provided. Doctors advised us that too many acute surgical patients were being presented at the ECC by ambulance crews. We saw there was no clear guidance for the South East Coast Ambulance Service on how to assess possible surgical patients. Local guidelines for ambulance crews stated that patients with abdominal pain could be taken to ECC, but surgical patients should not. This resulted in patients being referred to WHH or QEQM. Doctors reported that they found it a significant struggle to get surgical referrals accepted. They felt the current system was unsafe and unreliable, having to make long phone calls to WHH or QEQM to accept referrals. This put the safety of the patient and other patients in ECC at risk.

In the ECC we saw that patients were transferred from the ECC to the CDU to avoid four hour breaches in the ECC, as the ECC was not an A & E unit it was difficult to understand why the four hour target applied. Medical staff told us that patients were frequently moved to the CDU without a senior review. We saw there was no clear guidance for the South East Coast Ambulance Service on how to assess possible surgical patients. Local guidelines for ambulance crews stated that patients with abdominal pain could be brought to ECC, but surgical patients should not. This resulted in patients being referred to WHH or QEQM. Doctors reported that there were three occasions recently when patients brought in by ambulance with non – specific abdominal pain subsequently found to be requiring surgical referrals.

Demand for medical beds frequently outstripped supply especially in the winter period. In these circumstances patients could be placed in additional beds outside of the speciality. There were arrangements to ensure that outlying patients were reviewed by speciality teams and nursing staff reported they worked well.

We saw examples of usual visiting hours being varied to accommodate the needs patients and visitors with

extra-ordinary circumstances or who were very sick. We saw examples of relatives being supported to stay with a very sick patient during our visit. Visitors had been encouraged to visit elderly and frail patients during meal times to assist.

Access and flow

There was a single point of access for patients arriving at the ECC with patients being referred by their general practitioner's (GP), patients being brought in by ambulance and patients self-presenting.

The KCH had bed management meeting two times per day to look at the flow of patients across the hospital. We observed one bed meeting in the afternoon on the day we inspected. Nursing staff reported on the number of empty beds on their wards, patients who were due to be discharged and the number of patients that could potentially be discharged. We found that there was no discussion about what needed to be in place to discharge the patients that could be potentially discharged. Staff told us that up until recently the hospital had been running at full capacity due to winter pressures and that it was only recently that they had seen a reduction in the number of patients in the hospital.

The trust held video conferences twice daily to ascertain the bed capacity across the three main sites, William Harvey Hospital, Queen Elizabeth Queen Mother Hospital and Kent and Canterbury Hospitals where the bed capacity of each site was discussed.

During the period April 2014 to April 2015, 24% of patients experienced one ward move, 6% were moved twice, 2% three times and 1% were moved four or more times. This showed that more than half of patients were treated in the correct speciality bed for the entirety of their stay. Staff on Harbledown ward told us that they endeavour not to move patients around hospital; however there was no formal monitoring of patient moves but the bed manager kept a record.

We found that due to issues with patient flow, medical patients were transferred or admitted to beds designated for other specialities. During the period May to July 2015 statistical information provided by the trust showed these to be between 55 and 148 per month. This showed that medical care services were unable to care for patients within their allocated bed base.

Medical care (including older people's care)

From the data we reviewed for the period June 2013 – June 2014 the average length of stay for patients in medical services was better than the England average showing nephrology at 6.5 days (England average 7.6), general medicine 2.1 (England Average 6.4) and geriatric medicine 4.7 days (England average 9.8).

We noted that the hospital's referral to treatment (RTT) performance across the trust had been getting worse since September 2014 for patients starting consultant led treatment within 18 weeks of referral was below the England average of 87%. However across the medical care services speciality medicine, general medicine and geriatric medicine 90% or more patients were admitted for treatment within one month.

We reviewed showed data that demonstrated there was currently a 30 day waiting time for patients on the cancer pathway. We were told by senior staff in endoscopy that following a national awareness campaign there had been a significant increase in referrals, with inappropriate referrals and the availability of consultants this had contributed to the delays. Consultants had established a triage to streamline referrals and an additional locum consultant had been engaged but the situation was slow to improve. Current routine referrals to the unit waited on average six weeks. We saw that this information was monitored at board level.

To respond to delays in getting inpatients to the endoscopy department the nursing staff or health care assistants use a 'tugger' (a piece of equipment which is attached to a bed to enable it to be moved by one person) to transfer patients from the wards. Staff advised us that this has reduced waiting times for patients in the hospital to have their procedure.

The KCH did not have a discharge lounge so patients were discharged from the wards. We spoke with five patients expected to be discharged later that day but were not clear when this would happen. One patient on Harbledown had been due for discharge the day before they told us "I don't like hanging about like this". The patient had been told that they were being discharged on the day of our visit but had not been given any time or details. We found that there was no record of the patients discharge arrangements in their records. A nurse advised that other wards had a discharge checklist in place.

On Harvey ward, staff told us that the average length of stay was 63 days and they frequently had difficulty discharging patients to community based services which were coordinated through the local social services community care teams.

Meeting people's individual needs

We saw that patients had their needs assessed. However, there was not always a supporting plan of care devised to meet their identified needs and thereby minimise any risks to which they were subject found that nursing assessments were rarely fully completed. We reviewed 14 sets of patient records across Harbledown, Invicta and Treble found that that nursing assessment, repositioning charts, food charts and personal care round records were not completed.

We saw that a system of "intentional rounding" had been implemented to ensure that patients' fundamental needs were met. We saw that records were kept of these care rounds and noted that generally they were carried out at the specified frequencies. However, we did note that sometimes during early mornings' and evenings' records showed that these rounds were carried out late or not at all.

The trust employed a team of specialist dementia nurses and learning difficulty link nurses. We were told that these members of staff were an invaluable resource, providing support, training and developing resource files for staff to reference. On Harbledown ward we found that the dementia lead for the hospital was based there and the ward also had two nurses who were designated dementia champions. The ward also had a reminiscence display in the day room and that activities such as knitting were provided at the Wednesday and Friday club. The ward also ran a dementia café on a Thursday. This demonstrated that the ward was providing a range of activities to meet people's needs.

We found that there were arrangements to ensure the requirement that all patients aged over 75 years were screened for dementia within 72 hours of admission for dementia. We saw that the trust were consistently meeting their target with an average of 90% screening rates

Medical care (including older people's care)

The "This is Me" document designed to obtain information to assist staff in providing care designed to meet the individual's needs of those living with dementia was not routinely being completed.

We did not see any pictorial aides for use with people with learning difficulties, nor did we see the use of a standardised communication tools (for example traffic light documents, or patient passports) that enabled community staff or family members to highlight any special needs the person with learning difficulties may have.

On McMaster/Mount we saw that additional staffing had been requested to provide one to one support for a confused patient overnight.

On Harbledown we observed two patients who did not have easy access to a call bell.

On Harvey we saw that there was a patio area with potted plants and flower beds which was used to help patients during the rehabilitation following a stroke. The ward also had a day room with a large snooker table and large sofas.

We saw that bathrooms and lavatories were suitable for those with limited mobility. There were adequate supplies of mobility aids and lifting equipment such as hoist to enable staff to care for patients.

Hospital mattresses were fit for purpose and provided protection from infection and pressure damage. Where the risk of pressure damage was particularly high, staff could access specialist dynamic mattresses to ensure patients' needs were met and they were protected.

Staff explained that they could access bariatric equipment when it was required, and gave examples of how they had ensured it was ready and in place before a patient was transferred to their care.

We saw that clinical ward areas displayed printed health-education literature produced by national bodies. Some of this information was general in nature whilst some was specific to the speciality of the ward. For example, literature about living a full life following a stroke and diabetes care with information about associated charities and support groups was displayed.

We noted that all publications were in English with no information on how to obtain copies in other languages. The exception to this was the guide on chaplaincy services.

Learning from complaints and concerns

We noted that information on how to raise a concern or complaint was displayed in clinical areas throughout medical care services.

During the period January – March 2015 there were 52 complaints received for the medical division. The top three themes for complaints received were for delays, concerns about clinical management and problems with communication.

Each speciality reviewed complaints in depth on a quarterly basis and we saw from The Clinical Governance Report for Gastroenterology for the quarter to March 2015 that nine complaints had been received in the speciality with four being upheld. Further analysis identified a trend of complaints around doctor's attitudes and communications, OPD arrangements and the timeliness of referrals being booked for diagnostic tests. This demonstrated that complaints were reported and discussed at trust, division and speciality levels.

We saw evidence to support that complaints were investigated, learning points identified and feedback given at ward meetings.

A trust wide complaints newsletter has been produced for disseminating the learning from complaints to staff in the Trust. The first issue was sent out in June 2015 and was also attached to the trust News. The newsletter contains the complaints and compliments data for the quarter for each division and includes case studies identifying service improvements within the trust as a result of complaints.

Real life anonymous complaints were used by ward teams to act as discussion and learning aids and were also presented on the trust website for learning.

Patients had access to the Patient Liaison and Advice service (PALs), to provide information about NHS services and support to deal with concerns or complaints

Are medical care services well-led?

Medical care (including older people's care)

Good



Overall, we judged that medical care services were well led.

Staff acknowledged the steps that had been taken within the organisation to improve structures, processes and systems of accountability. Staff were aware of the trust and local service vision and incorporated this as part of their daily work. Individual wards and units had developed their own strategies which staff understood. We noted that staff showed a positive attitude to their work and spoke well of the organisation and their colleagues. They expressed a slowly growing confidence in their leaders and told us they were now more visible and approachable, and supported them to do their jobs well.

We found there was an appropriate system of clinical governance in medical services that identified risks and underperformance in key safety areas, and the remedial actions required to monitor performance. The governance system used comprehensive system of metrics presented as dashboards to ensure that quality and risk issues and trends could be readily identified and learning was disseminated to staff. There were examples of collaborative working with the voluntary sector and where patient representatives had been involved in developing and monitoring services.

We observed a caring and positive ethos, and staff acknowledged developments to embed a more cohesive culture of openness between senior managers and staff. Staff reported that although the culture was slowly improving they still did not always feel actively empowered or engaged with improvement being reactive and focussed on short term issues.

We found that staff and patients were engaged with the development of medical care services, and saw examples of innovative practice.

Vision and strategy for this service

The trust has undergone a level of change which was described by the Interim Chief Executive as “embarking on an improvement journey”. Managers and staff could articulate the trust vision which is to be known as one of the top ten hospital trusts in England and the Kent

hospital of choice for patients and those close to them. They described how the organisation’s mission to provide safe, patient focussed and sustainable health services with and for the people of Kent was simple but something they felt committed to.

We saw examples of where wards and medical speciality services had developed their own vision. For example on Harvey ward we saw displayed the ward vision. A nurse told us how this had been a collaborative effort with all staff involved in developing the team vision. The ward staff had also developed a set of service principles that staff signed up to.

Staff we spoke to at KCH knew who the chief executive was, and most staff were aware of the Trust’s initiatives to involve staff in the wider organisation, for example, staff presentations for improvements for the hospital and the Chief Executive Forums.

Governance, risk management and quality measurement

We found medical care services had a robust governance structure. Governance activity was co-ordinated by a dedicated post-holder. Each speciality held clinical governance meetings attended by the lead and other consultants, matrons, ward managers and the governance lead.

We saw evidence in the form of minutes of meetings, which showed that regular team and management meetings took place. We saw how these meetings had been used to share information about complaints and incidents but also to share good practice and positive feedback.

Staff understood their role and function within the hospital and how their performance enabled the organisation to reach its goals.

We saw that ward managers were provided with regular reports on incidents that occurred in their areas, complaints, survey results and staffing data. This information was discussed with the matron for the area who monitored for themes and trends.

Staff reported that although staffing levels and skill mix were constantly reviewed the lack of sufficient numbers of staff in some areas impacted greatly on the quality of the service. Bed managers had meetings twice daily when they also look at staffing across the whole site.

Medical care (including older people's care)

We spoke with the ward sisters across all medical services who demonstrated a good awareness of governance arrangements. They detailed the actions taken to monitor patient safety and risk. This included incident reporting, keeping a risk register and undertaking audits.

The organisation had a robust system for maintaining an accurate and current risk register for the division. Any member of staff could raise an issue for inclusion with the governance lead. After assessment control measures were identified to manage the risk. All managers we spoke with knew risks contained on the divisional and corporate registers and their status demonstrating understanding of the process. We looked at the registers and noted all the risks we had identified or had been informed of were included. We also saw that targets had been set with regards to actions planned to reduce risk, and that progress against these was recorded demonstrating active management of identified risks.

The trust had developed a leadership development programme, using external training expertise to support all people managers. We spoke with a matron who was enthusiastic about participating in this and the inevitable roll out later in the year to front line managers.

Leadership of service

Managers within the service were knowledgeable about the improvements within the trust improvement plan and their area of responsibility to support the organisation in providing care to patients that meets and exceeds the standards expected. We were told that many staff reported that gradually they felt more empowered to be involved in the changes rather than “watch it happen”.

Ward managers told us that matrons and members of the executive nursing team could be seen on the ward regularly and were approachable and helpful. Most staff told us that they felt supported by their line-manager to do their jobs well despite challenges, especially of capacity and recruitment. Staff of all grades were aware of the need for improvement and the challenges faced by the service. They were aware of, and engaged with, actions to mitigate the effects of quality and safety of care.

Leadership at local service level was on the whole good. Staff told us that they were generally supported by their managers and department heads. Senior managers,

matrons and heads of departments met regularly. Issues which required escalating were taken forward to the board to be dealt with. Results were communicated back to teams.

The leadership academy was accessible for all staff that have completed the Clinical Leadership Programme, the Aspiring Consultant Programme, the Medical Clinical Leadership Programme or equivalent. This enables skilled clinical and systems leaders to work together as a critical community.

We saw evidence of nursing numbers and skills mix being reviewed regularly. Wards had leadership from matrons however some staff did not know how to escalate problems beyond their ward manager and said that they had not met anyone more senior than the matron. They were not familiar with the management structure or the role and responsibilities of their managers and leaders.

The trust have increased the format and frequency of the CEO forums for staff which are held monthly on different hospital sites to engage as many staff as possible. Staff we spoke with were knowledgeable about these forums although they said that shortages of staff often made it difficult for middle grade staff to attend.

Staff told us they understood recruitment was still a problem and the problem was slow to resolve. They gave examples of staff that had left because of stress and the inability to cope with the work pressures.

Culture with the service

We observed that staff were positive about working for the trust, and took pride in the contribution they made personally to the care and treatment of patients.

Staff we spoke with told us they felt there had been a shift within the organisation resulting in a culture of openness that had not previously been there. It was early days and several managers felt strongly that senior managers needed to keep the momentum going in order for this to be embedded into everyday practice. For example, we saw a message from the Chief Executive encouraging staff to engage with our inspection team and to give an honest account of their achievements and challenges. A member of nursing staff said there has been a positive improvement in staff across the hospital that “now smile and say hello when seen in corridor when previously they would have kept their head down”.

Medical care (including older people's care)

During our focus groups and on the wards staff spoke about the low moral on the wards due to the high work load and low staffing levels on some wards.

Initiatives have been introduced with the establishment of a confidential report line, the introduction of a "Respecting each other" campaign, supported with a video and a culture change programme that has spear headed the organisation's approach to change.

On Harbledown staff told us that executive team had been invited to attend one of the wards coffee morning and that the director of nursing had visited the ward and attended the dementia knitting club.

The workforce was ethnically diverse with numbers of overseas-trained staff, especially nurses in post. The trust had participated in recruitment from abroad at a time when it was difficult for the NHS to recruit sufficiently qualified people in this country. . We saw that staff were enabled to observe their cultural identity. We were not told of any instances of discrimination and noted that staff from non-white British backgrounds had been promoted to senior positions.

Patients acknowledged a positive and caring ethos and were generally happy with their experience of care. Where there were concerns patients felt able to raise concerns with staff.

We spoke with the clinical lead who described the culture of consultants as positive, collaborative and pro-active with increasing involvement in clinical leadership and in quality and governance initiatives.

Generally staff described an environment with an evolving transparent, diverse and supportive ethos although we did receive comments that there were still pockets of a bullying culture operating on some wards.

Public engagement

The trust had various means of engaging with patients and their families these included various surveys such as friends and family test, inpatient surveys including real time monitoring questionnaires. In addition staff told us that they regularly canvassed patients to ensure they were happy with the treatment and care they received, they explained that this wasn't routinely recorded unless an issue was raised which couldn't be addressed there and then.

Stroke services had introduced ward based patient groups run in conjunction with charitable organisations such as the Stroke Association and Headway. A comprehensive welcome pack containing a wide range of information to inform and support patients has been produced. This meant that patients and families were given access to resources to help them understand and adjust to stroke and traumatic brain injuries.

Information was available to patients with visual signposts displayed to the local Healthwatch organisation, including a link to Healthwatch on the trust website.

A "hello my name is ..." was widely known by staff and during our visit and we heard examples of staff practicing this when engaging with patients on the telephone and at the bedside.

Staff engagement

Cluster meetings held on Fridays for ward manager's facilitated opportunities for staff to exchange ideas and experiences. We saw from notes that other staff including endoscopy staff, dementia care link nurses and assistant ward managers were encouraged to participate in the meetings.

The trust conducted staff satisfaction surveys in line with national policy. The latest published survey results for show that 2924 staff responded. This is a response rate of 41%¹ which is worse than average for acute trusts in England, and compares with a response rate of 50% in this trust in the 2013 survey.

All the staff we spoke with assured us they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested that the trust had an 'open culture' in which staff could raise concerns without fear.

We saw evidence during our inspection of information displayed on staff notice boards promoting the monthly staff recognition programme "You made a difference" which aims to recognise staff that has been nominated by their peers for having "gone the extra mile".

Medical care (including older people's care)

Consultants told us that relationship with the senior management team was improving and they seem prepared to listen. One consultant said, "The place is now much more 'How can we help?' rather than 'There's no money'."

Innovation, improvement and sustainability

We saw that individual ward and departments held ward meetings, and/or issued newsletters to staff to keep them informed.

Monthly video-link trust wide meetings held with diabetes teams including consultants and nurses, supported with face to face meetings held every three months has been instrumental in galvanising the "Think Glucose" initiative.

We found through our discussions with all grades of staff that staff felt informed and involved with the day to day running of the service, and its strategic direction.







Therapists in the Stroke unit are at the forefront of innovations in stroke rehabilitation with members of the team being keynote speakers at international stroke summits.

We saw that the division had identified a range of cost improvement plans (CIP's). We saw that appropriate risk assessments had been carried out to understand their potential risks to quality and safety.

We saw examples of innovative practice, such as the development of the stroke education programme and the diabetic awareness campaign "Think Glucose" being rolled out by the enthusiastic diabetic team.

The trust received an award in January 2015 for the most improved acute trust with regards to the Enhanced Quality Programme for Heart Failure, Pneumonia and Enhanced Recovery.

Surgery

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

Information about the service

The majority, (66%) of surgical activity at the Kent and Canterbury Hospital was day case work. Elective surgery contributed to 15% and emergency 18%. The main surgical speciality was urology at 48%, followed by ophthalmology at 30%. 2000 cataract operations were performed last year.

There are 56 inpatient surgical beds and 12 day case beds at the location. There are six main operating theatres, plus one endo-vascular theatre, along with associated clinical areas. Day case surgery was provided in three operating theatres and a procedure room.

We visited the two surgical wards; Clark (urology) and Kent, (Kent vascular with general surgery), along with the Channel day care surgery, operating theatres and their associated clinical areas. We also visited the ophthalmic surgical unit.

We spoke with 10 patients and 29 staff. We reviewed 11 patient records and made observations in each of the areas we visited. Information provided to us prior to the inspection and during the visit was reviewed and we took into account information received from members of the public and staff focus group discussions.

Summary of findings

The environment in which surgical services were provided was not always suitably maintained. Storage of intravenous fluids was not sufficiently safe.

Referral-to-treatment times were not always met. Theatre utilisation was not always maximised.

Staff were not always afforded the opportunity to have their performance formally reviewed. A number of staff had not completed all the required mandatory training, which supported the delivery of safe patient treatment and care. There was a lack of understanding regarding Deprivation of Liberty Safeguards.

Patient risk assessments were not always undertaken and acted upon.

There were safe and effective arrangements in place for reporting adverse events and for learning from these. Staffing arrangements in surgical areas were managed to ensure sufficient numbers of skilled and knowledgeable staff were on duty during day and night hours.

Consent was sought from patients prior to treatment and care delivery. Consultants led on patient care and there was access to specialist staff for advice and guidance.

Procedures were in place to continuously monitor patient safety and surgical practices. Patient treatment

Surgery

and care was generally delivered in accordance with professional guidance. Surgical outcomes were in the main good and results were communicated through the governance arrangements to the trust board.

Patients commented positively with regard to the level of information provided and their involvement in decision making. Most patients were satisfied with the treatment and care provided by doctors, nurses and other staff.

Surgical staff spoke positively about their departmental leadership and felt respected and valued. Staff were aware of the trust's values and direction of improvement. Staff reported having opportunities to develop their skills and expertise, and were supported by suitably skilled leaders. Staff were encouraged to be innovative and share ideas.

The governance arrangements supported effective communication between staff and the trust board. Risks were identified and continuously reviewed. The trust board was informed and updated with regard to service delivery and performance. The views of the patients were sought in respect to improving and developing services.

Are surgery services safe?

Requires improvement



The environment in which patients received treatment and care was generally suitable; however the kitchen used by patients on the Channel day surgery unit was not suitably maintained.

Patient risk assessments were not always carried out and acted upon.

Staff had not received all the mandatory safety training required to support the delivery of safe care and treatment to patients.

Safety checks and monitoring of standards was taking place in surgical areas. Despite this we noted intravenous fluids were not always stored safely on Clark Ward.

There was a formal process for reporting incidents and near misses, which was embedded in staff practice. The sharing of information, including learning from incidents was communicated via a range of methods. Most staff understood their responsibilities under the Duty of Candour.

The surgical divisions reviewed mortality and morbidity outcomes in order to identify where improvements or changes needed to be made.

Performance was measured against required safety targets with regard to patient safety and risks. Staff monitored patient's well-being in line with an early warning alert system and this was acted upon where deterioration in the patient was identified.

There were effective arrangements in place to minimise risks of infection to patients and staff. There was sufficient equipment to support the delivery of treatment and care.

Although there were vacancies in some areas, arrangements were in place to ensure staffing numbers and skills mix were appropriate to support the delivery of patient care safely.

Incidents

- A formal process was in place for reporting, investigating and learning from incidents, errors or near miss situations. Staff described with confidence the system used, the investigating process and shared learning

Surgery

from these. We were given examples of incidents and resulting action, which included additional training in the use of a patient lifting device and a change in the treatment protocol for patients having renal surgery. In the latter case they were to be provided with a pressure relief mattress for a minimum of 72 hours.

- Staff explained how the formal reporting system facilitated the feedback of information arising from an incident. This included feedback from the tissue viability nurse or the ward manager, who would insert comments in the electronic record to indicate if the actions taken were appropriate or if they ought to have considered alternatives.
- We reviewed a number of reported incidents and saw that the process included a description of the incident, action taken, lessons learned and approval status based on a traffic light system of red, amber and green. We also reviewed a range of information, such as meeting minutes and newsletters, and found the contents reflected the sharing of information and learning with staff.
- The divisional dashboard for surgical services indicated that across the three hospital locations there had been 38 serious incidents as reported to Strategic Executive Information System (STEIS). Serious incidents were reported to the National Reporting and Learning Service (NRLS). They were also investigated through a process of root cause analysis (RCA), with outcomes and lessons learned shared with staff. We viewed the RCA investigation report for 2014, which confirmed the process.
- We reviewed incident reports for the period January 2014 to the end of April 2015. Although it wasn't always possible to identify the hospital site where the report was generated, the information reported included summarised details of the matter, date of incident, location, stage of patient care and type of incident. We saw that information on the remedial action taken was recorded. The status of the incident and any actions taken or lessons learned were also recorded.
- There had been one Never Event at the Kent and Canterbury Hospital (K&CH) location, which involved local infiltration of anaesthetic to the wrong site. Never Events, which are a 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers' (Serious Incident Framework, NHS England, March 2013). This was not initially recognised

as a never event until after it was reported to the Strategic Executive Information System (STEIS). We found that staff were aware of the matter and the actions taken subsequently to avoid similar occurrences.

- Mortality and Morbidity meetings were held regularly and a range of minutes we reviewed confirmed this. We saw that action points, which included learning from relevant points were identified.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have, occurred. There was variable staff awareness of the terminology, depending on staff grade; however, we were able to see evidence that the principles were being adhered to. This included writing to the relatives with regard to the never event.

Safety thermometer

- The Kent and Canterbury Hospital participated in the NHS Safety Thermometer scheme, used to collect local data on specific measures related to patient harm and 'harm free' care. This 'snap shot' data was collected on a single day each month to indicate performance in key safety areas with respect to hospital acquired pressure ulcers, patient falls and catheter related urinary infections. This data was collected electronically and a report produced for each area.
- Data presented in the draft governance report for the surgical services division July 2015 indicated there had been 85 patient falls of varying nature between January and June 2015. The number of patients admitted with pressure ulcers was 68 and those who acquired a pressure ulcer for the aforementioned period was 31, two of which were more serious grade three type.
- Information was reviewed for ward areas and this indicated, for example, that on Clark Ward there had not been any patient falls or pressure ulcers in the month up to the date of our visit and they had achieved 100% harm-free care the previous month. Kent Ward results showed one patient fall in the month and no hospital acquired pressure ulcers.

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- Within the theatre environment staff used equipment to minimise risks to patients developing pressure sores, such as warming devices and pressure relief aids. They had received a certificate for efforts to prevent pressure ulcers.
- Theatre staff had also introduced a protocol for insertion of urinary catheters with a view to minimising the risk of developing a catheter related urinary tract infection. Staff had attended training regarding this and patient information was updated on the electronic observation tool when a catheter was inserted.
- Yearly IPC environmental audits and weekly cleaning audits for Kent Ward indicated good standards were achieved.
- Staff had access to personal protective equipment including gloves and aprons in all areas visited and we noted that staff used these for nursing and other activities, such as at meal times.
- There was access to IPC policies and procedures via the trust intranet to guide staff. These were in date and current. We observed staff complying with local infection control policies, which included correct hand hygiene practices and the removal and disposal of clinical waste. Isolation signage was in use and staff were seen to follow the associated instructions to minimise risks.

Cleanliness, infection control and hygiene

- There were identified staff with a responsibility for infection prevention and control (IPC). They undertook hand hygiene audits and checked equipment, such as cleanliness of commodes. The lead IPC nurse would also attend the ward if required.
- Information provided indicated that Clark Ward had two audits in May 2015 and Kent Ward one audit also in May 2015. Non-compliance was identified in all areas and action plans had either been submitted or were due to be provided. Examples of action plans were seen and these had dates for resolution.
- There were dedicated staff for cleaning ward areas and theatres, although theatres were only cleaned at night by domestic staff. This had caused problems with ownership. Cleaning of theatres was audited by the contractor and a theatre manager weekly.
- We reviewed the formal report, which provided evidence of audit of the standards of cleanliness delivered by the contractor. Where the standard fell below 90%, a red rating was assigned to the area. We noted for example a number of red ratings assigned to theatres for weeks two and three of June 2015 and Clark Ward had not achieved the required standard throughout June 2015.
- There was information available to guide domestic staff in the required cleaning standards and processes to follow in clinical areas. Domestic staff had been supplied with nationally recognised colour coded cleaning equipment, which enabled them to clean areas according to local best practice guidelines. We found that the surgical wards, theatres and clinical areas were clean. Patients commented positively on the cleanliness of the ward environment. One patient told us, "On the two or three visits over the year I have seen the ward was clean." Another patient said, "The ward is spotless, everywhere you go it is."
- Patients reported to us that they had observed staff use hand sanitising gel. A patient also commented on seeing the staff use aprons and gloves, and that these were seen to be removed and changed between patients.
- Staff had access to hand washing and drying facilities and we observed staff use both hand washing facilities and sanitising gel during the course of their activities.
- Hand hygiene and bare below elbow compliance was assessed on Kent Ward and results for June 2015 indicated 100% achievement. However, the checks of cleaning of commodes on this ward were less satisfactory, achieving a score of 76.92%. We checked four commodes and two shower stools whilst on the ward and found they were all clean.
- Results for local audits on Clark Ward indicated they achieved 100% for bare below elbow dress code, 89.66% for hand hygiene and 100% for commode cleaning in May 2015. We found all equipment, including commodes to be clean and ready for use.
- We observed that staff managed the handling of bed linen and disposal of sharps in accordance with national best practices.
- The handling and management of surgical specimens in theatres was done so in a safe manner, with registers for items and transport equipment available.
- Surgical staff working in theatres followed National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection: prevention and treatment of surgical site infections (2008).

Surgery

- Staff had access to a protocol to follow in respect to identifying and responding to sepsis.
 - We checked a range of equipment on wards and found these were clean and ready for patient use.
 - Infection surveillance figures were monitored and reported to the trust board of directors. Minutes of the meeting on the 26 June 2015 reported that there were no cases of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemias in May, and three cases of Clostridium difficile occurring within the trust during the month (against a trajectory of four). There were 44 cases of E.coli bacteraemia in May. Thirty nine cases occurred pre- 48hour and five occurred post-48hour. There were 13 cases of Methicillin susceptible Staphylococcus Aureus (MSSA) bacteraemia in May. All cases occurred pre-48 hour. Information did not identify the services in which these had arisen.
 - We reviewed a number of minutes held with surgical personnel and microbiologists, in which there was discussion of patients who had presented with problems requiring treatment for infections. The information included treatment paths and actions taken.
 - Infection prevention and control training was part of mandatory training for nursing and theatre staff. Two members of theatre staff had not received any IPC training. Figures presented to the board of directors indicated the following levels of compliance with required training: trust wide compliance for 78.5% for May and 81% for April.
- ## Environment and equipment
- On the K&CH site there were six main theatres and one endo-vascular theatre. There was an eight bay recovery area, with the addition of two paediatric bays. Day-care theatre provision consisted of three theatres, one procedure room, a recovery with four adult and one paediatric bays. Ancillary rooms, including dirty utility, anaesthetics, scrub, preparation rooms, and equipment stores were provided. An endoscopy wash area was provided for decontaminating flexible emergency endoscopes. Theatres were spacious; however, there were issues with storage of equipment, which despite the limitations were managed in an organised manner.
 - We observed exposed wood and holes in theatre flooring but noted on the forward plan that refurbishment was planned for August.
 - The day care surgery environment consisted of a reception and waiting area, toilets and changing rooms. There were two theatres, a procedure room and a four bay recovery, with one paediatric bay also. Associated clean and dirty utility areas were provided to support the surgical services. The day care ward had 10 bays, one side ward and a discharge lounge. The kitchen used by patients was not to an acceptable standard, with a rusting fridge, badly scaled sink, no work surface and damaged walls and paintwork.
 - Wards and theatres were accessible to individuals with disabilities and technical equipment was available to support individuals where required. Bariatric equipment was available and operating tables were suitable for patients within higher weight ranges.
 - Equipment checks and planned preventative maintenance (PPM) in theatres was conducted on a rolling programme. There were some out of date PPM tasks, which were being managed by the theatre lead responsible for equipment, who was addressing this with relevant engineering staff.
 - All plant and air handling was serviced on a rolling programme and the main service was taking place in August during theatre shut down.
 - Emergency resuscitation equipment was available in each area and had been routinely checked. Within theatres we observed excellent management of emergency equipment. Emergency items were easily located on the main corridor and were clearly labelled, clean and had been checked twice daily.
 - Anaesthetic machine checks had been performed in line with The Association of Anaesthetists of Great Britain and Ireland safety guidelines Safe Management of Anaesthetic Related Equipment (2009).
 - Staff told us the equipment library had started this year and equipment management had much improved access and availability. Most items were available from the library, with patient controlled analgesia pumps and epidurals accessed from theatres.
 - We found in our observations evidence of checks and servicing of patient equipment. Staff reported having enough equipment to enable the safe and effective delivery of care. A new ECG machine had recently been purchased on Clark Ward.

Surgery

- Single use equipment such as syringes; needles, oxygen masks and suction tubes were observed to be readily available and stored in an organised, efficient manner.
- Instrumentation which required decontamination between patient use was processed by an off-site provider. There were two equipment holds for clean/used items awaiting collection and all items were scanned for tracking purposes.

Medicines

- The management of medicines in theatres was reviewed by us and we found that temperatures on drug fridges had been checked daily. Controlled drug registers were complete and were expected to be audited by pharmacy; however, this was not always happening due to staff shortages. Theatre medical gases were signed off by a pharmacist according to a permit to work process.
- Emergency drugs were readily available in theatres. Medicines administered to patients in the anaesthetic room, theatre or recovery were written up and recorded on the patient care record.
- Staff on Clark Ward reported having pharmacy support on weekdays, with a top up of medicines and a review of discharge prescriptions. A back up cupboard was available for supplies outside of pharmacy normal hours.
- On Kent and Clark Ward we found there were secure arrangements in place for all medicines. However, on Clark Ward the door for the intravenous fluids was not locked and therefore could be accessed. Emergency drugs had been checked on all but one recent date. There was separate storage for cytotoxic medicines and epidurals and there was a policy in place for the preparation of the former products.
- A range of take home medicines were available on wards to support the discharge process, particularly as there had been on-going delays related to pharmacy capacity. A record was made when take home medicines were provided to patients.
- Controlled drug (CD) checks had changed in May and each entry in the register required the completion of two signatures to indicate the checking and administration process. We found on Clark Ward that all signatures had been completed since the change.
- Staff reported to us that there were double staff checks when preparing Insulin and medicines that required mixing. This provided a safer process, which reduced risks and errors occurring.

- Eye drops in preparation for ophthalmic surgery were instilled in accordance with prescriptions.
- Medicine errors were reported and investigated as part of the incident procedure. Errors were reported as part of the performance dashboard and we saw for example that there had been six reported errors on Kent Ward for the period July 2014 to June 2015. An example of a CD error was described to us and staff were required to complete a reflective summary and discuss this with the ward manager by way of learning.

Records

- Patient records were in paper format except for electronic discharge summaries to GP's. A standard surgical pathway document was used, which contained the documentation required for the patient journey from pre-assessment or emergency admission through to discharge. However, in many cases, numerous pages in the booklet were not completed as staff told us they were not relevant. The pages were not crossed out so it was difficult to understand if something had been missed in error, without clarifying with a member of staff. There was a risk that essential tasks could be missed.
- A standard care plan was used, which was in a tick list and sign format. This did not engender a personalised approach and we could not identify any specific requests, choices, likes and dislikes, which a patient had made. Staff told us patient specific requests were added to the handover information used at shift changes and a note was also made at the bottom of the care plan page.
- Staff recorded evaluation and progress notes, as well as information in respect to discharge planning in records. We observed evidence of involvement of the multi-disciplinary team, such as occupational therapists and physiotherapists. Information had been recorded in patient records to indicate the involvement of dietitian's and specialist nurses' interventions.
- Risk assessments, such as assessment of moving and handling, skin integrity, nutrition, use of bed rails and Venous Thromboembolism (VTE) were recorded in the care records reviewed on the wards. We saw required actions were taken by staff. This included prophylaxis treatment to minimise risk of VTE, pressure relieving mattresses and signage to indicate where food supplements were required.
- Records contained evidence of formal consent having been discussed and signed by patients.

Surgery

- Theatre staff followed the 'Five Steps to Safer Surgery', which included team brief, sign in, time out, sign out and debrief. We reviewed 10 sets of patient records in theatre and found 98% compliance with the required safety checks. A qualitative audit was being carried out, with 10 sets of notes selected randomly every day, which was achieving between 98 and 100% compliance.
- We saw there were audits to check staff compliance with World Health Organisation (WHO) safety checks. Audit results for 29 April 2015 indicated 97.25% compliance in main theatres and 100% in the day case unit.
- Patient records contained evidence of attendance at the pre-operative assessment where relevant. This included records of all screening, tests and assessment of risks.
- We checked two sets of patient records in recovery and found gaps in some areas. This included the falls risk assessment not having been completed in both records and a missing VTE risk assessment in one.
- We were told by a senior nurse that a documentation audit was carried out by the trust once per year and that ward staff also undertook an informal check on occasion.

Safeguarding

- Knowledge and understanding with regard to safeguarding vulnerable people was generally understood by the staff we spoke with. Some staff explained how they would make the senior person aware of a concern and this would be escalated to the safeguarding lead.
- Staff had access to a safeguarding protocol and named staff who were able to support staff in this area, although not all staff were aware of who the lead person was. Safeguarding concerns were identified and followed a process in accordance with trust guidance. This included involvement of an independent IMCA where required.
- There was inconsistent information about the areas of safeguarding training, with staff reporting that training addressed safeguarding children but not adults. However, we were provided with safeguarding vulnerable adult e-learning training figures for Kent Ward, which indicated two regular and one new staff member's training had expired and there were 11 staff booked on to forthcoming sessions, arranged prior to the expiry date.

- Staff told us safeguarding children was in the form of an e-learning programme. Safeguarding training was to be completed three yearly and was up to date on Kent Ward.
- Despite the conflicting information, we were given examples by staff, which demonstrated their awareness of issues that may impact on the vulnerability of adults. This included the actions taken to address an identified concern.

Mandatory training

- Staff confirmed they completed a number of subjects to fulfil mandatory training. This included for example; health and safety, fire, infection control, patient falls, VTE assessments, equality and diversity and governance.
- Figures for mandatory training on Kent Ward suggested that most training had been completed for the sessions that were due. The performance dashboard for the period July 2014 to June 2014 indicated 97.75% had completed the required training. However, we noted from information provided separate to the dashboard, that nine staff, including one new starter were due to complete dementia training.
- Figures provided to us for mandatory training within main theatres indicated below target for health and safety at 66%, with three staff never having had this training, and fire training at 86.7%. Two staff had never undertaken fire training, child protection, infection control and manual handling. Five staff in theatres had never undertaken equality and diversity training.
- Training figures for Clark Ward indicated gaps in manual handling practical sessions, life support, safeguarding children, and consent. We noted that only one member of staff appeared on the record as having completed once only conflict resolution training. None of the staff were reported to have undertaken safeguarding adult training, which was required to be completed every three years. There was a risk therefore that staff may not have had all the required knowledge and understanding regarding these areas of safety.

Assessing and responding to patient risk

- Staff used an early warning monitoring system via an electronic device, which was hand held but linked up to a central system. We saw from these that staff were recording the observations of patient safety parameters such as, heart rate, respirations, blood pressure and pain levels.

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- There was a outreach response team available attend to patients when their condition deteriorated and required escalation to medical staff. Nursing staff reported to us that the medical staff were responsive in such situations and they were willing to listen to contributions of patient information from less senior staff.
- Patients were assessed for actual and potential risks related to their health and well-being. Signage was in use where patients were identified as high risk of falls. Individuals susceptible to malnutrition were identified through a red tray system and nutritional risk score. They were supported to eat and drink and had supplements where appropriate.
- Patients were assessed for the risk of developing a venous thromboembolism. Where required prophylaxis treatment was prescribed and administered. We noted that the ward performance dashboards recorded compliance with this aspect of risk assessment/management. On Clarke Ward results for the period July 2014 to June 2015 indicated risk assessment completion was achieved in 88.3 cases but that thromboprophylaxis had only been given in 47.06 cases. The target was equal or above 95 for both of these elements. Kent Ward results for the same period indicated 90.77 of patients had a risk assessment completed and 85.25 of patients received thromboprophylaxis.
- Two hourly rounds were taking place, during which staff checked on each patient and assessed their needs and any changes in condition, to which they responded.
- An on-call consultant and registrar was available at all times. There was a dedicated emergency theatre, with a protocol in place for booking emergency patients.
- We received information from a member of the intensive care unit staff who advised us that there were issues with vascular trainees as they had not been covering general surgery patients for the past nine months. As a result they were only seeing vascular patients. This member of staff felt that this had contributed to a recent incident, where a patient's conditions had deteriorated and not been addressed as promptly as they would have expected. The incident reports were requested by us and subsequently reviewed. We noted the events had been fully described and included input on the decision making process from the F2 vascular doctor, a medical specialist registrar and an ITU specialist registrar. The incident report, which indicated further investigation

described the actions taken initially, and were based on the presumed underlying cause related to pre-existing condition. Action subsequently taken reflected the patient needs when their condition deteriorated further.

Nursing staffing

- The surgical division reported via the workforce performance report that the use of temporary staff and overtime had decreased to 143.35 whole time equivalent (WTE) staff in May 2015, from 165.82 the previous month. Agency staff usage was indicated as being in anaesthetics, although the figures were not broken down to indicate location.
- There was a designated person in charge each shift. A band 6 nurse was also available on nights to support staff on both wards, providing help with treatment or care, such as medicines.
- Staffing levels and skill mix were displayed on wards and we saw for example that on Clark Ward they had the required number of staff on duty at the time, which included nurses, associate practitioners and health care workers (HCA). Clark Ward staffing figures presented to us for May 2015 indicated that they had planned for 149 nurses on the morning shifts, 143 nurses for the afternoon and 62 for nights. Actual figures were, 148, 138 and 60 respectively. Associate practitioners were not planned for in the staffing figures but we saw that there had been 18 covering morning shifts, eight on afternoon and one on a night shift. The HCA were planned to be at the levels of 137 for mornings, 84 for afternoons and 59 for nights. The actual figures had been 114, 64 and 56 respectively. Overall the staffing levels enabled the safe delivery of treatment and care to patients.
- Vacancy rates were provided to us and we noted from these that on Clark Ward there were two whole time equivalent (WTE) band 5 vacancies, one of which had been filled and was due to commence employment. They also had 0.2 WTE vacancy at associate practitioner level. This grade of staff was equivalent to a band 4 and had expertise in a particular area. They could take their own patients but did not undertake medicines.
- Kent Ward establishment included 1.46 WTE vacancy at band 5 level and 0.30 at band 6. A band 5 WTE was due to start employment in September 2015 and a member of staff was returning from maternity leave to fill the nurse vacancies. A new HCA was starting in July 2015 to complete the staffing levels.

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- Where agency were used they were supplied by an NHS provider and were subject to appropriate induction before they could start work. Induction forms were provided by the agency to support the suitability of the placement.
- Theatre staffing establishment was approximately 60 WTE, with 12 vacancies, two of which were covered by agency and the others by in-house management. The day to day skill mix was seen to reflect the Association for Peri-operative Practice (AfPP) guidance.
- Day care nursing staff also worked in the recovery area and dedicated theatre staff supported the surgical pathway. There were no vacancies in day surgery but two staff were on long-term sick leave.
- Pre-assessment was ran by a matron with support from HCAs.
- Handover of patients returning from theatre was conducted clearly and concisely. Staff explained the nature of the surgical procedure the patient had undergone. They handed over details on specimens, medicines given and those to continue, the discharge plan and outpatient appointment. Information was signed by the handover staff.
- Ward handovers took place at each change of shift and included communications about each patient, any particular needs they had, any required interventions and discharge planning.
- We discussed the medical staffing arrangements with a doctor on Kendal Ward. They advised that there were usually two F1 junior doctors and one F2, with three additional F2 on the rota, covering nights. Each week F1 doctors had half a day in theatres and they did on-call one evening per week. The registrars were said to be good at providing support. A registrar was on-call and they dealt with admissions, so were not in theatres. A consultant was on-call each day, who undertook the ward round each morning and was available to respond to questions or see admissions. At night a senior house officer (SHO) covered urology and vascular wards, with a registrar and consultant on-call weekdays. Weekend cover included F1 on days, who undertook ward rounds. A SHO was involved in ward rounds and reviewed emergency admissions, with registrar support via on-call.
- Handover of patient specific information took place between outgoing and on-coming medical staff. This included information about any new patients admitted as emergency during out of hours.
- Patient information was handed over between anaesthetists and recovery staff following surgery, so that staff understood what care was to be continued. For example, monitoring and intravenous fluids.

Medical staffing

- Medical staff skill mix for the surgical directorate across the locations was 315 whole time equivalent (WTE) as of September 2013. This was made up of England comparable levels of consultants at 40%, slightly higher levels of middle grade doctors, at 16%, against England average of 11%. Middle grade doctors have at least three years at senior house officer or higher grade within their chosen speciality. Registrar group made up 30% of the medical workforce, against an England average of 37%. Junior doctors in foundation years one or two (F1/F2) contributed 15% of the medical staff, against England average of 13%.
- Surgical treatment was consultant led and there was always a consultant, registrar and F1 doctor on call. A rota was displayed in theatres, which confirmed the arrangements, this included anaesthetic cover. A separate team of staff were available for the emergency theatre.

Major incident awareness and training

- There was formal guidance available to staff in respect to the actions to be taken in the event of a major incident. Information was easily accessible and there were notices displayed advising staff where to locate the incident file.
- Staff on Clark Ward reported that they did not have specific incident cards for their area but they were required to take any overspill of patients.

Are surgery services effective?

Good



Staff did not always receive an annual performance review, and may not have had the opportunity to discuss learning and development needs. Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure safe and effective patient outcomes. There was generally a good

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understanding of mental capacity; however some staff did not have sufficient understanding of deprivation of liberty safeguards and there was no evidence to indicate training in the latter.

Patients were assessed, treated and cared for in line with professional guidance. Patients reported that staff sought their consent prior to treatment and care. Effective pain management was reported by patients and staff monitored this aspect of their care.

The nutritional needs of patients had been assessed and patients were supported to eat and drink according to their needs. There was access to dietitian's and medical or cultural diets were catered for.

Patient surgical outcomes were monitored and reviewed through formal national and local audit.

There was multi-disciplinary working in most areas and consultants led on patient care. There were arrangements in place to support the delivery of treatment and care through the multi-disciplinary team and specialists. There was access to allied support services out of hours.

Evidence-based care and treatment

- The emergency theatre protocol reflected Royal College of Surgeon principles and practice guidelines.
- We observed that theatre staff were following NICE guidance on falls prevention, pressure area care and venous thromboembolism.
- Patients who attended pre-admission assessment had pre-operative investigations and assessment carried out in accordance with NICE clinical guidelines. We reviewed a range of information, which demonstrated the processes staff followed with respect to anaesthetic assessment, fasting guidelines, lung function tests and medicines.
- We followed the care of patients from wards to theatre and recovery and found at each stage of the patient journey correct procedures had been followed.
- Day case admissions and discharge protocols were in line with the British Association of Day Surgery (BADs) guidance.
- Processes were in place for patients receiving post-surgical care to be nursed in accordance with the NICE guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. This included recognising and responding to the deteriorating condition of a patient.

- There was a sepsis pathway to follow where patient's needs indicated. Guidance for this was outlined within the Prevention and Management of the Deteriorating Patient Policy.
- Staff in recovery followed NICE clinical guidelines CG65, which concerned Peri-operative Hypothermia (inadvertent). They assessed and recording patient temperature at regular intervals.
- Patient care pathways were in use on the urology ward (Clark), for nephrectomies, robotic procedures and cystectomies.

Pain relief

- The 10 patients who spoke with us were asked about the assessment of their pain and how staff responded. Patients told us they were asked by staff if they had any pain at regular intervals. Those who experienced pain commented positively on the management of this, indicating that nurses had been extremely responsive in administering pain relief. One patient told us they had come into the ward in pain and that staff had been very quick to give them pain relief, also returning to check that this had worked. We heard staff asking patients about their pain and providing kind and reassuring responses before attending to the provision of pain relief. We saw too that pain scores were assessed and recorded in patient records.
- We observed that consideration was given to the different methods of managing patient's pain, including patient controlled analgesia pumps. Patients coming round from surgery in recovery were assessed for their pain and given pain relief as prescribed. Intravenous pain relief was given where needed.
- There was access to an outreach pain team for acute pain and a separate chronic pain team was also available.

Nutrition and hydration

- Patients could choose their meals and there were choices appropriate for cultural or therapeutic diets. Housekeeping staff checked with patients their preferences and patients could eat at any time. Finger food was available where patients preferred a lighter option. A cooked breakfast was available if the dietitian recommended it for nutritional needs.
- Pre-admission assessments included nutritional assessment of patients using a nationally recognised screening tool.

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- Fluid monitoring charts were in paper format and were used to record patient intake and output, including where they were receiving intravenous fluids.
- Blood sugar levels were recorded as part of the assessment of patients on the electronic record.
- Where the nutritional needs indicated, patients had a red tray to denote they required support to eat and drink or closer observation of their nutritional intake.
- Automated referral to the dietitian occurred when a patient nutritional risk score was two or above.

Patient outcomes

- Relative risk of re-admission performance for elective surgery procedures was slightly above the England average, with urology and vascular surgery accounting for the majority of these. Patients having non-elective urology, vascular or general surgery were all indicating a relative risk of readmission.
- Patient Reported Outcome Measures (PROMS), which were responses from a number of patients who were asked whether they felt things had 'improved', 'worsened' or 'stayed the same' in respect to four surgical procedures at the trust. Patient self-reported health outcomes for groin hernia, hip replacement and knee replacement were less than England average. The Oxford knee score indicated above England average for improvements in patient condition.
- The trusts results for the National Bowel Cancer Audit for 2014 indicated that 100% of patients were discussed at a multi-disciplinary meeting but, that only 1.4% were seen by a clinical nurse specialist, against an England average of 87.8%. The CT scan was only reported on in 0.6% of cases, compared with 89.3% England average.
- Lung Cancer Audit results for the trust in 2014 indicated that out of the 456 cases, 95.4% were discussed at a multi-disciplinary meeting, which was almost comparable to the England average of 95.6%. The percentage of patients receiving CT prior to bronchoscopy and surgery was below the England average at 85.6% and 13.6% respectively.
- We were provided with a summary of surgical service audit programme for 2015/16. We saw that there were 138 audits taking place including 14 related to critical care. National audit contributed 28 and there were 15 'must do' internal audits. The remaining were local

interest audits. We noted comments made with respect to the programme, which included some audits being slow to progress and action plans taking more than three months to produce.

- We observed that there was a process in place that evidenced the Royal College of Surgeons standards for unscheduled care were being followed. This included having consultant led care, prioritising the acutely ill patient and ensuring that preoperative, perioperative and postoperative emergencies led to appropriate outcomes.

Competent staff

- Staff confirmed they had an annual appraisals, during which they discussed their training and development needs. They also told us they were supported to develop and had access to internal opportunities, and were encouraged to progress in to senior positions.
- A member of staff on Clark Ward said they had always felt well supported and received help to develop their skills. This person said, "we are allowed to be good at things" and added that the e-learning system was much improved.
- We were provided with appraisal figures for the surgical directorate across the three locations. These indicated that 87% of anaesthetic staff had received an appraisal, 81% of general surgery staff, 87% of head and neck staff and vascular & urology 76%. Within trauma and orthopaedics 87% of staff had been appraised.
- We noted the local appraisal rates provided to us on site and found 77.8% of staff working in main theatres had been appraised at the time of our visit. The performance dashboard for Clark Ward indicated that the appraisal rate was 84.77% for the period July 2014 to June 2015. Data supplied by the ward indicated that eight staff had no appraisal completed or planned next to their name. Appraisal rates for the same period on Kent Ward were reported on the performance dashboard as 99.68%.
- Theatre staff had put forward their training requirements in the workforce plan for the surgical division. This was based on low to high risks; however, all training other than mandatory had been withdrawn until September 2016, which staff told us would impact on the ability to recruit to vacant posts in theatre.
- Newly qualified staff were assigned a preceptor and mentoring arrangements were confirmed by staff.

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- Induction arrangements were in place for all new staff joining the trust, and where agency staff were used they were provided with detailed induction information.
- Competency assessments were required for various nursing activities, such as cannulation and taking blood samples. Theatre scrub staff completed generic competencies for their role and then speciality specific competencies. The HCA who supported the pre-assessment service had competencies in ECG, phlebotomy, MRSA screening and basic patient observation.
- There were link nurses assigned responsibility for various areas of specialties. For instance; amputees, diabetics, falls, nutrition, stoma care and acute pain. They provided guidance and support to staff with respect to their area of focus.
- In recognition of the skills required to deliver end of life care, 25 of the 26 staff on Kent Ward had completed training in this area.
- Revalidation figures provided to us indicated that 60 surgical medical staff had been revalidated and four had been deferred.
- Patients who spoke with us reported feeling confident in the skills and abilities of the staff. All reported feeling safe and comments included, “you get a sense that everyone knows what they are doing.”
- Physiotherapists explained to us that nursing staff had been trained in the skills necessary to assist amputee patients get out of bed. This was in line with the British Association of Chartered Physiotherapist's in Amputee Rehabilitation (BACPAR).

Multidisciplinary working

- Within theatres a range of service representatives came together at the briefing meeting to review activity and capacity. This included bed managers, ward staff and radiology.
- A senior physiotherapist explained to us how multi-disciplinary meetings (MDT) were held every morning on Kent Ward, which although they did not attend, involved the occupational health staff. A nurse spoke to us about the MDT meeting, which took place on a Wednesday. This meeting provided an opportunity to discuss patients going home as well as those already discharged but would require further treatment. As well as medical and nursing staff presence, the radiologist attended this meeting.

- Staff on Clark Ward told us there was no MDT or ward rounds taking place there. Where patients required physiotherapy or occupational therapy they were identified on the white board. Staff reported having access to specialised nurses, including , tissue viability and other experts. This included medical photography, the speech and language therapy team (SALT) and dietitian's. We saw evidence of these staff having been involved in patient care in the records we reviewed.

Seven-day services

- There were scheduled theatre lists on a Saturday, with radiology available to support the service.
- Emergency patients had access to the CEPOD theatre.
- Physiotherapy was available via an on-call arrangement from 4.30pm to 8.30am Monday to Friday and from 8.30am to 8.30pm Saturday and Sunday. This was primarily for emergency respiratory patients.
- Pharmacy was open seven days a week, but weekend opening was restricted to 9am -12pm. The full range of pharmacy services was not available at weekends, the focus of weekend pharmacy working was to facilitate safe patient discharges, although there was limited review of admissions and other inpatient prescription charts. Outside core pharmacy opening hours advice and supply of medication was available via the pharmacy on-call service, with each site having their own pharmacist on-call.
- Microbiology services were available 24/7.
- Diagnostics were provided for core hours. CT and X-ray provision was available 24/7 and there was access to a radiologist in emergency situations.

Access to information

- Staff had access to guidelines and protocols via the ttrust intranet. Nine policies were due to be reviewed during June 2015 by relevant groups, such as the patient safety board and the critical care steering group.
- Information was also communicated to staff via a range of methods, including team brief, newsletter and minutes of meetings.
- There was access to information both for employees and the public on the ttrust website.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Surgical patients who spoke with us reported that they had been given information about the benefits and risks of their surgery prior to signing the consent form. One

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patient told us they had the procedure explained to them three times in a way which was easily understood. Another patient told us how staff talked through each stage of the surgical process and recalled having information prior to signing the consent form. Other patients told us staff sought their consent before providing aspects of treatment or care.

- We were provided with documentation, which was given to patients who were making decisions about forthcoming surgery. Examples of patient information with regard to consent included; endovascular aneurysm repair, bypass grafting and carotid endarterectomy. The content of these provided additional information to supplement explanations from medical and nursing staff.
- Discussion with staff demonstrated that they understood patient consent and the importance of obtaining this before undertaking any treatment or care. Staff were aware of the different types of consent and how they applied this in practice. There was an understanding of advocacy and involving family or Independent Mental Capacity Advocates (IMCAS) where best interest decisions needed to be made.
- Staff told us the pre-assessment process was an opportunity to identify if a best interest meeting was required where capacity was identified as impacting on the consent process.
- An assessment record was completed where mental capacity was identified. A flow chart was used to ensure that Deprivation of Safeguards (DoLS) were appropriate. Ward staff understood DoLS but also told us they would seek advice from the safeguarding lead if necessary. However, theatre staff were unable to recall if DoLS was part of their training and the matron did not consider DoLS necessary for theatre staff.
- Staff training figures for Mental Capacity Act (MCA) on Kent Ward were noted to be almost fully compliant. One new starter and one other member of staff were as yet to complete the required training.

Are surgery services caring?

Good



Most patients were satisfied with the quality of care and experience they had whilst receiving treatment and care on

the surgical wards. Patients told us they had been treated respectfully and in a dignified manner. We observed kind, compassionate and attentive care being provided by the multi-disciplinary team.

There were arrangements in place to care for individuals who had particular needs associated with cognitive impairment or disabilities.

Information was provided in meaningful way to patients and they were involved in making decisions and choices as far as able. Emotional support was provided to patients and their family when required.

Compassionate care

- Friends and Family Test (FFT) response rates for the period December 2013 to November 2014 showed a less than national average of 18.6%, compared with 31.7%. The highest response rate came from Kent Ward at 58%. We saw May 2015 results of the FFT on Clark Ward, which indicated that 97% of patients would recommend the ward out of 119 respondents. Results displayed on the ophthalmic unit indicated 95% would recommend the service. Comments made with these results included; 'friendly, cheerful staff', 'the care I received was second to none' and 'fantastic staff'. Kent Ward received 100% recommendation from the 55 responses received in June 2015. The ward had also received 58 compliments for the same month.
- We spoke with 11 patients, who with the exception of one reported very positively with regard to the treatment and care provided by staff. Comments made included, "everyone has been helpful and caring, brilliant, couldn't fault it", "they are very friendly" and "my care has been absolutely fantastic." Patients gave us examples of the way in which they felt their needs had been addressed and their privacy and dignity respected. For example, one patient told us although they were in a side room the staff had been very attentive and came in regularly to check on them. They said the staff always knocked on the door before entering and made sure they were respectful during intimate care. Another patient commented to us that it was their first time as a patient and they were rather anxious but that staff had conducted themselves very professionally when undertaking personal care. They told us the nursing staff treated them "impeccably."

Surgery

Other comments made to us included observations of kind and attentive care to other patients being cared for on the ward and privacy curtains being drawn before treatment or care.

- A patient who spoke with us in the ophthalmic surgical unit commented on the arrangements as follows, “timing excellent”, and “theatre staff were excellent, professional and caring.”
- We observed kind interactions between staff and patients, and saw evidence of positive engagement between patients and ward staff. Communications were generally heard to be delivered in a caring and responsive manner. However, we did hear from one patient that some of the staff were not as responsive to them. This person had communication difficulties and they told us that only a few nurses took time to find out from them if they had any issues or concerns. At the time they had been sitting in a chair for four hours and didn't feel they could ask for help. Although a buzzer was provided, this patient felt the staff were too busy and when previously used, the staff were said to have taken 40 minutes to respond.
- Patients received into the anaesthetic room and post-operatively into recovery were observed to be treated with dignity and respectfully. Staff spoke kindly, explained what they were doing and checked that the patients were comfortable. When able to drink, fluids were offered in sips through a straw. Patients were reassured and kept warm and pain free, before returning to wards.

Understanding and involvement of patients and those close to them

- With the exception of one patient all other patients who spoke with us reported having detailed explanations of the treatment and care plans and of feeling involved in decision making. One patient told us they felt involved in the decision making process; however, one of the doctors had not been very informative about their care and did not involve them. The patient told us they had to ask nurses for further clarification. This patient also said they did not feel in control of the temporary on-going care process and didn't feel safe because of their condition.
- Positive comments made to us by patients included, everything having been explained in a way that was understandable and of having the opportunity to ask questions. Options were said to be offered and patients

told us they felt informed enough to choose treatments that suited them. One patient told us, “From the time I came through the door, the nurses and doctors have gone through every detail with me.” They added that any questions they raised were responded to “brilliantly” and they were reassured. Another patient told us staff had asked their opinion, which made them feel part of the process. Further positive comments were made such as, a patient was impressed just how informed they had been by staff. One patient told us they had gone to a seminar at the learning centre, during which they saw a presentation and were able to take away leaflets about the procedure, as well as general information about the ward.

- One patient told us their relative had been treated with care whilst they waited. Staff had brought them a drink and the patient commented on the positive nature of this.
- We observed a range of information in leaflets and booklet form were provided to patients and their families. Information was detailed and comprehensive and could be requested in alternative languages or formats via the respective department.

Emotional support

- Patients reported to us of having their anxiety and nervousness was reduced by having good information and clarity from staff. However, aAnother patient told us they didn't feel their emotional needs had been addressed with respect to the on-going care once they left hospital.
- There was access to a range of clinical nurse specialists, such as pain nurses and those with additional skills in palliative care, robotics and prostate matters.
- There was access to Chaplaincy and counselling could be arranged through the community nurses.
- A ‘smart tool’ was in place for staff to follow with respect to who to contact in the mental health team. This provided a risk assessment for patients who exhibited behavioural and mental health problems. If support was needed in an emergency, contact was made through a pager system and patients were referred to the psychiatric liaison team who then arranged to see and assess the patient.
- All cancer patients had access to a CNS for counselling, which followed the patient to the community after their discharge.

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- End of life patients were offered counselling through the palliative care team.
- The trust had a specialist counselling service for vascular patients at Kent and Canterbury Hospital, where the service was based.

Are surgery services responsive?

Requires improvement



Access arrangements for patients requiring surgical procedures were generally well organised, although referral to treatment times did not always meet the required standards in some specialties. Theatre utilisation was not always optimised. There were delays at times in the discharge process as a result of limitations within pharmacy to prepare take home medicines.

The average length of stay following most surgical procedures was less than the England average. Patient's individual needs were assessed and responded to. Patients reported having their treatment and care needs met and that they were satisfied with support provided by a range of staff. Favourable comments were made from the majority of patients with regard to the quality and provision of food and drink.

The complaints process was understood by most patients and staff received information where complaints resulted in required action.

Service planning and delivery to meet the needs of local people

- The majority of surgical activity at the Kent and Canterbury Hospital was organised around the delivery of surgical specialities. This included; urology, vascular, breast surgery, renal, maxilla-facial, ear nose and throat (ENT), orthopaedics and general procedures.
- The Kent and Canterbury site is host to vascular and urological inpatient surgery. There may on accession be other specialities of surgery represented through the Day Surgery Unit.
- Surgical activity included planned elective procedures, either as an in-patient or as a day case. Emergency surgery arrangements were organised to facilitate a responsive service.

Access and flow

- Access to surgical services was via GP referral subject to consultation review or via the urgent care department.
- Patients had access to the pre-admission assessment service, which was provided in the day surgery unit. Pre-assessment was provided to both inpatients and those having day case procedures. All patients were seen by the pre-assessment team if they were going to have an anaesthetic or sedation. Individuals having a procedure under local anaesthetic were assessed over the telephone. If any risk was identified, they were required to have a face-to-face assessment. There was anaesthetic support for the service on a Tuesday and Friday morning.
- There was robotic assisted laparoscopic prostatectomy available at the location. Patients having their procedure undertaken using the robotic equipment were seen pre-operatively by the specialist nurse in order to understand the pre and post operative treatment and care.
- As part of the surgical services performance figures had been collected with respect to referral to treatment (RTT), admitted and non-admitted, in addition to incomplete RTT. Trust figures for the RTT percentages within 18 weeks, admitted adjusted, was below the standard of 90% between March 2014 and February 2015. Data was not split by location.
- We found from information provided the RTT for ophthalmology, thoracic medicine and urology met the 90% standard, whilst ENT, general surgery and trauma and orthopaedics did not. However, the popularity of the use of robotics for some procedures, meant patients were waiting longer for referral to treatment. The procedures also took longer than traditional methods and this took up more theatre time, creating additional backlog.
- The percentage of patients whose operation was cancelled and were not treated within 28 days was lower than the England average in seven of the eight quarters for 2012/13 to quarter three 2014/15. Only four patients had not been rebooked and treated within 28 days year to date.
- Results for the period June 2013 to July 2014 indicated that the average length of stay (ALOS) at the location was less than the average for the top three elective surgical procedures. The ALOS for non-elective general surgery was slightly above the average.

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- There was an acknowledgement by the surgical services that theatre utilisation for the location needed to improve. We saw the minutes for the theatre staff audit day meeting, held on 18 March 2015, which highlighted the need to make sure every theatre list was booked and to escalate those that were under booked. At the time they were piloting a new system that would provide daily reports of theatre activity. We saw by way of example figures for June 2015, which indicated that theatre usage varied between the lowest activity at 60.4% and highest of 99.3%, (urology) across weekdays.
- Efficiency and value measures for each month were posted on the wall within the ophthalmic unit. June 2015 figures indicated 69 operations had taken place, of which on-time starts were achieved in 86.4% of cases and theatre utilisation was 87%. Cancellations of patients for the period was 21 and there had been seven lost sessions, attributed to holiday, audit and on-call.
- Discharge arrangements were commenced as soon as possible in the patient care pathway. Equipment needs were addressed through the physiotherapy and occupational staff. Information regarding on-going care was provided to patients. This included for example, post-operative wound advice and exercises.
- One patient told us they did not feel particularly involved in agreeing the decisions around their discharge. Another patient reported feeling frustrated by the delay in going home due to awaiting medicines.
- Another patient reported how the anaesthetist understood their 'extra care needs' and how to care for them whilst moving them and inserting tubes.
- Individuals who were living with had learning disabilities were encouraged to have a 'passport' completed by next of kin or their carers. This would be used to guide staff in delivering the persons usual care needs as far as possible. The learning disability nurse was available to support staff and liaise with patients as required. An example of a nurse/carer supporting a patient living with learning disabilities through theatres was described by staff to us.
- Patients who had additional needs associated with living with dementia were cared for in accordance with their individual assessment. On Clark Ward there was a designated bay, which enabled closer observation of patients who had a cognitive impairment.
- Interpreters were available subject to pre-booking or via telephone. Staff were only used on Clark Ward as interpreters in exceptional circumstances.
- Patients who were able to eat and drink told us their nutritional needs were met. Comments made included, staff being responsive when a patient required a drink. Others told us food was edible and, "the food is great, with fantastic variety and choice for all dietary requirements.". A patient who was a vegetarian explained to us that they had plenty of choice and options in portion size, the food was good and was delivered hot. Patients also told us they had plenty of drinks and staff encouraged them to drink.

Meeting people's individual needs

- Patients told us about how staff met their individual needs. For example, a patient described how discussion about their surgery had led to the preferred decision to have it in two stages. Patients also told how staff responded quickly to their needs from simple bed changing requests to other more individual needs, such as wound dressings or help with meals. We also observed staff responding to the needs of patients, for example, when supporting them to mobilise and to return to bed in order to have required pain relief.
- A patient who told us they had complex care needs described how they had been seen by a range of different professionals in order to agree their 'universal care package.' This patient said they were safe in the knowledge that the staff understood their condition and that they did not have to repeat everything numerous times. They expressed the following, "my problem is part of their problem and it's their job to care for me."

Learning from complaints and concerns

- Information about the Patient Advice and Liaison Service (PALS) was available in patient areas.
- All but one patient who spoke with us knew how to raise a complaint and generally felt a level of confidence that in such a case this would be addressed.
- Complaints data was shared with staff and there was an awareness of the issues, such as complaints around delays in medicines for take home. A written complaints log was kept on Kent Ward and this included evidence of the actions taken.
- Staff on Clark Ward reported that they received very few complaints and that when they did, these were discussed at ward meetings. We saw that for the period July 2014 to June 2015 there had been seven concerns, 13 complaints and 521 compliments reported via the

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performance dashboard for Clark Ward. Complaints data reported for the same period with respect to Kent Ward indicated three concerns, nine complaints and 401 compliments.

- Few complaints had been received by theatres and in the main those received had related to administration around day-care arrangements.
- We reviewed complaints information provided for the period April to June 2015 and noted very few of these related to surgical wards or theatres. Those that did indicated individuals not being happy with their treatment, communication issues and delays in appointments.

Are surgery services well-led?

Good



Whilst many of the leadership and developmental changes were in their infancy, the divisional directors understood their roles and responsibilities and were committed to overseeing the standards of service provision in all surgical areas.

There was a clear direction of focus underpinned by the values of providing effective care, respecting one another, people feeling safe and involved and able to contribute to change. Work was in progress to develop the surgical directorate strategic aims and principles.

The governance arrangements had been strengthened and were starting to provide more robust information to staff at all levels and to the trust board.

The surgical directorates had identified actual and potential risks and had in place mechanisms to manage such risks and monitor progress.

Staff reported a positive culture, with approachable, visible leaders. Staff felt valued, respected and that their contributions mattered. Staff were enthusiastic and passionate about delivering high standards and they enjoyed working in the surgical areas.

Patients and staff were encouraged to contribute to the running of the service, by feeding back on their experiences and expressing ideas.

The surgical directorate encouraged innovation; learning and continuous development and a range of activities were in progress or being developed.

Vision and strategy for this service

- The surgical division was overseen by the nominated directors, with shared responsibility across the three hospital locations. The respective directors told us they were working to develop a clinical strategy for the future, which would promote the delivery of services over the three hospitals. We were told the corporate strategy had been worked on for the last year, using a hub and spoke approach; however, the financial position had meant the focus had needed to change. The senior clinical anaesthetist was taking the lead on engagement within the division to identify the most optimum pathway for electives and non-elective patients before the strategy could be presented to the trust board.
- We reviewed the draft strategic briefing document for the surgical division, 2015/16. This set out the short, medium and longer term plans, with a view to providing a service that met the current and future needs of the local population. During 2015 and beyond the strategy was to be presented to the public for consultation by the divisional clinical leads.
- Staff who spoke with us reported that the values were based around respect, openness and honesty. Others told us they had watched a five minute film about respect.
- Surgical division team brief provided the opportunity for all managers to discuss the Trust vision and values.

Governance, risk management and quality measurement

- The terms of reference for the surgical services clinical governance board set out the membership and purpose of the board. A divisional governance matron had been appointed in March 2015 and they were supported by band 6 managers to deliver the required data, which was now more robust and included complaints, action after review, incidents and learning. The latter data collection monitoring was only in its infancy, having started at the end of May. A designated medical lead had responsibility for governance and patient safety.

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- The surgical services clinical governance board meetings were taking place monthly on a Tuesday morning between 9am and 11am and that they rotated around the three sites. Information from these meetings fed into the theatre meetings.
- Individual surgical specialities had started to be invited to monthly governance meetings and were expected to present a summary of the performance dashboard from a clinical view.
- The departmental governance meetings, patient safety board, and RMGG fed into the divisional governance board. Minutes of the Surgical Services Clinical Governance Board for the months December 2014 through to April 2015 were reviewed by us. These meetings were well attended and summarised a range of detailed discussion around for example, audit results, the risk register, national CQUINS, patient safety and quality, as well as clinical incidents and compliance with patient assessments, infection control and complaints.
- We were provided with a draft surgical services division governance report for the location, covering data for June 2015. Information therein reflected figures and information related to valuing staff, patient safety, effectiveness, and the patient experience.
- The surgical services clinical governance board monitored and reviewed the divisional risk register and the associated change register. This was to ensure that progress was made on outstanding actions and change programmes. Unresolved risks were escalated where corporate or executive action was required. The trust board discussed and reviewed the surgical risks and considered mitigation by site.
- We reviewed the risk register, which encompassed risks across the three surgical locations. Risks were rated by consequence, likelihood and impact and saw there had been thorough analysis of potential and actual risks which related to the surgical divisions. For example, in theatres risks related to equipment replacement, which were to be addressed through budget requests.

Leadership of service

- The surgical services division was overseen by a managerial structure consisting of the head of nursing, divisional director and divisional medical director. Designated individuals reported into each respective

director, each having a responsibility for relevant surgical services. There was cross site working on a weekly basis by all three directors, which was aimed at fostering a unified approach.

- A communication away day had been held recently, during which leaders considered amongst other matters cultural change and the improvement programme. Audit days had also been planned, with the intention of focussing on education, training and speciality specific issues.
- A workforce action plan had been established by the senior divisional lead and when reviewed we noted this was a focused approach using a RAG risk based to affect change. Examples of action being addressed included, divisional communication, team based work, staff attitudes and behaviours, workforce planning and innovations.
- Monthly newsletters and weekly team meetings in theatre were held, which had contributed to improved communication across the team.
- Staff commented positively on the leadership visibility and accessibility. Staff reported they had seen the director of nursing and they could approach her if they needed to. Other comments included; “the best matron ever”, “very supportive and visible to both staff and patients.” The senior staff on Kent Ward were described as being, “hands on”, and had the capability, understanding and experience to lead.
- A member of nursing staff informed us they were undertaking a leadership course at the time. They told us the trust was developing leaders who were able to change the culture.
- Staff in the ophthalmic unit reported to us that they were well supported and in particular, that the lead speciality consultant was very supportive.

Culture within the service

- Theatre staff were genuinely happy to be at work and were very involved in the department. Staff told us they all had a responsibility and they had recently introduced ‘what a great place to work’ initiative. This enabled staff to address any obstacles and to address these from a bottom up approach.
- Staff on wards told us the culture was good at the location, with openness, greater awareness of matters and “no bullying.” Senior nurses stated they were proud of their staff, adding comments such as the team were “brilliant, good and responsive.” Staff on Clark Ward felt

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they provided a reassuring service to patients with the “aftercare touch.” Other comments from staff included a feeling that there had been a general change in the culture, where previously there was an expectation to get on with things, staff were now asked how they were, if they needed help and there was greater visibility and participation from matrons.

- We found that staff were comfortable to report incidents and near misses as well as raising concerns, without fear of reprisal. Staff confirmed there was a no-blame culture and feedback from reporting of incidents took place via a range of methods.
- Staff felt valued and respected and were encouraged to contribute ideas at ward meetings. We were told by staff that they were treated with fairness and equity. Other staff spoke about having their contributions recognised and one associate practitioner informed us they had received a ‘band 4 of the year’ award.
- We were told there had been opportunities for learning on the job and was teaching actively encouraged. Staff told us they identified training needs within their performance review.
- A member of junior medical staff told us their experience at the trust had been good. They said the consultant listened to them and had a “genuine interest”, adding that they helped them to work things out.
- Staff well-being was monitored through the performance dashboard. We saw for example that sickness rates on Clark Ward had been 4.58% for the period July 2014 to June 2015. Staff turnover was running at 14.29% on this ward. On Kent Ward sickness rates for the same period were 4.19% and turnover of staff was 13.2%.

Public and staff engagement

- East Kent Hospitals University NHS Foundation Trust (EKHUFT) had commissioned 'Healthwatch' Kent to undertake community engagement activities in order to seek public feedback on their current services and to raise awareness of the need to review how services were delivered in the future. Key findings including both positive and negative feedback from participants were communicated in a formal report provided to the trust in June 2015. We did not identify anything specific to

each hospital location; however, we noted information within a separate document, which set out the plans for 'delivering the future'. This included stakeholder engagement dates for meetings going forward.

- We saw from information provided that there were various public engagement events in the region,. fFor example, in relation to abdominal aortic aneurysm (AAA). Vascular and prostate nurses also held focus groups. The use of the robot for surgery had recently been presented in London. In addition there were a number of listed dates available for the public to engage in the ‘vascular programme advisory board’.
- The staff survey results had been sent to all staff electronically. Results had been discussed at meetings, with a view to identifying how they could be improved in general and were not specific to theatre or other surgical areas.







Innovation, improvement and sustainability

- Junior medical staff commented to us on the availability of opportunities for improvement. This included having a journal club and educational sessions, where papers were presented and discussed. There was opportunistic learning on ward rounds and in multi-disciplinary meetings, and mortality and morbidity meetings. Each facilitated the discussion of incidents and learning from these.
- The matron overseeing the pre-assessment service was reviewing the service in order to improve the accessibility to specialty teams. For example, having designated days for colo-rectal, where the patient could see the consultant, the anaesthetist, pre-assessment nurse and specialist nurse in one visit. An initial trial was to take place with orthopaedic patients, who would have the opportunity to link with the physiotherapist's and the ‘joint school’.
- There were various improvement activities in progress. This included for example, within the ophthalmic services, stoma nurse specialist and theatre efficiencies. We saw an example on Kent Ward of work undertaken by a nurse to improve the monitoring of patients upper limbs following surgery. This had resulted in a diagrammatic observational chart for recording the colour, sensation, temperature and presence of a pulse in the arm.

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- An 'improvement hub' had recently been established. This was an accessible area for all staff, with information sharing and facilities to enable staff to provide feedback, ideas and suggestions for improving services.

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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 separate areas. There are four level two high dependency beds and four level three intensive care beds. There are four intensivists (a physician who specializes in the care and treatment of patients in intensive care) who work between the hours of 8am to 6pm Monday to Friday. Out of hours a CCU and general anaesthetic rota cover CCU. All consultants are anaesthetists.

A Critical care outreach team of four nurses work between the hours of 8am to 6pm, seven days a week and assist in the management of critically ill patients across the hospital. Outside of these hours the clinical site manager provides cover. Critical care outreach nurses also provide cross-site cover across the Trust. Between April 2014 and March 2015, the outreach team saw 619 patients.

We spoke with three patients, five relatives, nineteen staff including nurses, doctors, consultants, senior managers and support staff. During the inspection we looked at care and treatment and we reviewed care records. We received comments from our listening events and focus groups. Before and during our inspection we reviewed performance information from, and about, the trust.

Summary of findings

Patients were cared for in a clean and safe environment and staff showed good awareness of reducing the risk of infection. On the day of our inspection staff were very busy but we witnessed a well-co-ordinated team and a good standard of patient care and safety.

We found the care delivered in the unit reflected best practice and national guidance. There were systems in place to measure patient outcomes and the quality of the service provided. Care needs were risk assessed and the unit could demonstrate a track record of delivering harm free care, with the exception of a trust-wide problem of inconsistent practices relating to the safe use of nasogastric (NG) tubes. Instances of non-compliance with NICE guidance and a lack of adherence to the trust's own standard operating procedure had led to occurrences of avoidable risk to patient safety.

Appropriate measures in place to ensure that patients were protected from the risk of acquiring hospital acquired infections, and staff were observed to follow trust infection control guidance. Staff had access to Personal Protective Equipment (PPE) and was observed using it in line with trust policy.

The unit could demonstrate delivering care that reflected national guidance and took into account the

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latest research. The care delivered was assessed by continuously audited to ensure a high standard and outcomes that were in line with the England average when compared to other critical care units.

Patient had their dignity respected and their human rights protected whilst in the unit. Appropriate systems were in place to report and action safeguarding concerns and issues relating to the Deprivation of Liberty Safeguards (DoLS). We saw evidence that demonstrated that patients and their loved ones had their individual preferences taken into account when planning care.

Patients and relatives spoke positively about their experience of care and treatment. Staff showed good communication practices and used this to ensure patients with complex needs received timely and expert treatment. There was a positive drive to increase the use of the Confusion Assessment Method for the ICU (CAM-ICU) for patients at risk of delirium.

Medical records were fit for purpose, kept confidential and stored appropriately. There were systems in place to ensure the safe storage, handling and administration of medication.

There was evidence that staff implemented learning from incidents and that training for staff helped them to continually improve patient care. The conversations we had with staff and the data we reviewed demonstrated a healthy culture in the department towards incident reporting. Regular Mortality and Morbidity (M&M) meetings were in place to monitor mortality on the unit.

We found sufficient numbers of skilled staff who had the appropriate skills needed to care for critically ill patients. The unit had a robust competency bases induction and ongoing learning and development programme for all staff.

Patients were looked after by a multi-disciplinary team that included appropriate consultant input. Leadership and educational support on the unit was found to be strong. Feedback received from staff about their line managers and culture in the unit was very positive and complimentary.

There was an appropriate major incident plan in place. Staff were able to tell inspectors of their roles and processes to follow should a major incident occur.

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Are critical care services safe?

Requires improvement



We found the service delivered at the Kent and Canterbury Hospital critical care unit to require improvement. This relates primarily to the lack of compliance with NICE and National Patient Safety Agency (NPSA) guidance for the use of x-rays in confirming NG tube placement. Although incidents relating to this had been investigated, there was a lack of evidence that learning had been disseminated to all units in the trust. This had resulted in avoidable risks to patients being poorly managed.

The CCU had a robust incident policy in place which was being followed by staff at all levels. We found evidence that incidents were being reported and learned from to avoid recurrence. Senior staff conducted root cause analysis investigations and their outcomes and learning actions were then shared with unit staff to aid learning from these events. We saw evidence that all the incidents reported were used to identify and theme. The unit also held regular M&M meetings which reviewed the unit mortality to ensure it was delivering safe care.

Safety thermometer data was collected, analysed and displayed in the unit to demonstrate safe, harm free care being delivered. The data demonstrated good patient outcomes on an on-going basis.

There were systems in place to ensure that medication was stored, handled and administered in a safe way. The environment was clean and well-maintained and monthly cleanliness and infection control audits were used to quickly address any problems.

Medical records were stored appropriately and kept confidential. The medical records we viewed demonstrated that people had their needs and plan of care discussed with them, when possible. They also showed that patients loved ones were also respected and included in care planning when applicable. Staffing levels were planned using an acuity tool and there were plans in place in the event that staffing fell below a safe level. The skill mix of nursing and medical staff reflected national guidance. Staff had an awareness of their roles in following safeguarding

procedures and major incidents. There was sufficient consultant out of hours cover. We found a sufficient supply of medical equipment that was services in line with trust policy.

Incidents

- Between July 2014 and June 2015 there had been 122 reported incidents, of which 22 were medication errors and 4 were difficulties related to staffing levels.
- Incidents were reported, investigated and learned from. Incident data was collected and analysed to identify trends and themes and was widely displayed to aid learning. Incidents were investigated using root cause analysis best practice guidance from the National Patient Safety Agency.
- The root causes of medical errors were investigated and their outcomes through meetings and there was evidence that actions were implemented. For instance, the standard of written prescriptions had been improved following an investigation and the prescription process for hemofiltration (renal replacement therapy) had been simplified.
- Junior doctors took part in monthly Morbidity and Mortality meetings, which were usually led by an Foundation Year 2 grade (FY2) junior doctor and a consultant anaesthetist. These meetings were attended by anaesthetists and up to two nurses but no other specialties.
- Staff we spoke with were aware of the Duty of Candour. A nurse in charge told us that this was incorporated in the Datix incident reporting system and that it was followed up with relatives and the patient as soon as the incident had been reported. There was clear guidance on who was responsible for following the Duty of Candour.
- We found that there were trust-wide problems in adhering to the guidance of the NPSA on the use of x-rays to confirm initial placement of a nasogastric (NG) feeding tube. This had led to avoidable patient harm, which had subsequently been addressed by the senior management team through the reinforcement of NG tube standard operating procedures with Cortrak-trained practitioners.

Safety thermometer

- Safety thermometer monitoring and data was used robustly in the unit to measure and improve the

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standard of care. The results were displayed prominently near the entrance to the unit. The data we reviewed demonstrated consistent harm-free care being delivered to patients.

Cleanliness, infection control and hygiene

- We observed good infection control practices. All bedside staff wore protective aprons and gloves, or washed their hands before and after examining each patient. Alcohol gel was used appropriately. There was an infection control notice board to communicate updates to staff. A patient told us, "The ward is very clean, they're cleaning non-stop here".
- Sharps bins were no more than two thirds full and were labelled and dated as per the trust's policy.
- Medical equipment staff told us that equipment returned should have a preliminary and documented clean by staff but that this did not often happen in practice. This meant that medical equipment staff had to spend time decontaminating items, which could cause a delay in them being available again.
- Infection control audits had been completed and indicated that compliance failures were followed up by an accountable member of staff.
- Between April 2014 and March 2015, the CCU had no instances of MRSA infection and two instances of *Clostridium difficile*. Root cause analyses and learning from the instances had been documented and staff told us that this had been widely disseminated.
- In the five months prior to our inspection, there had been 100% compliance with hand hygiene and bare below the elbow policies. Commode cleanliness compliance had not always been completed due to a problem in obtaining documentation from the contractor. Where an audit had been possible, commode cleanliness compliance was always above 80%. Risks associated with a sluice facility had been highlighted in an infection control audit and were being addressed by a senior nurse.
- Data provided demonstrated that the unit had regular legionnaire testing in place.

Environment and equipment

- The unit operated a pre printed ward diary that not only contained vital information about the unit but all the

necessary daily and weekly emergency equipment and environmental checks. This meant that the nurse in charge could easily identify if the checks had been carried out.

- An emergency intubation trolley was available on the unit and had been checked regularly.
- A difficult airway trolley was available in a nearby theatre department which could be easily accessed in the event of an emergency.
- A transfer bag with emergency equipment and a transfer trolley were readily available and had been checked daily.
- Emergency equipment for the High Dependency Unit was shared with the surgical ward. This equipment was checked regularly in line with trust policy.
- A medical equipment library was available between the hours of 8am to 4pm Monday to Friday. Outside of these hours porters provided cover and there was a facility for staff to log equipment requests out of hours. Staff told us that they were able to access the necessary equipment out of hours. An information board described the process for out of hours staff and each equipment shelf had photographs of the equipment and what they were called.
- Staff told us that the separation of the ICU and HDU units did pose a risk but that this had been mitigated by a new policy that the HDU always had a minimum of two staff present.

Medicines

- Intra Venous inotropic infusions (modify the force of contractions of muscles) were not standardised across the trust. This carried a risk to the service users if staff were transferred from their usual place of work to a site using a different concentration. Whilst nursing staff had measures in place to avoid the risk of drug errors, this practice is not suitable in the long term and does not mitigate the risk.
- Medication was safely and securely stored. An appropriate returns procedure was in place and was being followed. Controlled drugs (CDs) were safely stored and regularly checked as per trust policy. Review of the CD log demonstrated double checking on sign out and on sign in when drugs were received from the pharmacy.

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- Fridges used to store medicine were locked and minimum and maximum temperatures had been recorded daily. This demonstrated that medication was being stored within safe recommended temperatures.

Records

- Records were stored safely and kept confidential in line with trust policy.
- Risk assessments had been completed for patients as part of their medical notes and included a range of risk assessments for example, falls, pressure areas, urinary tract infections, nutrition.
- There was a single bundle of paperwork for nursing assessments in use since January 2015, including a daily nurse care plan. At the time of our inspection this had not yet been audited which meant there was no data to demonstrate the success or highlight areas of improvement required.
- Patients had their clinical observations monitored as frequently as their clinical condition indicated. These observations were documented on standardised intensive care documentation. High dependency patients also had their observations recorded on the electronic tool used throughout the hospital. This meant that there was a significant amount of clinical data available to ward staff upon the patient's discharge, which was useful to identify clinical trends.

Safeguarding

- Staff were able to demonstrate an understanding of the safeguarding of vulnerable adults and the Deprivation of Liberty (DoL's) Safeguards. They were able to describe the escalation process required to raise a concern and how to contact on-call specialists.
- Urgent access to learning difficult and mental health teams was good and staff told us that other specialist help, such as for people with overdoses, could be obtained quickly if needed.
- 93% of staff had attended level 1 safeguarding training according to the data provided.

Mandatory training

- All CCU staff had undertaken hand hygiene and safeguarding vulnerable adult training. 98% of staff had completed intermediate or advanced resuscitation and blood transfusion training.
- Some training was offered to staff using online e-learning. Staff generally told us that this was

ineffective as they regularly encountered IT problems, for which there was no support outside of office hours. In some cases an alternative to e-learning had been provided on request. For example, a safeguarding lead had delivered a training session on safeguarding vulnerable adults, DoLS and the Mental Capacity Act (2005) training instead of the usual online session.

- A dedicated practice development nurse and clinical nurse educator were available and delivered in-house training that had been requested by staff or indicated as necessary from the senior team. Each training session was evaluated and where staff requested changes or improvements, these had been made. For instance, following feedback from staff, a course length had been increased from five days to six, training included more scenarios and a change of speaker had taken place on one programme.
- Training sessions were interactive and started with a formative test so that the trainer could understand existing levels of competence and knowledge. Staff received a revision document after each training course as a permanent reference point.
- Training was delivered in line with the most recent Intensive Care Society guidelines.

Assessing and responding to patient risk

- Patients had their care risk assessed and monitored continuously in the unit.
- If a patient's condition worsened, it was reported to the unit doctor and they immediately received a medical review. There was instant access to medical staff on the unit which meant that patient reviews were timely.
- High dependency patient had their conditions monitored using the National Early Warning Score (NEWS) system. Their NEWS scores were recorded on the electronic recording tool (Vitalpac) before they were discharged to ward areas. This meant that ward staff could identify trends and themes in their clinical observation data which aided the continuity of care. We found evidence in the medical records we viewed that showed scores were acted upon and that patients received medical reviews.
- Patient in ward areas also had their NEWS recorded on the electronic system. This meant that the outreach team could monitor patients medical conditions. It also meant that those who required intervention and an increased level of care receive it in a timely manner.

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- CCU staff were routinely deployed their nursing staff to the emergency care centre to assist with complex and emergency cases. This was a result of an action taken after an M&M review to improve patient outcome.

Nursing staffing

- An acuity tool was used to ensure nursing levels were safe. As bed use was flexible, with the ability to use the HDU as a step-down unit, staffing levels were continually monitored. A weekday health care assistant provided additional support and a band four practitioner with two years of CCU experience was in post.
- Daily staffing levels were clearly displayed and correlated with the staff rota. Staff on the CCU frequently travelled to other sites (William Harvey and Queen Elizabeth, Queen Mother hospitals) to support other CCUs overcome staffing shortages. Some staff told us that relocations were taken in turn and shared equally by senior staff, which created a positive attitude amongst junior staff. However one member of staff told us, "There's too much moving around, no-one likes it. We can't even take annual leave unless the other units have said they don't need help – that's not fair, we're employed here, not at the other sites"
- All nursing staff were expected to contribute and encouraged to ask questions during ward rounds.
- The critical care outreach team, which cared for patients with acute pain and those with a tracheotomy, supported the nursing skill mix. Outreach nurses were able to escalate deteriorating patients to the CCU registrar although there was no formal protocol for this.
- Nurses had received training in the use of the transfer trolleys for inter-hospital transfers.
- New staff were given a supernumerary period during their induction. This meant they were not included in the daily staffing numbers. This system enabled and encouraged structured learning and periods of confidence building for new staff.
- Agency nurses were rarely used as short staffing was most often covered by staff from other Trust sites. This was confirmed by the rotas we viewed.

Medical staffing

- There were nine junior medical staff, including six training posts. Non-trainee staff sometimes covered anaesthesia as well as CCU until a consultant started their shift.

- The junior doctors' we talked with felt supported by their consultants and felt there was sufficient medical staff to provide cover for the unit.
- Consultants were available from 8am to 6pm, Monday to Friday and from 8am to 2pm at weekends. The consultant responsible for covering the unit ITU during the day is not expected to undertake other duties. Out of hours cover was provided by consultant anaesthetists which meant that they did not always have the desired critical care training. Consultant cover was available twenty four hours a day in line with the national recommendations.
- Handovers were well organised and each member of staff took it in turns to examine each patient and make notes, including the consultant. Handovers took place twice daily and trainee medical staff were always involved.
- The Consultant patient ratio did not exceed the national range identified as being between 1:8 – 1:15 and the ICU resident/patient ratio should not exceed 1:8.
- Junior doctors were actively involved in the ward round handover and shared jobs with the registrar, such as ordering scans.
- We observed that an emergency rapid sequence induction (RSI) was undertaken with assistance from the senior nurse. Plan A and Plan B were verbally articulated but there was no checklist for RSI.
- Out of hours an CCU general anaesthetic rota provided cover. This was acknowledged in the vision and strategy of the service, where it was acknowledged that more consultants were needed for round the clock cover.
- Anaesthetic registrars provided medical staff training delivering three month modules that followed guidance from the Faculty of Intensive Care Medicine as well as the training standards of the Royal College of Anaesthetists.

Major incident awareness and training

- Staff were spoke with were aware of the major incident plan. All staff had watched a training video and signed a tracking document to indicate they had read the policy.
- Local emergency evacuation plans were clearly displayed and readily available.
- The medical equipment library was not included in the major incident plan and so it was not clear how the need for equipment would be coordinated in such an event.

Critical care

Are critical care services effective?

Good



We have judged the service delivered at Kent and Canterbury critical care unit to be effective.

Care and treatment was provided in line with national best practice guidance and was individualised to the needs of each patient. National Institute for Health and Care Excellence (NICE), Royal College of Surgeons (RCS) and the Intensive Care Society (ICS) frameworks were used to deliver evidence-based care. Data relating patient outcomes indicated that mortality and unplanned readmissions were within the expected levels nationally.

Staff had access to high quality specialist training that was delivered by dedicated clinical educators. There was evidence that patients were cared for by a team with good multidisciplinary working practices. Good practice was followed in obtaining consent and adhering to the requirements of the Mental Capacity Act 2005 (MCA).

Patients had their pain needs assessed and addressed in a timely manner. Feedback from the patients and their relatives and the documentation we viewed demonstrated this.

The unit use a MUST (Malnutrition Universal Screening Tool) to identify patients' nutritional needs. We found evidence that patients were risk assessed, weighted, referred to the appropriate multidisciplinary therapists when admitted to the unit. There was evidence that national guidance was being followed which meant that patients received nutrition as soon as possible.

We found evidence of a multidisciplinary patient centred approach to the care delivered on the unit. This was evidence in the care notes we viewed, conversations with patients their relatives and the staff we talked with. There was a seven day approach to the care delivered on this site with adequate provision of diagnostics, medical reviews and other support services out of hours.

We found a very supportive environment for staff to learn and develop their skills across the three units. There was a strong commitment from the practice educator, university

links and unit mentors to facilitate personal learning and career development. Staff had the opportunity, and were encouraged and supported to acquire new skills and share best practice.

We found ample information available for patients and their relatives available in the unit. Patients received care from competent unit staff.

Evidence-based care and treatment

- The CCU provided care and treatment based on the NICE acutely ill patients in hospital guidance and that issued by the Royal College of Surgeons and the Intensive Care Society.
- The outreach team used Wardwatcher (a tool to collect data for surveillance purposes) to provide three monthly audits of activity by type and location to maximise their efficacy.
- During a handover ward round, staff observed good housekeeping practice with a FLATHUG (an evidence based tool to prevent ITU associated complications) proforma which was completed this at the bedside daily. This included a nursing review of feeding, Feeding, Lines, Analgesia, Thromboprophylaxis, Head up – all patients should be nursed in 30° head-up position unless contraindicated, U – GI (Gastro Intestinal) Ulcer prophylaxis, Glucose and Sedation.
- Staff demonstrated an active awareness of the risks of patient delirium and discussed this for all patients seen during handover. The CAM-ICU tool (is a validated and commonly used score to help monitor patients for the development or resolution of delirium) was promoted more frequently through an active Delirium Group.
- VitalPAC was used routinely to record blood results, (VTE) venous thromboembolism assessments, to track invasive lines and to assess ward able patients. This information was also recorded on paper 24 hour observation sheets and on a body chart in the hospital notes. The medical records we reviewed demonstrated that theses assessments were in place for all patient's.
- A 4.30pm handover took place between the clinical site manager and the on-call medical registrar which was used to plan escalations for patients with a NEWS (National Early Warning Score) of six or above.
- Pan-surgical audit days took place twice each month, which included combined specialty meetings. This

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encouraged audit, audit analysis and learning and development opportunities in the department, as well as presentation and discussion of previous audit outcomes in the department.

Pain relief

- Each patient had their pain needs assessed and these were acted upon. For example, analgesia was prescribed on admission to the unit and Medicine Administration Record charts and observation charts demonstrated that medication was administered and pain scores were routinely measured.
- A patient we spoke to said, “My pain is well managed” and another told us, “I’ve no pain now, I was in agony. They really helped me, nothing was too much trouble, they were superb”
- 100% of respondents in a recent relative’s survey indicated that the pain management of their family member had been ‘excellent’ or ‘very good’.
- We observed that where an epidural was in place, epidural block level observations were in line with trust policy and best practice guidance, with safety precautions in place. For instance, naloxone and IV fluids were prescribed in case of an emergency.

Nutrition and hydration

- MUST risk assessments were in place and patients were weighed on admission. Patients received the most appropriate type of nutrition and hydration dependent on their condition, i.e. NG (Naso Gastric) or TPN (Total parenteral nutrition) and PEG (Percutaneous endoscopic gastrostomy) feeding. HDU patients had access to the regular menu or special diet if required. Patients had their needs assessed regularly by nursing and medical staff and had MDT input into nutritional feeding plans.
- We observed fluid and food intake was recorded as appropriate to ensure the patients were receiving adequate intake. The five records we viewed demonstrated this. The trust’s adult nutrition policy had been updated in March 2015 and had been disseminated to all staff, including those trained to deliver NG tube feeds. This was to ensure that the trust became compliant with NICE and NPSA guidance.
- Patients told us they were very happy with the quality of the food they received during their admission.

Patient outcomes

- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. Results from ICNARC showed that patient outcomes were within the expected ranges but higher than the national average for similar units in some areas. For instance, from April 2014 to April 2015, mortality rates were higher than the national average in three quarters, with mortality rates consistently between 20% and 40%. In all but one quarter in the same time period there were no unit-acquired infections in blood.
- An anaesthetist told us that they contributed to a quarterly report looking at survivors of major trauma. They said that the hospital was third out of 128 hospitals in the Trauma Audit and Research Network (TARN) for survival data. They told us, “We’re very proud of those figures.” We have not been able to verify this claim with TARN due to the low level of submitted data to them from this hospital.

Competent staff

- 53% of the CCU registered nurses had undertaken a post-registration intensive care course, which met the standards of the Intensive Care Society. This included all of the band six and seven nurses. As turnover of staff was low, there were no posts for them to progress into. Staff were therefore supported to seek other appropriate pathways. For instance, one had become a pain nurse and some had been able to join the critical care outreach team.
- All of the staff we spoke with told us they were happy working in the CCU and they felt confident and competent as a result of an intensive, on-going training programme.
- Staff had annual appraisals that they were positive about. One member of staff said, “The appraisals are used to identify training needs and they’re a chance to sit down with someone senior and discuss what’s going well and any issues you’re having.” Three-monthly meetings for band five Registered Nurses (RN) acted as a forum to discuss any issues that had come from supervisions or appraisals. 94% of nursing staff had received an annual appraisal with the remaining staff scheduled to undergo an appraisal imminently.
- Junior doctors we spoke to told us that they undertook invasive procedures using a phased-step approach that included watching and assisting procedures before completing them under supervision.

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- Junior doctors told us their induction experiences were adequate. FY1 grades came in to the hospital one week earlier and FY2 grades were allocated one week per year without patient responsibility to ensure their training was up to date and to facilitate research and audit activity.
- CC outreach nurses were offered ongoing, specialised training by a dedicated learning and development nurse. Courses included caring for the critically ill patient, arterial blood gas interpretation, advanced ECG (electrocardiogram) interpretation, fluid balance and monitoring, respiratory failure and sepsis awareness. Training sessions were offered across all trust sites and some were offered on a drop-in basis to maximise flexibility.
- The CCU had a band four practitioner role in place that staff were very positive about. The nurse in charge said, "This role is a trailblazer for the trust. They are proactive, involved and very knowledgeable; incredibly safe." Another member of staff said, "This role is an excellent asset to us." The individual in this role provided clinical support to senior nurses and had undertaken additional specialist training to enable them to deliver care and treatment to ICS standards.
- As turnover of staff was low, there were no posts for them to progress into. Staff were therefore supported to seek other appropriate pathways. For instance, one had become a pain nurse and some had been able to join the critical care outreach team.
- Study days and teaching shifts were made available to all staff. One member of staff said, "We're asked in advance what we want to work on and training is based around this. The clinical nurse educator's modules are excellent, we're fortunate to be so supported"
- We saw evidence that nursing staff had their registration with the nursing and midwifery council checked annually and medical staff have regular revalidations.

Multidisciplinary working

- We saw a good standard of multidisciplinary working during a ward round. For instance, a member of staff from haematology attended to review the use of the massive transfusion pathway in a patient overnight.
- Physiotherapists did not attend morning ward rounds and instead attended for a briefing each morning to discuss and plan individual care needs.
- Where an inter-hospital transfer was required, a consultant led planned MRIs and a middle grade doctor

dealt with CT (Computed tomography) emergencies. There had been no non-clinical inter-hospital transfers in the year prior to our inspection. In all cases such a transfer would occur only if the skill mix of available staff was appropriate.

- The Medical records we reviewed demonstrated a multi-disciplinary approach to the care delivered. Patients had daily physiotherapy reviews, occupational therapy input as well as dietician and speech and language therapy inputs and reviews.
- The unit offered psychiatry, podiatry and neurologists referrals. They were able to offer these services with these specialists as part of their rehabilitation programme. An outreach nurse we spoke to said that 'communication with GPs was variable and could be difficult for patients who needed a referral to a psychologist.'

Seven-day services

- The unit provided consultant-led care seven days a week. Consultants worked on the unit between eight a.m. and two p.m. at weekends and out of hours cover was provided by consultant anaesthetists.
- A physiotherapist came to the unit on a daily basis Monday to Friday and a pharmacist was available during the same period. Out of hours and over the weekend, an on-call system was in place.
- We found sufficient access to screening and diagnostic services out of hours.

Access to information

- Patients and their relatives were offered detailed information on conditions specific and invasive procedures. This was followed up by the outreach team who used the rehabilitation pathway to give people a continuous level of information on demand.
- We saw an 'information for relatives' leaflet had been produced based on feedback given in questionnaires, including an explanation of what happens in CCU. Staff routinely provided information to patients and their relatives during the admissions process.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

Critical care

- Appropriate MCA (2005) decision-making and consent pathways were in place. We saw evidence of this from the documentation staff used, such as WHO (World Health Organisation) forms and the Sepsis Seven pathways.
- The Medical records we reviewed demonstrated Do Not Attempt Cardio pulmonary Resuscitation (DNACPR) orders were in place, reviewed and discussed with relatives and when possible, with patients.
- Staff told us they were able to obtain an urgent referral within two hours with the psychiatric team and could also engage an independent mental health advocate if needed.
- A DoLS assessment team was available on-call and staff told us they worked well with CCU staff for the critical care perspective.
- 91% of CCU staff had completed informed consent training and an ethics symposium had been held to support staff in understanding the principles of consent.
- Learning difficulties, DoLS and MCA team members were rostered to attend band five meetings to discuss areas of best practice and learning from specific patient cases.

Are critical care services caring?

Good



We have judged the services delivered at Kent and Canterbury critical care unit to be caring.

Staff demonstrated an acute awareness of the physical and emotional needs of patients and their relatives and put this at the forefront of their communication and approach. We saw that staff routinely asked for consent from patients before providing care and they spoke to people with respect and with mindfulness of their dignity.

Emotional support was provided to relatives by the CCU nursing team and various specialist trust wide nurses. The feedback we received was very complimentary about staff interactions and the support provided. Patients and their relatives told us “nothing was too much trouble” for the staff and that they “felt cared for” and “very safe”. One family in particular wanted it noted just how “wonderful, fantastic and hardworking” the CCU team were, and

described the lengths staff went to ensure they were kept informed about their loved ones progress during a very stressful time. They told us “they saved our dad” and “it’s a first class service”.

Discharges to ward areas followed the unit protocol. Patients were discharged with a medical and nursing letter to aid care continuity in ward areas. A full handover was also provided to ward staff when the patients arrived. Their vital signs and test results were stored on the electronic recording system which meant their data was used to aid care continuity. The outreach team also had access to the patients data when they were discharged, which meant they could monitor patients process remotely and intervene if necessary to prevent deterioration.

Compassionate care

- All of the patients and relatives we spoke with told us that they were happy with the compassion and approach of staff. A relative we spoke to said, “There are no words I can use to tell you how wonderful everyone has been, the staff have gone out of their way and they are always smiling.” A patient told us, “The staff were so understanding and went above and beyond their roles to make a difference”
- On reviewing five medical records we saw that patients were given individualised care. For instance, a nurse had noted that they had not changed a patient’s dressing as it was more important for them to sleep properly for the first time in several nights. Patients had also been able to have their hair washed, which greatly improved their comfort
- Staff demonstrated an acute understanding of the need for compassion and kindness. One member of staff said, “What’s better than chocolate or a card is seeing the patients walk back into the unit, fit and well, it’s the best thing about the job”

Understanding and involvement of patients and those close to them

- During the inspection we observed all staff introduced themselves to the patient and explained what they were doing during a ward round.
- Patients and relatives told us they were happy with staff communication. A relative said, “They ring me to tell me

Critical care

how he's doing and nothing is too much trouble." A patient told us, "We get perpetual attention from the doctors and nurses and there is nothing I would change about the way I was cared for"

- On reviewing five medical records we found that relatives had been regularly involved and updated on the care their loved ones received in the unit.
- Staff offered diaries to patients or their relatives where the individual had been ventilated for three days or more. An excellent, informative information pack was available to relatives to explain the purpose and importance of patient diaries. The diaries can be used to aid patients' memories and help with PTSD (Post Traumatic Distress Disorder).

Emotional support

- Patients and relatives told us they were happy with the level of emotional support they received from staff. A patient told us, "I've had remarkable care from home to here" and another patient said, "Staff were friendly, happy and helpful."
- Comments from patients and their relatives included words like: Respectful, Love, Care, Excellent, Welcoming, Professional, Friendly, Dedicated, Thank you.
- There was an established pathway in place for staff to refer patients to psychologists for specialist support if needed. Emotional support was also embedded in the assessment that people receive prior to their discharge, for the outreach team's rehabilitation programme.
- The chaplaincy service was also involved in providing emotional support to patients and their relatives.

Discharge and handover to other wards

- We observed that new CCU discharge paperwork had been introduced on the unit. The FY2 doctor was responsible for writing the discharge letter, which was structured and checked by a consultant.
- Outreach nurses were able to support the transfers of level three patients at times.
- Staff told us that they used an electronic discharge summary as well as a verbal handover and a discharge summary written by a junior doctor to discharge patients from the CCU to a ward.

Are critical care services responsive?

Good



We have judged the services delivered at the Kent and Canterbury critical care unit to be responsive.

The care delivered was found to reflect the needs of local people. It was also found to reflect people's individual needs. This was evidence from the medical records we viewed and the conversations we had with patients' and their loved ones.

The unit provided a rehabilitation programme post-discharge that was evidence based and tailored to the needs of each patient. There was a geographical separation between the CCU and HDU that was managed appropriately and in a way that minimised risk to patients. Bed occupancy was reported as being high. The staff ensured they met the individual needs of people through effective planning and using staff skills appropriately. National recommendations for unit occupancy is currently set at 85% which meant that the unit was continuously exceeding this target and exceeding this may pose infection risks to patients'.

A robust and accessible complaints process was in place and we found evidence that it had been used appropriately to investigate and resolve and learn from complaints. Data we viewed demonstrated that high satisfaction rates with the service delivered. The unit had low levels of complaints and staff were able to demonstrate learning actions from past investigations.

We found evidence of a well-established and effective bereavement service in operation.

Service planning and delivery to meet the needs of local people

- There was a trust-wide rehabilitation of critically ill patients led by a CC outreach sister. This was a six-week programme of one-hour sessions that included a full assessment followed by exercise, discussion sessions, emotional support and the use of patient diaries.
- If a patient was not able or did not want to attend a group class, staff were able to offer one-to-one support.

Critical care

- The CC outreach sister told us that sessions were individualised to patient need and they were able to attend for as long as they wanted, with the flexibility to invite relatives to accompany them recent sessions covered included.
- Staff we spoke to told us they used a Critical Care Rehabilitation Pathway document to ensure all patients were assessed appropriately before being discharged or transferred to another ward. Between April 2015 and June 2015, between 80% and 98% of patients each month had received a rehabilitation assessment prior to their discharge.

Meeting people's individual needs

- A learning difficulties pathway was in place and a link nurse was available. This included an established process for referring patients with more than three annual admissions, or four annual admissions from the Accident and Emergency department, to the community learning difficulty team.
- Patients told us that they were happy with the care they had received. One person said, "I've had great care, they saved my life." A patient also wanted to tell us how staff had taken the time to explain their options to them. They said, "I didn't want surgery but the doctor was fantastic and told me why I needed it, I'm now grateful to him, as I was just scared"
- Although the HDU unit was slightly isolated from the main CCU area, it was used as a step-down unit before patients were transferred to wards. Staff told us that this worked well and that it had psychological benefits for patients and their relatives.
- We found that staff provided excellent bereavement support to relatives. This included a specific bereavement pack that was provided for relatives and includes information on health and wellbeing of the relatives, support groups, bereavement register forms and a list of suggested organisations which need to be notified of a death. There is also a notification of death form which needs to be filled out once and used to inform a range of organisations. This meant that relatives were spared the emotional upset of repeated form filling.

Access and flow

- Staff we spoke to told us that the HDU was used at times as a step down for long-term CCU patients, which freed up level three beds for more complex patients.

- A senior charge nurse told us that the HDU was never used for level three patients and that during times of exceptional overflow, the paediatric recovery area would be used and staffed by CCU nurses.
- An Enhanced Peri-Operative care for High-risk patients (EPOCH) trial for bed capacity had been highlighted to the trust by the critical care lead as a strategy to improve flow.
- In the six months before our inspection, 261 patients had been discharged, of which 107 were delayed. Less than half of the delayed discharges were under 24 hours and there had been relatively few night time discharges.
- We reviewed audit data received from the trust, in the year before our inspection, there had been one month where admissions were delayed by over four hours.
- No non-clinical transfers had taken place in the year leading to our inspection.
- In each month between February 2014 and February 2015, bed occupancy had been at or above 65% and in one month occupancy was at 100%. Length of stay in the same period was at or below the national standard, with the mean length consistently between 3 and 5 days.
- A standardised admissions and evaluation documented process was used for all patients admitted to the unit.
- Data demonstrated very low numbers of elective surgery cancelled due to lack of CCU beds. When the data was reviewed in detail the cancellations appeared to be for other reasons outside of the unit's control.

Learning from complaints and concerns

- There were no active complaints in the unit at the time of our inspection. We found that previous complaints had been managed and resolved effectively, for instance, by moving staff or checking levels of skill competency.
- Where a complaint had required an investigation, this had been completed in detail and by appropriately qualified staff. Complainants were able to use a health complaints advocate and complaints were handled in line with the NHS Complaints Policy.
- Feedback from complaints investigation was shared with staff at staff meetings. This was evidenced in the meeting minutes we reviewed.

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- There was information displayed and in booklet form available to patients and their relatives which explained how to make a complaint. There was also support provided from the PALS (Patient Advice and Liaison Service).

Are critical care services well-led?

Good



We have judged the critical care unit at the Kent and Canterbury critical care to be well led.

The unit had its own vision and strategy that was established with input from staff. However, staff told us of the uncertainty they faced because they were unaware of how their unit fitted into the trusts vision for the future. Staff told us they felt anxious about the future and feared a critical care service reconfiguration.

We found evidence of effective governance and risk management processes. Staff were aware of these processes and had confidence in their function and were aware of actions taken as a result of using the escalation concerns via these channels.

There was an established, efficient and well-respected leadership team in the unit. Staff we spoke with were eager to tell us, unprompted, how positive they felt about working in the CCU. They also told us they felt very supported by the senior staff who were described as approachable and effective managers. A robust escalation process was in place for any member of staff experiencing difficulties or concerns. Staff felt confident they could raise concerns and had these dealt with in an open and transparent manner.

The senior staff team was visible on a daily basis and they were involved in the work of their team. Staff told us they felt listened to and were comfortable in making suggestions or raising concerns. They also told us of the pride they felt about the culture in the unit and the indicative overall drive for excellence. We found areas of innovation in the management and leadership strategies of the unit, alongside a culture that encouraged staff to perform well.

The unit had effective systems in place that encouraged staff and public engagement.

Vision and strategy for this service

- In August 2014 a consultant intensivist and a consultant nurse established a strategic vision for the CCU. This strategised the unit's future to overcome known staffing problems and to ensure that the unit was compliant with the standard of the Intensive Care Society and the Department of Health.
- Staff told us that they were aware of the vision and the wider strategy of the trust and that they felt involved in this and able to make suggestions or comments if they wanted to.
- We found that there was a focus on maintaining the quality of care offered by the service by ensuring that future staff were appropriately inducted and trained. For instance, staff were concerned that a high level of future retirement would leave the CCU understaffed. As a strategy to mitigate this, an education and academic link nurse were both in post to offer consistently good training and experiences to nursing students.

Governance, risk management and quality measurement

- During a morning handover we noticed that a smart card had been left near a computer in CCU unattended. This meant that data protection standards were not always adhered to.
- There was a critical care steering group in place, through which staff were encouraged to remain up to date on CCU protocols, which were readily available electronically. The group also produced minutes that included a list of audits to date.
- Meeting minutes we viewed demonstrated that service risks were identified and reported and acted upon. Information was passed to the multidisciplinary critical care steering group and the surgical division governance board when appropriate.
- There had been attempts to standardise care across the three trust sites but more work was needed in some areas. For example, a standardised weaning protocol was not in place and the checking of NG tube placement and inotrope infusion mixes were not standardised. Following our inspection, the chief executive of the trust provided evidence that the standard operating procedure for the use of x-rays to check NG tube placement was made to be compliant with NICE guidance across the trust.

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- From looking at the minutes of meetings we found that there was good governance and risk management practices in the unit. Staff we spoke with were aware of the function of governance and the importance of risk management and learning.

Leadership of service

- We found evidence of a strong and proactive leadership in the unit.
- Staff told us that they were aware of the new Chief Executive (CEO). One individual described him as “friendly”. A member of staff also said, “There is a good team working at K & C”
- Staff were able to tell us about the escalation process they would follow if they were unhappy about something. One person said, “I’ve never had to escalate anything in 15 years. Issues are dealt with locally very effectively.” Another said, “The matron is great – she spent time reflecting with me and offered a very caring debrief after a death.”
- Staff told us that the matron was consistently visible on the unit and that the clinical nurse educator regularly helped out. One member of staff said, “There’s an open reporting culture here, the matron is always open, she’ll go out of her way to help. The senior nurses too, they’re a lovely bunch.”

Culture within the service

- Communication between staff of all grades was very good. Consultants, band seven nurses and a clinical nurse educator met every three months to ensure the continuity and sustainability of the service.
- Although staff regularly worked across hospital sites within the trust, we found that integration of band five and six nurses in the hospital could be improved.
- Band five RN ‘s told us that annual study days were used to air grievances, share good practice and that in general they were very positive experiences. One person said, “I’ve never been aware of bullying here. People are generally happy to work here and we have a great team – staff from other units want to come and help out.”
- We found that a culture of safety was embedded in the service. For instance, staff told us, “There’s a general culture here of second-checking everything. We’re all aware of our own competence and wouldn’t do anything we don’t feel comfortable with.”







Public and staff engagement

- Attendance and engagement with the Critical Care Network was poor. The critical care lead told us that a new consultant from another hospital at the trust would formally take on the role of trust link for this.
- Staff told us that they were able to influence the running of the service and as a result felt that they could work to the best of their ability. For example, staff sent on long transfers said they were often left hungry for long periods. As a result, a lunch box containing snacks was kept inside the transfer trolley to ensure that staff were not left without sustenance.
- Results of a staff survey in CCU were prominently displayed and showed that 99% of staff were positive about working there. Comments from the survey included, “I feel appreciated for my work” and “I am recognised for my contribution and commitment”
- Staff were recognised and rewarded for their commitment. One member of staff had been able to attend the British Critical Care Association conference as a reward for their attendance record.

Innovation, improvement and sustainability

- The CCU used the THINK campaign to reduce the amount of drug errors. This encouraged staff to think about the following process; Person, Medication, Reason, Dose, Time, Route, Documentation and Response.
- A member of staff had been trained as a ‘We Care Champion.’ This meant that staff who had concerns or worries could approach them in confidence. They would then act as a liaison between human resources and senior managers and offer one-to-one support to the member of staff, including techniques to help such as encouraging the person to keep a reflective diary. To maintain confidentiality, the CCU champion would act as a contact for staff in different units and CCU staff could contact any champion outside of their own unit.
- The investigation of staffing issues was excellent. For instance, a nurse had been able to attend an assertiveness course after a discussion found that they had been intimidated by the knowledge of more senior staff.

Services for children and young people

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

Information about the service

The Kent and Canterbury Hospital (KCH) children and young people's service has a purpose built children's assessment centre. The centre offers children and young people outpatient appointments or day surgery. Children may be referred by a G.P to the centre for observation and assessment.

The centre has a range of facilities for children, young people and their families. Services included: Dolphin ward ambulatory unit; day surgery; and a variety of child development services including community paediatricians, physiotherapy, speech and language therapy (SALT), occupational therapy (OT), and psychiatry. Facilities at the centre include a gym, a multi- sensory room and parents' resource room. There are also four clinic rooms.

Dolphin ward, the children's assessment unit (CAU) is open Monday to Friday from 8.00am to 5.00pm. It has a five bedded medical ward and a five bedded surgical ward with a high dependency unit (HDU). The CAU provides care for children and young people between the ages of 0-15 years. The unit meets the needs of children who require on-going assessment or short stay treatment, who are then able to be discharged home rather than being referred for inpatient admission.

Children are seen in other areas of the hospital such as the emergency care centre (ECC), main theatres and outpatients. The ECC offers children emergency care between 9am and 4pm Monday to Friday. Outside these

hours and at weekends' children are taken to A&E departments at William Harvey Hospital (WHH), Ashford, or Queen Elizabeth The Queen Mother (QEQM) Hospital, Margate.

The K&C urgent care centre (UCC) offers a twenty four hour, seven day a week service providing treatment for children and young people with minor injuries.

The CAU provides open assess for children to attend when referred by their GP, the community nursing service or other healthcare providers. The outpatients clinics held in the centre include a consultant-led clinic for general paediatric conditions, a registrar-led paediatric baby clinic for six to eight week old babies and eye clinics conducted by specialists in different eye disciplines.

We spoke with five parents and one child and with six staff, including doctors, nurses and support staff. We observed care, case-tracked two patients and looked at patients' care records. We reviewed other documentation, including performance information, provided by the trust. We received comments from parents and from people who contacted us to tell us about their experiences.

Services for children and young people

Summary of findings

Staff understood their responsibilities to raise concerns and report incidents and were fully supported by the trust when they did so. The children's and young people's service had systems in place to ensure that incidents were reported and investigated appropriately. Processes were in place for lessons to be learned and these were communicated widely to support improvement in other areas as well as services that were directly affected.

The trust was using the Kent safeguarding children's board procedures; but had not produced a trust safeguarding children policy. Staff worked effectively with others to implement protection plans. There was active and appropriate engagement in local safeguarding procedures and effective working with other relevant organisations.

The children's assessment unit (CAU) had been designed and built with children in mind. The ward areas provided a safe environment for children and families which were effective for cleaning and maintenance.

Staffing levels and skill mix were planned, implemented and reviewed to keep children and young people safe at all times.

Risks to children and young people were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies. Staff recognised and responded appropriately to changes in risks to children and young people who use services.

Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations.

Feedback from children, young people and their families who use the service was consistently positive about the way staff at CAU treat people. The friends and family test (FFT) results were consistently favourable in regards to services at CAU.

There was a strong, visible person-centred culture. Staff we spoke with were motivated and inspired to offer care that was kind and promoted children, young people, and their families' dignity. Relationships between staff, patients, and their families were caring and supportive.

Staff took patients and their families' personal, cultural, and social needs into account.

Staff were fully committed to working in partnership with children, young people and their families and making this a reality for each patient. Staff always empowered patients and their families to have a voice and to realise their potential. Children, young people, and their families' preferences and needs were always reflected in how care was delivered. Children, young people and their families' social needs were highly valued and embedded in their care and treatment.

Children and young people's needs were met through the way services at the KCH CAU were organised and delivered. Children and young people's services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services provided.

The needs of different children and young people were taken into account when planning and delivering services. Children and young people's care and treatment was coordinated with other services and other providers.

Reasonable adjustments were made and actions were taken to remove barriers when children and their carers found it hard to use or access services.

The values for children and young people's services had been developed with elements such as compassion, dignity and equality. However, there was no long-term vision or strategy in place for children and young people's services. The trust had conducted a recent strategic review of children and young people's services, and concluded that the proposed strategy of children and young people's services operating from one site was not viable. At the time of our inspection there was no decision pending on what the vision or strategy would be for children and young people's services.

Services for children and young people

Children and young people's staff were unaware of the trust's strategic goals for children and young people's services as the trust had not made a final decision about the future strategy for the service.

The board and other levels of governance within the organization had undergone changes in the past 12 months. The chief nurse and director of quality had been instated as the children and young people's services lead. The service's structures, processes and systems of accountability were set out and understood by staff.

There was an effective process in place to identify, understand, monitor and address current and future risks. Performance issues were escalated to the relevant committees and the board through clear structures and processes. Clinical and internal audit processes were in place.

The leadership was knowledgeable about quality issues and understood what the challenges to children and young people's services were, and were taking action to address them. However, face to face monitoring at KCH CAU was a challenge due to the matron being based at QEQM.

Leaders at every level prioritised safe, high quality, compassionate care and promoted equality and diversity. The culture change programme encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.

There was evidence that the leadership had introduced processes that would actively shape the culture through effective engagement with staff, people who use services and their representatives and stakeholders. Senior leaders encouraged a culture of collective responsibility between teams and services. But, these processes were not embedded.

The children's and young people's service was proactively engaging with and involving all staff to ensure that the voices of staff were heard and acted on. The leadership actively promoted staff empowerment to drive improvement and a culture where the benefit of raising concerns was valued. Safe innovation was being supported and staff had objectives focused on improving the culture of the trust.

Are services for children and young people safe?

Good



Staff understood their responsibilities to raise concerns and report incidents, and were fully supported by the trust when they did so. The children's and young people's service had systems in place to ensure that incidents were reported and investigated appropriately. The service had not had any serious incidents (SI) in the previous 12 months.

The trust was using the Kent safeguarding children's board procedures; but had not produced a trust safeguarding children and young people's policy. Staff worked effectively with others to implement protection plans. There was active and appropriate engagement in local safeguarding procedures and effective working with other relevant organisations.

Staffing levels and skill mix were planned, implemented and reviewed to keep children and young people safe at all times.

Risks to children and young people were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies. Staff recognised and responded appropriately to changes in risks to children and young people who used services. Plans were in place to respond to emergencies and major situations.

Incidents

- The children's and young people's service had systems in place to ensure that incidents were reported and investigated appropriately. We did not review any serious incident reports during our inspection, as the service had not had any serious incidents (SI) in the previous 12 months. The senior matron told us they reviewed all incidents that were flagged as moderate or above on the trust's electronic incident recording system. Moderate incidents would have a root cause analysis (RCA) completed as part of the investigation of incidents. The senior matron told us they monitored incident reports for themes and to ensure incidents were investigated promptly. Identified learning from incidents and lessons learned from incidents would be

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shared across teams. For example, as a result of one incident involving a delay in the time Ametop gel was applied to a child's skin, (Ametop is a local anaesthetic that numbs the skin), procedures had been changed so that all children would have the gel applied on arrival for theatre.

- All the nursing and medical staff we spoke to stated that they were encouraged to report incidents via the electronic incident recording system. We viewed the trust's incident log and saw that actions had been addressed and actions were being recorded in a timely way. Reports provided by the trust showed that a total of 24 incidents had been reported between 1 January 2015 and 30 April 2015. Incidents were monitored by the senior matron for trends. Incidents were standard agenda items at children's and young people's departmental governance group meetings.
- The trust had produced a comprehensive action plan that provided guidance for staff on actions that should be implemented following an incident.
- The children and young people's service held monthly departmental governance meetings. Safety and risk were standard agenda items at the meetings. The meetings were attended by a staff representative from each children and young people's service area from across the trust. Where incidents had been reported a full investigation had been carried out and steps were taken to ensure lessons were learnt. Action plans were produced following investigations. These were monitored and tracked to completion at subsequent meetings. Staff told us that learning from incidents was cascaded to ward staff at team meetings.
- Staff told us they understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns. Staff confirmed that they received feedback on incidents that took place in other areas of the service as well as their own. Staff and managers told us they were satisfied there was a culture of reporting incidents promptly within children's and young people's services. Incidents were audited on the trust's electronic reporting system.
- Staff we spoke with told us they would be alerted to patient safety alerts by email. Staff told us children and young people's services would take action to respond to relevant alerts. The senior matron told us alerts would

be discussed at departmental governance meetings. Staff described how completed actions would be reported to the Department of Health's (DOH) central alerting system, (CAS). We did not see any completed actions during our visit.

- We looked at the clinical governance arrangements for reporting risk and found that the children and young people's services risk register was site specific. For example, there were a number of trust wide risks identified as well as risks in other trust locations. The register did not have any identified risks relating to services offered by KCH CAU on the register.
- Staff and managers we spoke with were aware of and able to explain the duty of candour. There is also a contractual duty of candour imposed on all NHS providers of services to 'provide to the service user and any other relevant person all necessary support and all relevant information' in the event that a 'reportable patient safety incident' occurs. Senior staff told us they had not had reason to use the duty of candour since its implementation in November 2014.
- Mortality and morbidity meetings were held monthly as part of the children and young people's audit meeting. All junior doctors, consultants and nursing staff were invited to the meetings. A schedule of cases for each meeting was planned and any actions required were identified and recorded. Learning was shared across the various medical, nursing and other professional scheduled meetings.

Safety Thermometer

- The trust was using the NHS Safety Thermometer. This version does not relate particularly to the safe care of children as it refers to pressure area care, falls, urine infection and embolism rates. The safety thermometer results demonstrated that in these categories for the 12 months prior to our inspection children and young people's services had been 100% harm free. The senior matron told us children and young people's services were in the process of introducing the paediatric safety thermometer.
- The trust used a balanced score card to monitor services. The balanced scorecard is a strategic planning and management system that is used to align business activities to the vision and strategy of the organization, improve internal and external communications, and

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monitor the organizations safety and performance. We viewed the trust's balance scorecard for the past 12 months. The information was not specific to KCH but provided assurance that across the trust's children and young people's services staff sickness rates were within expectations and there had been no 'never events' reported on the strategic executive information system (STEIS). STEIS is a national reporting framework for the reporting and learning from serious incidents.

- The trust informed us that children and young people's services were benchmarked at KCH by the friends and family test (FFT).

Cleanliness, infection control and hygiene

- We viewed the staff training record and saw that 100% of staff at KCH CAU had received up to date training in infection prevention and control.
- A private company was contracted to provide cleaning services across the trust. The CAU and day surgery were housed in a new purpose built building. All the areas of KCH we visited looked clean and tidy.
- Monthly infection control audits were undertaken by the matron. We viewed the May 2015 'hygiene code environmental audit' for Dolphin ward. We saw that services were meeting national institute for clinical excellence (NICE) standards for infection control. There were effective arrangements in place for the storage, handling, and disposal of clinical waste. This demonstrated that infection control was prioritised at KCH and children and young people were provided with care and treatment in a clean environment.
- We saw that checklists were used to verify that designated cleaning tasks had been completed. At the time of our visit, children's and young people's services were achieving trust standards for hand hygiene. The service was also achieving compliance with NICE national specifications for cleaning. We saw that personal protective equipment (PPE) including gloves and aprons were readily available and used by staff.
- Hand washing facilities and hand sanitising gels were readily available. 'Bare below the elbow' policies were adhered to. The importance of all visitors cleaning their hands was publicised in all the CAU and main hospital areas we visited.
- There had been no reported cases of clostridium difficile (C. diff) or methicillin-resistant staphylococcus aureus (MRSA) for children's and young people's services across the trust in the past 12 months.
- There were suitable arrangements in place to support staff with infection control issues. An infection control link nurse provided support to staff.
- We viewed the trust's infection prevention and control (IPC) policy. This included a manual that provided guidance for staff on IPC, including guidance on the collection of clinical specimens. The IPC policy had been reviewed and updated in May 2015.
- We noted each clinic and treatment room had a separate hand washing basin with hand wash and a dispenser for disinfectant gel. We saw staff regularly washing their hands and using disinfectant gel between patients.
- However, we noted the dispenser in the corridor next to the reception area was installed too high and not easily reachable by people of small stature or people using a wheelchair. The child health matron said this issue had been raised and would soon be remedied.
- Staff wore clean uniforms with arms bare below the elbow, as required by the trust's policy.
- Staff wore personal protective equipment (PPE) such as disposable aprons and gloves when required. Staff changed the paper towel on the bed trolley in-between patients.
- There had been no recent cases of Clostridium difficile or MRSA infection.
- There was a lead nurse for infection control, who ensured staff adhered to the hygiene code of practice and the trust policy on infection control.
- The premises were cleaned daily by domestic staff from a contractual company and there was a regular cleaning audit by their quality officer and a member of staff. Staff said prompt action would be taken to remedy any cleaning problems found. Areas checked included all the clinical rooms, waiting and play areas, staff locker rooms, toilets, bathrooms, sluices and the clinical waste disposal facility.

Mandatory training

- We viewed the children and young people's services training spreadsheet. We found that 100% of paediatric staff and 85% of staff on the CAU had completed mandatory training in fire safety. 100% of staff at KCH

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CAU had completed mandatory training in: moving and handling; health and safety; information governance; infection prevention and control; and safeguarding children and young people. 85% of staff had up to date training in equality and diversity. This meant children and young people could be sure that staff had the necessary training in the trust's processes and practices.

- Staff we spoke with confirmed that they were up to date with training. Staff told us the matron and ward managers monitored staff training and would prompt staff that needed to update training.
- Staff we spoke with confirmed they had received an annual appraisal in the past 12 months. The trust's balanced scorecard indicated that across children and young people's services over 90% of staff had received an up to date appraisal.
- Members of staff interviewed said they had received mandatory training in topics such as moving and handling, infection control and safeguarding vulnerable adults and children. For new staff these topics were included during the induction period.
- Staff said they were given two days to attend training and were also able to access e-learning to update themselves on topics which included safeguarding; and equality and diversity.
- All staff had been trained in paediatric immediate life support (PILS) which included simulation training.

Safeguarding

- Staff we spoke with understood their safeguarding responsibilities and knew what to do if they had concerns. 100% of staff had up to date training in safeguarding children and young people.
- The children's safeguarding meeting minutes 1 July 2015 recorded that all children's safeguarding policies and procedures had been reviewed and updated. The trust was using the Kent and Medway procedures for safeguarding. The trust informed us that the Kent and Medway procedures had been created following extensive collaboration with all partner agencies, and the trust had participated fully in their compilation and updating. We saw that these were available on the trust's intranet, and were based on best practice and local safeguarding protocols. However, the trust did not have a safeguarding policy that was specific to the trust,

that provided trust specific guidance for staff working at K&C or across the trust. This meant staff would not have access to a children and young people's safeguarding policy that was specific to the trust.

- Staff on the wards had access to the contact details of the local authority safeguarding team for out of hours safeguarding advice or to report concerns. The trust had information sharing protocols in place with the local authority.
- The trust employed children's safeguarding lead nurses who worked with wards and departments, raising awareness and offering support, advice and resources where necessary. Each safeguarding lead nurse worked collaboratively with other health and social care organisations.
- We spoke with the trust's safeguarding lead nurse who told us work was in progress in training all staff to an appropriate level as set out in the intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff, 2014'. The trust had an action plan in place to ensure compliance with the intercollegiate guidance. We viewed minutes from the trust's children's safeguarding meeting dated 1 July 2015. These recorded that the trust was in the process of conducting a gap analysis to ensure that staff across the trust received safeguarding training to the appropriate level for their role. The target date for the completion of training was the end of the year. The safeguarding lead told us the gap analysis figures were fed back monthly to the trust's board.
- The trust's safeguarding lead told us the trust's safeguarding training and practice was based upon the Kent Safeguarding Children's Board (KSCB) policies and procedures. This included recommendations from 'Working together to safeguard children, 2015'. The safeguarding lead nurse told us they were a member of the KSCB learning and development group.
- The trust had recently identified a named consultant for children's safeguarding. The trust's children's safeguarding lead was a qualified midwife and registered nurse. There were also named children's safeguarding leads at all the trust's hospital sites. Staff we spoke with told us they would liaise with the safeguarding lead if they had safeguarding concerns.

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- The safeguarding lead told us children who were known to have safeguarding concerns would be flagged on the patient admissions system (PAS) to alert all staff who came into contact with the child.
- The trust was in the process of rolling out training to safeguard women or children with, or at risk of, female genital mutilation (FGM) and trafficking as part of the trust's child sexual exploitation training. Child sexual exploitation was a standard agenda item at the trust's children's safeguarding meetings. However, the trust did not have specific guidance available to staff on FGM, and were relying on staff accessing information from the Kent and Medway safeguarding children's board website.
- Access to children's wards had key codes on all access doors. We saw the CAU receptionist checking people's identity and appointments on the trust's system. The receptionist had a clear view of the CAU entrance and the patient waiting area. This meant the CAU was taking action to minimise the risk of abduction to children and young people.
- The trust worked in partnership with statutory agencies such as the local authority and police to safeguard vulnerable children.
- Both paediatric registrars and nursing staff had received training in safeguarding vulnerable adults and children to the required level three. Supporting staff confirmed they had been trained to level two.
- Staff were able to describe the referral process for alleged or suspected child abuse and knew the names of the safeguarding lead and those within the safeguarding team.
- We visited the day surgery theatres. These were modern, bright, purpose built theatres. The day surgery theatres were next door to the children's day unit and had child-friendly dedicated paediatric recovery bays.
- We walked the patient journey from the CAU to the main theatres. We saw that the corridors were bright and well maintained. The main theatres had a waiting area for parents so that they could wait for their children outside the recovery bays. There were two designated paediatric recovery bays that had child friendly décor and were well equipped.
- Age-appropriate resuscitation and emergency equipment was available for staff across children's and young people's services. Daily safety check protocols for emergency equipment were in place and up to date. All equipment in use had been appropriately checked and cleaned and had been serviced regularly. The resuscitation trolley was checked daily and staff signed the checklist form after each daily check.
- The CAU areas had an ample supply of appropriate toys that could be cleaned safely. We did not see the toy cleaning records; but a HCA told us they cleaned toys daily.
- An established audit programme was in place for reviewing infection control and cleanliness in clinical areas.
- The CAU unit had received an environmental audit by the matron in May 2015. We saw that action had been taken to address environmental and infection control risks. For example, the audit identified that paper work had been stored on the floor in the linen cupboard. Actions had been identified to remove the paper and a member of staff had been designated to carry out the work. During our inspection we saw that the paper in the linen cupboard had been removed and the linen cupboard was being used for its intended purpose.

Environment and equipment

- The CAU had been designed and built with children in mind. The ward areas provided a safe environment for children and families which were effective for cleaning and maintenance. Staff had access to age appropriate recovery equipment for children following surgery.
- Entrances to all children's ward areas and clinics were secure, entry was granted by a member of staff at the CAU reception. The environment was secure for patients. Entry to the unit was via swipe cards for staff.
- The service had an equipped gym and sensory room on-site. We did not see any children or young people using the gym or sensory room during our inspection.

Medicines

- The trust had a paediatric lead pharmacist for children and young people's services that staff could liaise with and ask for advice.
- Medicines were stored safely with room and fridge temperatures checked regularly and recorded. We viewed records medicines were being stored at the

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required temperatures. All the drug store cupboards were locked and controlled medicines were stored in separate locked cupboards. Where medicines required refrigeration, fridge temperatures were checked daily.

- Children's weight was clearly documented and prescriptions were appropriate for the child's weight. We viewed nine children's medicine administration records (MAR). Children and young people's allergies were clearly recorded in their medical records.
- Children's and young people's medicines were audited on a quarterly basis by the trust's pharmacy.
- Nursing staff told us their training in medicines administration was up to date. Nursing staff were aware of policies on the administration of controlled drugs and the Nursing and Midwifery Council's Standards for Medicine Management.
- All medication errors were reported as incidents, recorded on the electronic system, investigated and reviewed at the monthly governance meeting. Staff were open and reported medication incidents. We saw evidence that these were investigated, and staff involved in incidents were seen on an individual basis, during which they were asked to reflect on the incident. Where the incident was a prescribing error, senior medical staff were informed and the error was followed up with the doctor concerned.
- Medicines were stored safely and securely in a lockable medicines cupboard in the treatment room, which was locked when not in use.
- There were no controlled drugs in use. Staff adhered to the trust medication policy and procedures.

Records

- Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept confidential on Dolphin ward and the clinics we visited.
- We viewed the staff training record for KCH CAU. We saw that 85% of nursing staff and 100% of administrative staff had up to date training in information governance.
- We looked at three sets of notes on Dolphin ward; we found them to be accurate and legible. Staff told us patient Information was easy to find.
- Documentation for admitting patients and assessing needs and risks was child-centred.

- Leaflets explaining patients' rights to access their medical records were available on the ward. The trust's website carried information on people's rights under the Freedom of Information Act 2000.
- We viewed the trust's audit report for March 2015 and saw that an audit of note keeping in paediatric therapies was scheduled to be included on the 2015-16 audit plans.
- We found children and young people's records had been maintained by both doctors and nurses within the CAU. We randomly checked three records. We were also shown the patients' electronic records. We found these records had been completed appropriately.
- All patients' clinical notes and confidential information were kept in locked cabinets within the CAU treatment room.
- For patients requiring transfer to a hospital, risk assessment forms such as for pain management and additional observation charts such as the paediatric early warning score PEWS charts were used to identify critical conditions needing medical intervention.

Assessing and responding to patient risk

- The trust used the PEWS to enable staff to recognize "at risk" children and to trigger early referral to medical staff, to ensure early intervention and to prevent deterioration. The trust had produced age appropriate PEWS charts. Each chart had age specific values on the back which were used to generate a PEWS score, and assist staff in assessing risk. This meant staff were enabled to recognise changes in risks to children and young people and respond appropriately.
- We saw appropriate care pathways were in use and were in keeping with the relevant clinical or nursing guidance. For example, we viewed the guidance 'guidelines for the use of PEWS in the ECC minor injuries unit (MIU) to facilitate safe transfer of children to the Emergency Department'.
- The trust used paediatric assessment tools (PAT). These were used to triage children and young people's pathway through the service, including the emergency department (ED). Children were triaged against the appropriate pathway and given a red, amber, green (RAG) rating, to assist staff in prioritising patients. These included: rash assessment tool; respiratory assessment tool; fever and convulsions assessment tool for children aged two years and over; respiratory assessment tools

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for children aged two and over; and a febrile child assessment tool. Guidance directed staff that all children should be triaged against the appropriate pathway and their RAG rating documented in their case notes. Records we viewed confirmed staff were following guidance and recording in accordance with the guidance.

- Staff on Dolphin ward told us the ward occasionally stayed open later than 5.00pm to facilitate discharge and avoid the need for overnight transfers of patients to inpatient wards at WHH or QEQM hospital. This meant some children could be discharged home, rather than staying overnight in hospital.
- Senior staff told us that the biggest risks for children and young people's services were the children and adolescent mental health service and looked after children. Both of these risks were identified on the children's and young people's risk register; actions had been identified to minimise the risk.
- We spoke with staff on the day surgery who told us that if following surgery or assessment the general health of a child deteriorated, the child would be transferred to either WHH or QEQM hospital or to an outside specialist hospital. We viewed the trust's 'patient transfer and escort policy'. We saw this provided staff with guidance on transferring a child or young person from KCH to other trust sites.
- The CAU had a paediatric registrar on site Monday to Friday (09:00-17:00 hours) to see patients referred by family doctors, community nurses and other healthcare professionals. This meant that patients had been seen promptly by the paediatrician, who was supported by a nurse.
- When a patient arrived at the CAU, the nurse saw the patient first and carried out general observations, including the patient's blood pressure, pulse, temperature, weight and height. There was regular monitoring using the PEWS chart and pain chart, as required. The PEWS chart used depended on the age of the child: less than 1 year, 1-5 years, 5-12 years and over 12 years. It was used to help staff recognise a deteriorating patient.
- Patients were seen and assessed by the paediatrician registrar, who gave the required treatment accordingly. If the patient required admission to the hospital, arrangements for transfer were made promptly.

Nursing staffing

- At the time of our visit staffing levels were adequate, as was the required skill mix. Staffing levels conformed to the Royal College of Nursing (RCN) guidance 'defining staffing levels for children and young people's services' 2013. There was a minimum of two registered children's nurses at all times in all children and young people's areas. We viewed staffing rotas for the previous month that confirmed this.
- We viewed the children and young people's child health dashboard. This recorded that across the trust, children and young people's services were achieving 96% of rostered staffing levels.
- All nursing staff on the CAU were specialist children's nurses. Dolphin ward rostered five or six nurses per shift with a health care assistant (HCA) to support both clinical and non-clinical activity. The trust used the 'Health Roster' tool to estimate the number of nursing staff and skill mix required to maintain safe staffing numbers. The skill mix was reviewed daily by the ward manager to ensure compliance with the RCN guidance on staffing. RAG ratings were used to assess safe staffing levels. The RAG ratings indicated that overall staffing levels across children and young people's services were generally appropriate across all shifts. The CAU had five to six nurses on the roster per shift, and one HCA to support both clinical and non-clinical work.
- All qualified nursing staff were trained in paediatric immediate life support (PILS). Dolphin ward had one full-time nurse who was qualified in European paediatric life support (EPLS). However, the trust informed us that six nursing staff across the trust were scheduled to receive paediatric life support training in October 2015.
- KCH had three band 7 and ten band 6 nurses who were qualified emergency nurse practitioners (ENP). This was the equivalent to 10.35 full time ENP's when fully staffed. However, two ENP's were on maternity leave, this meant the cover at the time of our inspection was the equivalent to 9.35 full time ENP's.
- Children and young people had access to therapists such as physiotherapists, occupational therapists (OT) and speech and language therapists (SALT).

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- Staff told us that if children were being seen in the ECC and outpatients departments' specialist children's nurses from the paediatric service could provide advice and support. Staff told us that when they were aware that children were being seen and treated in clinics outside of the CAU such as dermatology the service would make arrangements for the clinic to be held in the KCH paediatric unit, where children and young people could be supported by trained children's nurses.
- The CAU staff consisted of two children-trained nurses (band 5s, one full time and one part-time), a full time healthcare assistant (HCA band 2) and two receptionists, who job shared.
- The CAU was open from Monday to Friday from 09:00 to 17:00 hours. The staffing level per shift comprised one nurse (band 5) and one HCA. They were supported by a receptionist. Some of the staff also worked in Kent and Canterbury hospital on ward duties to make up their hours and to enhance their nursing skills.
- Staff we spoke with said the staffing level and skill mix was adequate for the CAU.
- The senior matron who was responsible for the general management of the unit, was based at William Harvey Hospital. Staff said the senior matron visited regularly and was contactable by telephone if needed. The senior matron was present on the day of our inspection.

Medical staffing

- KCH CAU is a day unit which is open Monday to Friday 9.00am to 5.00pm; there is a consultant present on site during this time.
- The trust's medical staffing skill mix was 30% consultants; this was 4% below the national average. However, this was mitigated by the trust's senior house officers, doctors with at least three years or more experience in children and young people's services, making up 21% of medical staffing, this was 14% above the national average. 43% of medical staff were registrar level, this compared with a national average of 51%. 5% of the medical staffing mix were junior doctors, completing foundation year 1 or 2. This was slightly lower than the national average of 7%.
- KCH medical staffing consisted of four consultant paediatricians. Two of the consultant paediatricians

were shared with WHH and one consultant paediatrician was shared with QEQM hospital. Medical staffing levels were compliant with the royal college of paediatric and child health (RCPCH) 'Facing the future' standards.

- Middle grade medical cover was provided by QEQM hospital staff. One middle grade doctor was rotated from QEQM hospital to KCH during the CAU's opening hours of 9.00am to 5.00pm. A junior doctor from WHH was also provided during the CAU opening hours.

Major incident awareness and training

- Staff were aware of the trust's major incident and business continuity policy; senior staff understood their roles and responsibilities within a major incident. Staff told us they had not been involved in a rehearsal for a major incident.
- A copy of the trust's major incident plan was kept in the manager's office. Staff could also access the plan on the trust's intranet 'Share Point' and on the staff portal 'Staff Zone'.
- The trust had an escalation policy for dealing with surges in demand on children and young people's services. The policy was RAG rated and had an action plan to provide guidance for staff at each stage.
- The senior matron told us the trust's escalation policy would be used at times of inclement weather.
- The trust had an emergency planning team who could provide advice to staff. We saw that the contact details of the emergency planning team were available to staff on the trust's intranet.
- The unit had a copy of the major incident policy, which had been updated in April 2015.
- Staff had access to a seven minute major incident awareness video. The video showed the types of incidents to be prepared for and the roles of staff in the event of a major incident.

Services for children and young people

Are services for children and young people effective?

Good



Children and young people attending the CAU had good outcomes because they receive effective care and treatment that met their needs.

Children and young people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.

Children and young people had comprehensive assessments of their needs. The expected outcomes were identified and care and treatment was regularly reviewed and updated. Children and young people's outcomes were positive, consistent, and met expectations.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services. Accurate and up-to-date information about effectiveness was shared internally and used to improve care and treatment and children and young people's outcomes.

Children were cared for by a multidisciplinary team of skilled staff including medical, nursing, physiotherapists, occupational therapists (OT), and speech and language therapists (SALT). Staff felt supported and had access to training. Consultant support and presence was provided from 9.00am to 5.00pm Monday to Friday. Outside these hours children needing specialist paediatric care would be transferred WHH in Ashford or QEQM hospital in Maidstone.

There was good multidisciplinary working within the unit. Local team meetings had been held and staff had received good guidance regarding clinical governance. Parents confirmed their consent had been obtained before care and treatment had been provided. Staff had been given appraisals and appropriate training to carry out their roles. Nurses had all been trained in paediatric nursing.

Evidence-based care and treatment

- Children were treated according to national guidance, including guidance from the National Institute for Health and Care Excellence (NICE), and the Royal College of Paediatrics and Child Health (RCPCH). We saw

appropriate care pathways were in use and were in keeping with the relevant clinical or nursing guidance. For example, the CAU had 'guidelines for the care of paediatric patients admitted to Kent and Canterbury Hospital, Monday to Friday 9.00am to 5.00pm, that required intubation and mechanical ventilation'. This clearly detailed the procedures staff should follow if child was admitted to the CAU and deteriorated; or actions staff at the ECC should take if a seriously ill child was taken straight to the ECC by their parents.

- KCH surgery were using the world health organization (WHO) safe surgery checklist. The checklist identified three phases of an operation: before anaesthesia, before an operation commenced and before patient's left the operating room. In each phase, a checklist coordinator confirmed that the surgery team had completed the listed tasks before proceeding with an operation.
- Policies, procedures and guidelines were available to all staff, including temporary staff, via the trust intranet. However, some staff we spoke to said there was sometimes difficulties accessing them when necessary due to glitches with the trust's electronic system, 'Share Point'. Staff told us that due to this it sometimes took time to access information.
- The trust had a range of guidelines available to guide staff when providing care and treatment. We viewed 'the guidelines for acute asthma in children'; these had been ratified by the trust's paediatric clinical governance team in February 2014 and were due to be reviewed in February 2016.
- Staff followed the trust's clinical policies and procedures, which were based on guidelines issued by NICE and the RCPCH. Staff knew where to find policies and local and national guidelines, which were available on the trust's intranet.
- We viewed the trust's clinical audit progress report, March 2015; this outlined the progress of the trust's program of audits at a particular point in the year. Staff told us that a meeting had been planned to review and monitor the progress of clinical audits on the 30 June 2015. Records we viewed confirmed this.
- The service was involved in a range of local and national audits. For example, we viewed the children and young people's audit planner for 2015-16. Work was in progress to audit the service's implementation of a range of

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national audits, including: national diabetes audit, which was having data collected at the time of our visit; and the national paediatric asthma audit, which was due to commence data collection in November 2015. We saw that work was also in progress on a range of local audits. These included an audit of 'initial health assessments for looked after children'. This audit was having information processed at the time of our visit and results were unavailable.

- Most policies and procedures were up to date but some were currently under review. For example, the RCA policy had recently been updated following the latest guidelines from NHS England entitled 'What is a Serious Incident' and 'Never Events Policy'. The trust policy regarding the RCA timeframe for completion was changed from 45 days to 60 days.
- Nursing staff confirmed that they had attended monthly staff meetings, where changes to policies and procedures and guidance had been cascaded down and discussed.

Pain relief

- Pain was assessed and managed appropriately. We observed age-specific tools in use in the CAU and the appropriate national guidance was followed.
- We did not see any patients being administered pain relief. Staff told us patients were given analgesia, as required, and staff monitored whether the analgesia had adequately relieved the child's pain.
- Appropriate equipment was available including equipment for patient-controlled analgesia (PCA).
- A nationally recognised pain management tool was used as part of children and young people's assessment. Pain scores were recorded on patient's PEWS charts.

Patient outcomes

- We viewed the CAU's standard operating procedures (SOPS). We saw that the CAU had procedures in place to monitor the CAU performance. The key performance indicators (KPI) were: a child referred to a paediatric department must not be discharged without being seen or the case being discussed with a senior clinician; paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an

advanced nurse practitioner: nurse assessment within 15 minutes of arrival: medical assessment/ANP within 1 hour of arrival: senior/speciality medical review & decision making with a clear management plan within 4 hours of arrival. The CAU was meeting its identified SOPS KPI's at the time of our inspection.

- The trust used a balanced score card to monitor services. The balanced scorecard is a strategic planning and management system that is used to align business activities to the vision and strategy of the organization, improve internal and external communications, and monitor organization performance against strategic goals. This meant patients could be sure that the trust was monitoring the quality of its performance against defined performance measures.
- We viewed the children and young people's audit planner. We saw the service had plans in place to ensure they took part in national clinical audits. Audits that were not in progress had commencement dates. This ensured that the trust had a framework of action in place; including the review of all clinical guidance and the undertaking of gap analyses to ensure all specialist services who provide care for children had a detailed clinical audit programme in place for 2015/16. The service also had a programme of audits that would be undertaken at a local level across children's services to monitor the quality of care provided to children and young people. However, we did not see evidence of how audit results had been fed back to staff to ensure that the results could be used to improve service delivery, this was due to audits either being in progress or awaiting commencement.
- The trust performed worse than the England average in the Nation Paediatric Diabetes Audit (NPDA) in controlling blood glucose levels. The trust had 15.9% proportion of children with a glycated haemoglobin (HbA1c). This compared with the national average of 18.5%.
- The trust had a slightly lower emergency readmission rate at 0.7%, than the national average of 0.8%. Overall, multiple re-admission rates for children with long-term needs was similar to the national average. The multiple re-admission rates for children aged 1-17 years with asthma was 17.6% compared to the England average of 17.3%. The multiple re-admission rate for diabetes was 11.4% compared to the national average of 14.6%. The

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multiple re-admission rate for epilepsy was 32.8% compared to the national average of 28.6%. We saw that the service had suitable discharge planning arrangements in place to reduce the likelihood of patients being readmitted.

- The trust had slightly lower or similar emergency re-admission rates for all recorded specialities other than non-elective general surgery, which was much higher than the national average, but this may have been due to low numbers of children and young people receiving this service.

Competent staff

- Staff we spoke with during the inspection confirmed that they had received an annual appraisal. All of the nursing staff we spoke to told us they felt well supported by their ward team and the senior nursing and managerial staff.
- Junior medical staff reported good access to teaching opportunities and said that they were encouraged to attend education events.
- The trust had an on-going training programme training staff in PILS. All trained medical and nursing staff were trained in PILS. Theatre staff including anaesthetists were trained in paediatric life support. We saw guidance displayed on the walls on Dolphin ward for staff explaining the procedures for paediatric life support.
- Staff we spoke with told us they received regular 1-2-1 supervision with the ward manager.
- Staff told us band 5 nurses received bi-annual practice competence meetings. We viewed the band 5 nurses meeting agenda for May 2015. We saw that the meeting had related practice issues to the CQC key lines of enquiry (KLOE). The meeting covered: guidance for staff in recording staffing levels as an incident; providing support to new and agency staff; accessing equipment; assessing patients' risk; and gaining written consent.
- The medical staff we spoke to all confirmed that they had received an appropriate induction when they started work and had an appraisal to identify training needs. Staff said they received access to clinical supervision and good training opportunities.

- The trust informed us that across the trust all qualified nursing staff who had dealings with children were trained and had annual updates as part of their role specific annual training in the use of PEWS.
- Staff told us they had regular bi-monthly staff meetings with the manager. A staff member told us, "We are a small, but very supportive team."
- The nurses working in the CAU were trained in paediatric nursing. They were also trained in paediatric immediate life support (PILS).
- Staff said they had received good support to develop their skills and knowledge. A member of staff showed us how they accessed e-learning, trust policies and procedures and clinical guidelines online.
- Staff said they had been given annual staff appraisals by their line manager.

Multidisciplinary working

- There was evidence of multi-disciplinary team working in all departments, both internally at the trust and with external service providers. There were regular multi-disciplinary team meetings. We saw evidence of engagement with external agencies such as social services and networking with other children's services to share specialist expertise. For example, the trust's safeguarding lead was a member of the Kent safeguarding children's board (KSCB) learning and development group.
- The service for children and young people offered at KCH included community paediatricians, speech and language therapists (SALT), physiotherapists and occupational therapists (OT). Parents we spoke with told us services worked well together and offered a seamless service.
- We spoke with senior staff who told us that the care for children with complex conditions was shared internally with WHH and QEQM hospital, and externally with other specialist hospitals. Staff told us there was good joint working and coordinated care. For example, staff from the trust worked closely with staff from the Royal Marsden hospital offering a specialist oncology service for children. The specialist team from the Royal Marsden had provided support and training to trust staff in caring for children with cancer.
- There was multidisciplinary working within the service, within the trust and with external healthcare providers,

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such as GPs, social services and community nursing teams. Patients seen at the CAU and the outpatients clinics were referred by GPs, community nurses, hospitals and other providers.

Seven-day services

- KCH did not offer a seven day children and young people's inpatient services. The CAU and Dolphin ward were open from 8.00am to 5.00pm weekdays.
- Children requiring emergency care would be seen 9.00am to 4.00pm Monday to Friday in the KCH hospital ECC. This meant that outside these hours children requiring emergency care would need to travel to the A&E department at WHH in Ashford, or the A&E department at QEOM hospital in Margate.
- The KCH ECC offered a seven day minor injuries unit (MIU) but this was a mixed age service for both adults and children with minor injuries.

Access to information

- Staff had access to patients' care records to enable them to deliver effective care and treatment.
- Children and young people's services used an electronic discharge notification system (EDN). EDNs were produced on a child's discharge. A copy of the child's care summary was instantly sent electronically to the child's GP, a copy was given to the parents and a hard copy was placed in the child's medical notes. This ensured children had continuity of care on discharge.
- Staff demonstrated how they accessed the trust's policies, procedures and guidelines via the intranet. Staff had access to e-learning to complete their mandatory training.

Consent

- Consent documentation we viewed had been completed appropriately. Parents were involved in giving consent to examinations, as were children when they were at an age to have a sufficient level of understanding.
- Staff we spoke with were aware of Gillick competence, this is a decision whether a child 16 years or younger, is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff told us they would always speak with a child and

encourage them to involve their parents where appropriate; but would respect the rights of a child deemed to be competent to make a decision about their care or treatment.

- Parents we spoke with confirmed that staff explained what they were going to do and asked for verbal consent before they examined their child.
- Staff had received training regarding Gillick competence. These guidelines helped staff to balance children's rights and wishes with the staff's responsibility to keep children safe from harm and to help staff assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions.
- Members of staff were aware of the Mental Capacity Act 2005 and, if the situation arose, they would adhere to the Act and take appropriate action in the best interests of the patient. Staff confirmed that there had not been any patients subject to Deprivation of Liberty Safeguarding (DoLS).

Are services for children and young people caring?

Good



Feedback from children, young people and their families who use the service was consistently positive about the way staff at CAU treated people. The friends and family test (FFT) results were consistently favourable in regards to services at KCH CAU.

There was a strong, visible person-centred culture. Staff we spoke with were motivated and inspired to offer care that was kind and promoted children, young people, and their families' dignity. Relationships between staff patients and their families were caring and supportive.

Staff took patients and their families' personal, cultural, and social needs into account.

Patients and their families were active partners in their care. Staff were fully committed to working in partnership with children, young people and their families and making this a reality for each patient. Staff always empowered patients and their families to have a voice and to realise their potential. Children, young people, and their families preferences and needs were always reflected in how care was delivered.

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Children, young people and their families' social needs were highly valued and embedded in their care and treatment.

Parents were pleased with the care and treatment their child had received in the children's assessment centre. Parents felt well informed and they had access to information leaflets on various medical conditions and on the complaints procedure and on how to contact the Patient Advisory and Liaison Service (PALS).

Compassionate care

- We had limited opportunities to observe children and young people receiving care during our inspection. However, when we did observe care we saw positive interactions between staff, parents and children. We saw staff responding in a considerate manner with children, young people and their families in all of the areas we visited. We saw that staff spent time with children, young people and their parents to ensure they understood their care and treatment, and were supported throughout their time in the CAU.
- We spoke with 13 children, young people and parents who were attending outpatients' clinics at the CAU. They all told us that the doctors and nurses were very kind and they did not have any concerns about the care or treatment they received.
- Day surgery staff demonstrated awareness of parents' anxiety when a child was admitted for surgery. Staff told us they would reassure anxious parents, and encourage parents to spend time with their child pre-operatively to alleviate the child's anxiety. Parents were encouraged to accompany children to the operating theatre, where they could wait in a designated waiting area outside the theatre until their child was in recovery, when they could visit the child and offer comfort and support.
- The NHS FFT is an opportunity for patients to provide feedback on services that have provided them with care and treatment. We viewed the friends and family test (FFT) results for Dolphin ward. We saw that in the period 1 April to 30 April 2015, 28 patients or their relatives had responded to the FFT of these 26 or 93% were extremely likely to recommend the service to their friends or family, none of the patients who responded were

unlikely to recommend the service. For the period 1 May to 31 May 2015, 28 patients responded to the FFT, 100% of patients or their relatives were either likely or extremely likely to recommend the service.

- All of the parents we spoke with told us they felt involved in planning and making decisions about the care and treatment of their child. For example, a parent told us, "They have been very kind to my child. My child has been coming here since they were born. They've always taken an interest and played with them. They've bought them Easter eggs and Christmas presents."
- We saw staff closing doors when providing care or treatment. The CAU had individual bays that had screens and side rooms. Staff told us side rooms would be used for private conversations with children, young people, and their parents. This ensured patients' privacy and dignity was respected at all times.
- Parents we spoke with gave positive feedback about the service and were complimentary about the staff working in the children's assessment centre. Both children and parents were treated with respect and dignity. We observed staff were compassionate and understanding.
- One parent said, "The service was quite good. We have no problems whatsoever; we are happy with the doctor's support and care."
- Another parent said, "We have been to the clinic and saw the same specialist. Staff are always helpful; they always listen. We like this clinic; the children's play area is great and there are plenty of seating areas within sight of the play area to watch our child at play while we wait."

Understanding and involvement of patients and those close to them

- All of the children, young people and parents we spoke with told us they felt very involved in their care. We saw medical and nursing staff in clinics and on Dolphin ward spending time with children, young people and their parents to ensure they understood their care and treatment. A young person who was attending the CAU told us, "I'm 16 and I've been coming here since I was 11. They are very friendly. I know the nurses so well they are more like aunts."
- All of the children, young people and parents we spoke with said that they had been involved in their care and in making decisions around their treatment.

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- All of the patients and parents we spoke with said that they had been involved in their care and in making decisions around their treatment. Parents told us they were seen in a timely way. A parent said, “That’s what I like about coming here; you aren’t left waiting around. You usually get seen quickly.”
- During our visit, we observed staff communicating with children and parents to ensure they understood their care and treatment. Most parents we spoke with told us they felt well informed and could ask any questions of the staff if they wished to do so.
- Children, young people and parents we spoke with told us staff talked to them and explained procedures in a way they could understand. A young person told us how staff had spent 20 minutes explaining the purpose and use of a cannula, (this is a tube that can be inserted into the body for the delivery or removal of fluid), due to the young person being anxious about a procedure. The young person told us, “It was the way they explained it that got me through it.”
- Staff told us that interpreters were available if children, young people or parents required interpreters. Staff had access to a telephone interpreting service. However, staff said the hospital’s own staff would be approached to interpret in the first instance via a request by email.
- We noted that there was information available in all the wards and departments for parents. However, there was limited information in a child friendly format. The senior matron told us the trust had identified a lack of child friendly information and that child friendly leaflets were being drafted.
- The CAU had information boards, these displayed information informing parents about services that could be accessed in the hospital and also in the local community.
- In the children’s assessment centre there were information leaflets on various medical conditions, including eye conditions, available to parents. There were also leaflets on how to make a complaint and how to contact the patient advisory and liaison service (PALS).
- Parents we spoke with felt they were well informed and had been consulted before their child was treated. Parents felt involved in the care and treatment of their child.

Emotional support

- We found that children, young people and parents were supported emotionally while receiving care and treatment at the hospital. For example, KCH encouraged parents and carers to stay with their child and provide support and comfort. Parents we spoke confirmed that they stayed on with their child when they were receiving care and treatment.
- It was evident from our discussions with staff that they were aware of the need for emotional support to help children and families cope with their care and treatment. All the parents and relatives we spoke with confirmed that staff were emotionally supportive during our discussions with them.
- The nursing staff on the CAU received positive comments from parents in regards to providing parents and children with emotional support. Parents we spoke with told us the practical and emotional support provided by nursing staff was valued by them. For example, a parent told us, “I know the staff here, they are very supportive.”
- Staff we spoke with were aware of how anxiety can impact the welfare of the child and made provision, where needed, to manage this. For example, a band 4 nurse was able to explain how they used distraction techniques with pre-operative children to alleviate their anxiety. The staff member told us, “We have a games console on Dolphin ward, a DVD player and books. We try to take their minds off the procedure as much as possible.” We saw that the CAU had toys available in the reception area, as well as an adolescents area with age appropriate toys, to keep children occupied prior to receiving care or treatment.
- Staff told us children and young people who were experiencing mental or emotional distress had access to a child psychologists.
- The senior matron told us the hospital chaplaincy service would offer support for parents and others close to a child who had received bad news. The chaplaincy team had access to multi-faith support for children, young people, and their families where there was a need. The chaplaincy service was available 24 hours a day, 365 days a year.

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- We observed staff were caring and supportive and offered emotional support to parents and their child when they arrived at the CAU.
- The parents of a child said they felt welcomed and reassured by a member of the nursing team as they waited for their child to be seen for the first time. We observed the child was relaxed and playing in the children play area.

Are services for children and young people responsive?

Good



Children and young people's needs were met through the way services at the KCH CAU were organised and delivered.

Children and young people's services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services provided.

The needs of different children and young people were taken into account when planning and delivering services.

Children and young people's care and treatment was coordinated with other services and other providers.

Reasonable adjustments were made and actions were taken to remove barriers when children and their carers found it hard to use or access services.

The CAU provided open access for patients to be treated without having to wait long. Within the centre, there were a number of outpatients clinics provided for the local communities.

The unit had a paediatrician on site during opening hours from Monday to Friday. There was a referral system through direct contact with the registrar on duty. GPs and healthcare professionals of all disciplines could refer a child.

Each patient received personalised care and treatment. There had been no complaints received about the service.

Service planning and delivery to meet the needs of local people

- The trust had considered consolidating children and young people's services into a single site. At the time of

our visit services were undergoing review and no decisions had been reached about the geographical locations of children and young people's services in the long-term.

- The RCPCH's comprehensive review of children and young people's services had offered the trust recommendations for improvements. We saw that the trust had implemented or work was in progress to implement some of the recommendations from the RCPCH
- Staff told us that all young people over the age of 16 would be consulted without a parent being present, but could have a parent present if this was their preference. Children and young people under the age of 16 would have their capacity to understand information assessed in accordance with Gillick competency. However, senior staff said they would encourage all children and young people to involve parents where appropriate, so that children and young people could have family support.
- Half of the CAU was allocated to community work. The CAU also housed the Mary Sheridan Centre for children with special educational needs, physical disabilities and a range of neuro-developmental conditions including epilepsy and Autism. Honey Bears Nursery was located at the CAU site. Staff told us the Mary Sheridan Centre and the nursery provided good links for local children in Canterbury with complex needs to the CAU services.
- We found that in other areas of KCH where children were seen and treated the general environment was not child friendly. The main outpatients department did not have a children's waiting area. However, staff told us that where possible children's clinics would be moved to the CAU. For example, dermatology and haemophilia clinics had been relocated to the CAU.
- Water was available to children, young people and families. The main hospital building had a restaurant where families could purchase food and refreshments; as well as a 'league of friends' shop. This meant patients and their families could purchase food and drink on KCH site.
- There were adequate baby changing facilities available in the KCH main reception.
- Both doctors and nursing staff said they worked well with local GPs, local authorities and other healthcare professionals.

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- There was open access to the CAU once a patient had been referred by their GP or another healthcare professional. The child's vital signs checks and other observations were done by a children's nurse (band 5) before they were seen by a paediatrician registrar on site without delay. This avoided the need to go to the accident and emergency department.
- The outpatients' clinics within the children's assessment centre served the needs of the local communities. On the day of our inspection, the orthoptist held a clinic from 09:00 to 12:00 hours and saw 6 patients. There were eye clinics open on other days for different eye conditions that affect children. There was a paediatric clinic conducted by a consultant and a clinic carrying out checks on babies between six and eight weeks old conducted by a registrar. There were referrals by some local GPs who had arrangements with the service.

Access and flow

- On the day of our inspection there were few children present in the CAU and KCH receiving treatment. However we spoke with staff and some of the children and families that were attending clinics at the CAU. We followed the pathway a child would take if they were undergoing either day surgery or surgery in the main theatres.
- The CAU met the needs of children who required ongoing assessment or short-term care and treatment who were able to be discharged home, rather than referred for inpatient admission.
- We viewed the trust's guidelines for transferring patients from KCH ECC or MIU to either WHH or QEQM hospital. We saw that the trust used a range of paediatric assessment tools and triage pathways to support the flow of children through the emergency departments. Children were triaged against the appropriate pathway and a RAG rating was documented in their case notes.
- Children who presented as a 'green' rating would be assessed and treated within the ECC or MIU department and educated about going to their GP in future. Children who presented under the 'amber' rating had a pathway where they may be under the care of the MIU and be managed by the MIU and would be discharged home.
- The trust also had a pathway for children who presented at the ECC or the MIU under the 'amber' and 'red' pathway who would be referred to the paediatric team immediately. This meant that between 9.00am and 5.00pm Monday to Friday a referral could be made to the CAU on site at KCH. Whilst out of hours a child assessed as 'amber' or 'red' would be 999 transferred to either WHH or QEQM emergency departments.
- Staff we spoke with were aware of the trust's guidance on transferring patient's to other trust hospitals or external care providers. We viewed the trust's patient transfer and escort policy. This provided comprehensive guidance for staff in transferring children to other trust hospitals or external providers of care and treatment. The policy had a risk assessment that staff would undertake prior to the transfer of a patient. It also had both medical and nursing checklists which would need to be completed prior to the patient being transferred. We did not see any patients being transferred during our inspection.
- The trust informed us that pathway for the transition of children and young people to adult service only occurred in some specialities, such as diabetes, oncology and cystic fibrosis. However, the trust had identified that the transition to adult services needed to be embedded by using a more robust, proven and validated transition pathway. The trust was in the process of reviewing the transition to adult services pathway and work was in progress to trial the Southampton "ready, steady go" transition programme. There was a provisional date of January 2016, for the diabetes team to commence trials of the programme.
- There was a steady flow of patients attending the three outpatients clinics and the CAU.
- The registrar for the CAU was taken ill on the day. However, cover was provided by the consultant and the registrar, who were present for their own clinics. They saw these patients in-between their clinic sessions.
- Patients who required treatment did not have to wait very long to be seen.
- Staff said they had had to contact a few parents to rearrange appointments. This was only for non-urgent cases, such as patients requiring routine blood tests or medical checks.
- Staff explained the procedure following the assessment and treatment provided before a child was discharged home using the electronic discharge notification (EDN) method of information transfer. The EDN notified the GP of all information relating to the treatment.

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Meeting people's individual needs

- The service used personal child health records (PCHR), referred to as red books. Parents were encouraged to bring these books to each hospital appointment or admission in order to facilitate sharing of child health records and hospital admissions.
- There were play areas in the CAU's reception. Staff we spoke with told us that the service was flexible enough to meet the needs of all children regardless of the complexity of their needs. We observed good facilities for children with disabilities. For example, the CAU had a sensory suite for younger children or children with learning disabilities. Support was available for children with learning disabilities or physical needs, the trust had an accessible gym and access to registered learning disabilities nurses, as required.
- The trust informed us where children had complex needs or multiple diagnoses the management of the child would be at the tertiary centres, (these are large hospitals that provide specialist care), or within the trust's specialist clinics. Each child had a local paediatrician who would see them when required and was aware of their care management plans. Children who were pre-school age had a key worker from the trust's early years support team.
- The trust informed us that any child or young person presenting at KCH ECC or MIU with symptom suggestive of a mental health problem between 8.00am and 10.00pm, would be referred immediately to the child and adolescent mental health team. The hospital had direct telephone contact with the service through the switchboard during these hours. Out of hours patients would be referred to the on-call paediatrician and a decision would be made whether the child or young person should be admitted as an inpatient to either WHH or QEQM hospital until a formal referral could be made to child and adolescent mental health service. If inpatient care was required staff would undertake a safe transfer risk assessment to ensure the safe transfer of the patient to the inpatient hospital.
- There were limited age appropriate leaflets and booklets for children and young people that explained

the different procedures they could have, as well as medical or surgical conditions. The senior matron told us the trust had identified the lack of child accessible information and work was in progress to address this.

- Staff told us that the trust had access to interpreters if required and information in other languages for people whose first language was not English. We did not observe any interpreters being used during our inspection.
- The information boards on Dolphin ward provided a good range of written information about treatment and care for a range of conditions.
- There were adequate facilities for breastfeeding mothers at the CAU as well as baby changing facilities.
- Staff said each patient was given personalised care and treatment.
- Patients and their families did not have to travel far to be treated.
- Translation services were available for patients and families for whom English was not their first language.
- The environment was safe and secure. The waiting and play area was spacious, with suitable facilities for patients and their families.

Learning from complaints and concerns

- Complaints were managed in accordance with trust policy. Staff and managers on the children's and young people's wards told us that they preferred to resolve concerns at ward level. Staff said these were not recorded, but if they could not deal with the concern immediately parents would be directed to make a formal complaint. Parents we spoke with all said that they had not raised any complaints with the service. All the parents we spoke with told us they thought staff would be approachable if they wished to raise issues.
- Information regarding complaints and concerns was on display in wards and departments we visited. Leaflets detailing how to make a complaint were freely available. We only saw leaflets in English. This meant non-English speakers would have to request information on how to make a complaint from the ward staff.
- The service held monthly governance meetings. The minutes of these meetings showed complaints to the service were a standing agenda item and would be discussed at the meetings. We saw that complaints were

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discussed in the child health quarterly report. For example, in the January 2015 report 11 formal complaints had been received across the trust's children and young people's services. We saw that complaints were monitored and themes identified. Learning from complaints had been identified and procedures had been put in place where a complaint had been upheld.

- Senior staff we spoke with were able to explain the trust's complaints process and how it fed into the hospital's clinical governance processes. The senior matron told us they would monitor all complaints to the children and young people's service; and that all formal complaints would be logged through the patient liaison service (PALS). Themes from complaints were monitored at governance meetings and by PALS.
- The senior matron who oversaw the children's assessment centre said they had not received any formal complaints. This was confirmed by the complaints spreadsheet for the period from 01 April 2014 to 17 July 2015.
- The senior matron told us that any complaints would be investigated and responded to within 28 days, in accordance with the trust's complaints policy and procedures.
- Staff said any concerns or complaints raised would be discussed at team meetings so that lessons could be learnt.

Are services for children and young people well-led?

Good



Children and young people's staff were unaware of the trust's strategic goals for children and young people's services as the trust had not made a final decision about the future strategy for the service.

The board and other levels of governance within the organization had undergone changes in the past 12 months. The chief nurse and director of quality had been instated as the children and young people's services lead. The service's structures, processes and systems of accountability were set out and understood by staff.

There was an effective process in place to identify, understand, monitor and address current and future risks.

Performance issues were escalated to the relevant committees and the board through clear structures and processes. Clinical and internal audit processes were in place.

The leadership was knowledgeable about quality issues and understood what the challenges to children and young people's services were, and were taking action to address them. However, face to face monitoring at KCH CAU was a challenge due to the matron being based in QEOM.

Leaders at every level prioritised safe, high quality, compassionate care and promoted equality and diversity. The culture change programme encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.

There was evidence that the leadership had introduced processes that would actively shape the culture through effective engagement with staff, people who use services and their representatives and stakeholders. Senior leaders encouraged a culture of collective responsibility between teams and services. But, these processes were not embedded.

The children's and young people's service was proactively engaging with and involving all staff to ensure that the voices of staff were heard and acted on. The leadership actively promoted staff empowerment to drive improvement and a culture where the benefit of raising concerns was valued. Safe innovation was being supported and staff had objectives focused on improving the culture of the trust.

Staff said there had been improvements under the new Chief Executive. The trust organisation chart was on display in the unit. The service was well managed. The child health matron who managed the service had attended clinical governance meetings and cascaded information down to staff. Staff felt well supported by their line manager and the doctors running the clinic. They felt they provided a good service to the local community. People attending for the first time felt welcomed by staff.

Vision and strategy for this service

- Safety and quality were clearly the top priorities for the management team. However, the trust had undertaken a lot of work on the children' and young people's strategy in regards to a proposed move to a single site with area hubs. Staff told us this strategy had been

Services for children and young people

abandoned in the week prior to our visit due to a central location being required and this being prohibitively costly. Staff told us the trust were now looking at care and treatment to be provided in two locations; but, a decision had not been finalised on the future strategic direction for children and young people's service.

- The chief nurse was the non-executive lead for children and family services. The chief nurse had regular meetings with children and young people's staff. Staff told us the chief nurse was visible and approachable.
- The nursing and medical management team were aware of how they fitted into the wider management model for the trust. Staff we spoke with were aware of the vision and values of the trust, and said that they felt they were kept informed. Staff told us the trust's vision and values were communicated on the trust's emails. We saw posters displayed on Dolphin ward and the main hospital site that communicated the trust's vision and values.
- The trust had a vision statement and a strategy consisting of a number of priorities. For 2015/16, the first priority of the trust was to focus on delivering the improvements identified in the Quality Strategy in relation to patient safety, patient experience and clinical effectiveness.
- Staff knew who the CEO and board members were. The organisation chart was on display in Dolphin ward.

Governance, risk management and quality measurement

- There was an effective governance framework in place and responsibilities were defined. The clinical governance committee met monthly and was primarily concerned with the delivery of safe, high quality patient centred care, and to provide assurance to the division that the key critical clinical systems and processes were effective and robust. These systems included: performance; incidents; risk; patient experience; quality improvements and sharing 'best practice'; guidance and frameworks; health and safety updates; and information governance.
- A risk register was in place which identified the key concerns for children and young people's services across the trust. There were 16 items on the register.
- The trust's child health senior management team held a monthly governance meeting. The risk register was a

standing agenda item and up-dates were provided on all identified risks. Where risks had been mitigated they were removed into the risk register's removal folder with reasons for the removal. The governance meetings were minuted with action points and distributed to committee and non-committee members across children and young people's services.

- There was a trust clinical working group that met monthly at KCH. This was a consultants meeting where service issues, education, training and audits were discussed. Members of this group were consultants; however the meeting was also open to specialty doctors. This meant there was a forum for medical staff to standardise processes across the trust and identify where actions needed to be taken.
- There were governance arrangements in place that monitored the outcome of audits, complaints, incidents and lessons learnt throughout the service. We looked at copies of governance meetings, risk registers, quality monitoring systems, and incident reporting practices. These demonstrated that there were management systems in place that enabled learning and improved performance, and were reviewed on an on-going basis.
- Systems were in place for clinical governance. There was a monthly clinical governance meeting, attended by the child health matron, at which issues were discussed by senior staff members and decisions were made to improve the care and services.
- Local management and staff teams had regular meetings to address local issues and to ensure lessons were learnt. Staff confirmed information had been cascaded down to them at the local staff meetings.

Leadership of service

- The Dolphin ward's matron's office was based in QEQM hospital. This meant senior staff at the trust were managing staff across multiple sites, and the matron was monitoring services at the CAU at a distance most of the time.
- We were unable to speak with the Dolphin ward manager as they were on leave on the day of our inspection. However, we did speak with the children and young people's senior matron who was visiting the CAU. The Senior Matron was based at The William Harvey Hospital. Staff we spoke with told us that leaders at the locality level were visible and approachable.

Services for children and young people

- The chief nurse and director of quality had been appointed as the children and young people's lead on the board of directors. Senior ward staff we spoke with said that they felt supported by senior management, and if they raised any concerns about the service, they would be listened to. Staff told us that the board of directors were more visible than they had been in the past.
- Consultants had their roles defined by the trust's job planning process and received annual professional development reviews.
- Staff said there had been improvements under the new CEO. A member of staff said, "Things have been put in place. We never used to have meetings for band 5 nurses; now this has been incorporated since the new CEO came." Another staff member said, "We now have a buddy system which staff can access if they feel bullied or harassed. It's good for staff who need help."

Culture within the service

- The trust had embarked on an improvement agenda. This included the launch of a culture change initiative in January 2015. Staff we spoke with told us they were aware of the culture change initiative.
- Children and young people's staff told us that there was a positive culture at KCH CAU, and that staff supported each other well. We saw that staff worked well together in multidisciplinary teams to provide holistic care to children. Staff told us the culture of the service was focused on meeting the needs of children, young people and their families. A member of staff at the CAU told us, "There is a real team ethic here. We all achieve better outcomes if we work together."
- Staff described an open culture, where they were encouraged to report incidents, concerns and complaints to the ward manager. Staff we spoke with told us they felt able to raise concerns and these would be listened to.
- Staff said the ward manager was approachable, supportive and very encouraging.

Public and staff engagement

- The trust informed us that they used the friends and family test (FFT) to collect feedback about services.
- Children, young people and parents we spoke with told us they had been actively involved in decision making. For example, a young person told us, "They always talk to me about my treatment ask if it's O.K with me."
- Patients' families were complimentary about the CAU service and the staff who cared for and treated their child. People attending for the first time felt welcomed by staff.







Staff engagement

- The senior matron told us the trust had held a number of staff focus groups in the past 12 months as part of the trust's change agenda.
- We viewed the child health division's staff survey results spreadsheet. We saw that 80% of staff responded feeling satisfied with the quality of work and patient care they were able to deliver: 70% of staff responded they were able to contribute towards improvements at work.

Innovation, improvement and sustainability

- The trust had introduced a culture change programme, 'let's make our trust a great place to work.' The trust outlined to staff that the programme was the beginning of a long-term and sustainable change at the trust to ensure staff felt supported and inspired about working for the trust. The trust was publishing regular updates, 'our improvement journey', which explained some of the initiatives across the trust to help the trust achieve improvement goals. All the staff we spoke with were aware of the culture change programme, and most reported that the culture at the trust was improving. A member of staff told us, "We are definitely moving forward."
- The RCPCH invited review programme report 2015 found that Dolphin ward; CAU, at KCH had achieved and exceeded the goals of ambulatory care, and recognised the service model as "a beacon of excellence for the children and young people" of Kent and Canterbury.

End of life care

Safe	Requires improvement	
Effective	Inadequate	
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 who worked across all three acute hospital sites. In addition there were two clinical nurse specialists (CNS), two counsellors and a social worker on this hospital site. The SPC team was supported by a medical palliative care consultant from the Pilgrim's Hospice.

The SPC team were available Monday to Friday from 9am to 5pm. Outside these hours support was provided by the Care of the Elderly team and telephone support by the local hospice. There were 740 deaths in the Kent and Canterbury Hospital from April 2014 to March 2015.

We visited a variety of medical and surgical wards including: Marlow, Kent, Taylor, Invicta, McMaster/Mount, Harvey, Clinical Decision Unit (CDU), Brabourne, Treble and Clarke. We also visited the mortuary, patient experience offices, the Chapel and the porters lodge. We reviewed the medical records relating to the end of life care of six patients. We observed care on the wards and spoke with three patients receiving end of life care as well as one family member. We received comments from public events we attended and from people who contacted us individually to tell us about their experiences. We spoke with 33 members of staff that included porters, admin staff, senior and junior doctors, nursing staff of all grades and managers of services. We reviewed other performance information held about the trust.

Summary of findings

The trust's specialist palliative care team demonstrated a high level of specialist knowledge. The team provided individualised advice and support for patients with complex symptoms and supported staff on the wards across the hospital. We found reduced resources for the team and concerns regarding sustainability of the service. The planned improvements could not be implemented on current resources.

There remained a lack of Trust Board direction for end of life care with a non-unified approach across the various wards and departments. There was limited end of life care training and use of the trust resource pack was patchy and not kept up to date. Wards struggled with staffing levels and there were no extra staff in place to support end of life care.

All staff we spoke with, both clinical and non-clinical, demonstrated a very high level of care, pride and attention to detail in the provision of a good quality service for patients identified as end of life. Patients and families we spoke with described good quality care from staff. The trust worked with the East Kent regional strategy in line with evidence based practice and guidance.

End of life care

Are end of life care services safe?

Requires improvement



The trust had an incident reporting system in place that staff were aware of and used. However, the electronic systems supporting this were described as very slow. We found that incidents reported did not reflect the number of concerns raised when we spoke with staff. Staff raised specific issues regarding changes in the last rights process and introduction of new equipment that identified conflicting training and guidance for different staff groups.

Medicines were well managed, however the trust were using out of date syringe driver prescribing and record of administration forms. Record keeping was of a good standard for patients identified as at end of life. Identifying patients at end of life was sometimes delayed and there was on-going work and audits to raise awareness with staff. The Liverpool Care Pathway had not been replaced and there was poor end of life document management.

The Specialist Palliative Care Team (SPC) were not able to provide out of hours cover. Telephone advice was available from the local hospice and there was some support from the Care of the Elderly Team within the hospital. A palliative care consultant from the local hospice provided limited medical services in hours.

There was a well-managed mortuary in a clean and ordered environment. Record keeping was to a high standard.

Incidents

- There was an electronic incident reporting system in place that all staff we spoke with were aware of including administration staff, doctors, nurses, mortuary staff and porters. However, we were told that the IT systems generally were very slow and frequently did not allow access. The incident reporting system was described to us as, "Slow and clunky."
- Porters were employed by a company contracted by the trust and did not have direct access to the trust electronic system but reported into their company system. We were told that there was one person within the company responsible for ensuring that relevant incidents were entered on to the Trust system.

- The Trust and the contracted company provided us with reports on incident reporting that related to the transfer of deceased patients or to the mortuary.
- The contracted company report for the time period 7 November 2014 to 4 June 2015 consisted of five incidents, three of which related to Kent and Canterbury Hospital (KCH) with appropriate action and learning completed.
- The Trust reports for April 2014 to July 2015 consisted of 19 incidents, five of which related to WHH. All had actions and learning recorded with one making reference to a concern following recent changes to the last rights procedure. We were told that this had been reported and that the member of staff had received feedback from their manager.
- At the focus groups as well as during the inspection staff described a lack of clarity regarding the recent changes in equipment and in the last offices procedure. The number of reported incidents did not reflect the number of issues staff raised with us.
- We found a lack of full understanding and knowledge of the legislation regarding Duty of Candour amongst the staff we spoke with. However, staff demonstrated a knowledge and understanding of the requirement to be open with patients and families where an error had been made and the importance of involving them in results and actions from any subsequent investigation. Staff provided examples where they had had such discussions with patients and families.

Environment and equipment

- The mortuary had a keys and coded entry system in place that porters had access to, with a bell for other visitors to the area.
- We saw that equipment such as fridges and hoists were regularly maintained with records kept. We saw the installation documentation for the new hoist dated 6 February 2015. The trolley checks were dated 16 June 2014 and were told the next checks were booked. Maintenance checks were coordinated by the mortuary manager at the William Harvey Hospital.
- There was an alarm system in place to ensure that the fridge temperatures were always within the correct temperature range.
- There was a good supply of personal protective equipment such as gloves, as well as cleaning products and wipes. The area was cleaned to a high standard.

End of life care

- Mortuary staff reported that they work on their own and we saw that they did not have access to a lone worker alarm.

Medicines

- Medicines on Harvey ward were stored in a clinical room with keypad access. All the cupboards inside were locked including the controlled drugs cupboard. We saw an extensive range of medicines available for patients on the ward and available for discharge.
- Individual patient medicines were in their lockers on Harvey ward. Staff told us that patients were encouraged to self-medicate and supported if they were not able to do so.
- We saw examples of anticipatory medications prescribed for end of life care patients in the medical records we looked at.
- The trust were using out of date syringe driver prescribing and record of administration forms. These referred to two types of pumps no longer used in the trust.

Records

- We reviewed the medical records of six patients and found the DNACPR forms were at the front of the medical records allowing easy access in an emergency. All decisions and discussion with patient and family were recorded on the appropriate form and dated. Three of the forms did not contain a review date or any additional comments.
- We saw good documentation of patient care on Invicta ward where a patient was transferred to the local hospice. There was excellent documentation about consent, discussion with family and DNACPR in place.
- We looked at a patient record on Clark ward and these demonstrated evidence of the discussion regarding preferred place of death (PPD) and the agreed plan was in place.
- We saw a high standard of record keeping in the mortuary. All registers, signing in books, boards and checklists were properly completed and monitored. There was a well ordered system for documents including maintenance and training records.

Safeguarding

- Staff demonstrated a good knowledge and understanding of safeguarding vulnerable adults.

- Safeguarding e-learning was part of mandatory training and this was monitored by the ward managers.
- The relevant local authority and social services contact numbers were available for staff.

Mandatory training

- Much mandatory training was e-learning with some face-to-face training such as the practical part of moving and handling training.
- There was significant reliance on e-learning to ensure that staff were updated regularly. However, staff told us that the trust IT systems were not fast or reliable enough to support this training. They described difficulties accessing the courses, the slowness of the system and the completed training was not always saved and recorded by the system. This meant that their managers thought they had not undertaken training and that in turn impacted on their receiving their annual salary increment.
- We saw records of mandatory training in the mortuary that included fire safety, moving and handling, information governance, infection control, equality and diversity and health and safety.
- Porters we spoke with said they received annual updates on mandatory training, some of which was e-learning. Transfer of deceased patients and mortuary procedures were included in their mandatory training. However, we heard of some lack of clarity in the training provided by the external company. The porters said that there were some differences between their training and the ward nurses training with regard to infection prevention and control. The ward staff expected porters to wear gloves and aprons during transfer of the deceased into the concealment trolley whereas the porters said they were told by their company that they should not wear gloves and aprons.
- We followed up with the company management team and were subsequently provided with the Transfer of Deceased Patients protocol. This clearly stated that disposable gloves should be used before handling a body. Aprons were not mentioned but the protocol stated, "... they shall always ensure they follow infection control procedures at all times ..."
- Our understanding was that porters should not wear gloves when pushing the concealment trolley along the hospital corridors but should wear them on the wards. This was not clearly understood by all porters we spoke with.

End of life care

Assessing and responding to patient risk

- Once patients were deemed to be for end of life care the ward staff tried to move them to a side room on the ward where possible.
- From the records we looked at, identifying patients for end of life care was sometimes delayed. This was also evidenced by the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) audits carried out by the trust and included appropriate and rapid escalation in response to the early warning scoring process in place. There was ongoing work and audits in place to raise awareness with staff.
- Once patients were identified for end of life, care and treatment was in place for each patient's needs.
- We found there was no structured approach to end of life care since the Liverpool Care Pathway (LCP) was removed in 2013. However, staff used the principles of the LCP and treated each patient as an individual. The Trust "End of Life Conversation" documentation was not in use at the time. This had been developed to support full discussions with patients and their families on their diagnosis, prognosis and options. Further work to embed the document in practice was underway.
- The exception to this was in Critical Care. There were guidelines and a nursing care pathway with complete documentation including the "End of Life Conversation" document. We saw decisions and discussions recorded in the documentation.
- We were told of a trust-wide Critical Care end of life pathway group that was multi-disciplinary. The group were working on joint GP and hospital DNACPR decisions as well as other EOLC documentation and training. The consultant nurse for critical care was a member of the trust End of Life Board.
- The end of life care resource file varied from ward to ward. We saw the folders on Marlowe, Kent and Brabourne wards. The CDU department do not have a resource folder but have access to the trust electronic system which holds the relevant up to date documents and information.
- Not all folders were complete and the discharge checklist contained reference to the Liverpool Care Pathway (LCP).
- On the specialist neurological ward we were told they experienced one to two deaths a month and a patient

would be recognised as needing EOLC during daily ward rounds. They were aware of the five priorities of the dying person and a poster was displayed on the ward. Symptom guidance was also displayed on the ward.

- Staff on other wards said they required advice and support when identifying a patient at end of life. This would be discussed with senior staff and seek advice from the SPC team.
- We asked six wards regarding their training for syringe drivers. All confirmed that they had received the training and had up to date competencies but only one ward kept a record of this training.
- Palliative care link nurses were appointed for each ward. However, with staff changes, not every ward had them at the visit. Again we found varied practice.
- The Last Offices Policy was not available on all the wards we visited.
- There was up-to-date guidance on symptoms and the five priorities of end of life care available on the Trust intranet.

Nursing staffing

- The Specialist Palliative Care Team (SPC) consisted of a trust-wide nurse consultant with two clinical nurse specialists, two counsellors and one social worker on each acute hospital site. There was no cover for annual leave or sickness for the nurse consultant role. The nurse consultant covered holiday periods for the clinical nurse specialists.
- The SPCT were unable to provide out of hours cover. Telephone advice out of hours was provided by the hospice.
- The SPCT told us that they had to prioritise their time for the more complex patients. They were aware that the ward staff would like more support to reassure them that they were providing appropriate care for less complex patients identified at end of life.
- We were informed that nurse recruitment was on-going and that there were some shortages on some shifts for most wards. Nursing staff described good care for end of life patients but told us that they covered this care within the normal staffing establishment. Staff ensured that patients and families were given the time and support they needed at end of life but this meant that other staff on the shift took on extra patients during this time.

End of life care

- The porters were employed by an external company. Those we spoke with felt that whilst they were busy there was generally sufficient numbers of staff.
- There was one Relative Support Officer working 25 hours per week for the hospital. This was not felt to be sufficient for the winter months with the increased admissions and deaths and had been discussed with managers.

Medical staffing

- There was 0.6 whole time equivalent palliative care consultant input visiting K&C from the hospice. They undertook one ward round each week, attended some multidisciplinary cancer meetings and undertook some training.
- There was no medical palliative care consultant cover out of hours.
- We were informed that there was, and never had been, any service level agreement regarding medical time between the trust and the hospice.
- We heard that junior doctors received weekly teaching and attended the Grand Rounds.

Major incident awareness and training

- The trust had a business continuity management plan in place with a framework for disruption of services. This covered major incidents such as winter pressures, severe loss of staff, loss of electricity or water.
- Most staff we spoke with were aware of the hospital's major incident plan such as winter pressures and fire safety incidents, and they understood what actions to take in the event of an incident such as a fire.
- Mortuary staff were aware of major incident planning and coordinated the daily storage tracking.

Are end of life care services effective?

Inadequate



The trust worked with the end of life care regional groups and followed national guidance. The specialist palliative care team demonstrated a high level of specialist knowledge and provided support for patients and staff. Out of hours advice and support was provided by the local hospice.

Trust audits highlighted on-going challenges in identifying and decision making around end of life care. Where

decisions were made there was evidence of good multidisciplinary care and treatment. Documentation supporting the five priorities for care at end of life was under development, with patchy use of what was already in place.

Recent changes to the last rights procedure and introduction of new equipment was not clearly consulted with staff prior to implementation. This impacted on the competence and confidence of staff at a sensitive time.

Evidence-based care and treatment

- The trust was part of the four Clinical Commissioning Groups' end of life work stream to improve end of life care across the region. The work was based on national guidance.
- The trust followed the manual for cancer services (2004) that reflected the National Institute of Health and Care Excellence (NICE) guidance for improving supportive and palliative care for adults with cancer.
- There was an SPC team that provided specialist knowledge and worked alongside other specialist nurses in providing evidence based care and treatment.
- In September 2014 the SPC provided the trust with a report against the quality statements contained in NICE Quality Standard 13 (QS13) on end of life care for adults. This included the plan going forward within the trust and the wider East Kent end of life care strategy. The report demonstrated that much was still under development within the region, such as the Electronic palliative care register (EPaCCs) originating in primary care and hoped to be implemented in the trust during 2015-2016.
- Audits regarding Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) were undertaken regularly across the trust. These highlighted the need for further improvement in identifying end of life care patients.

Pain relief

- Pain levels were routinely collected together with vital signs and pain was promptly treated. We saw these recorded in the patient records we looked at.

Nutrition and hydration

- We saw evidence of extensive input regarding nutrition and hydration in patient records we looked at.
- We observed that water jugs were full and accessible for patients. Hot drink trolleys were seen on the wards.

End of life care

- We saw examples where dietary needs had been catered for and patients' food and fluid intake monitored in the patient records we looked at. One example was the input of a specialist dietician doing advance care planning around nutritional needs for patients requiring PEG feeding (for people who need tube feeding for long periods of time).

Patient outcomes

- An audit of completion of DNACPR forms was carried out in May 2014 at all three acute hospital sites. Results clearly identified good practice and practice that required improvement for each site and trust-wide against the 2013 results. KCH results demonstrated 97% for completion of the reason for DNACPR and 100% where the signature, job title, date and time was completed by the health care professional, to 35% of the forms containing the name of the multidisciplinary members contributing to the decision. Actions and recommendations were included as well as reporting the results to the EOLC Board.
- The surgical teams carried out small audits of completion of DNACPR forms at regular intervals with a summary provided to the trust governance lead.
- The trust used an early warning and patient observations system to identify deteriorating patients. The Critical Care Steering Group oversaw the trust's Deteriorating Patient Programme and provided six monthly reports to the Patient Safety Board. We were provided with the report for the period 1 October 2014 to 31 March 2015. The programme measures a variety of topics that include vital sign recording and compliance with the DNACPR policy. The report reiterated the challenge of identifying and decision making around end of life care.
- The hospital submitted annual data to the National Council for Palliative Care in respect of the Minimum Data Set, a process for monitoring activity. We requested the most recent submission but this was not provided.
- The trust did not take part in the National Care of the Dying Audit for Hospitals 2013-2014. However, we have seen evidence that the trust has registered for the National End of Life Care Audit for 2015.
- We were told that the standard to issue of the Medical Certificates of Cause of Death (MCCD) was within three working days. There was an ongoing audit of times to issue across all three sites. For the period 1 July 2014 to 30 June 2015, 928 certificates were completed of which

102 were over the three day standard, 33 by just one day. This represented 89% compliance with the Trust standard. The Trust stated that a change in policy for the Margate Coroner's Office had caused some delay and was a specific problem during February to April 2015.

Competent staff

- End of life care e-learning was available on the Trust's electronic training system. We were told that the SPC team provided a variety of sessions for staff over 2013-2014 including the role of palliative care and end of life at a grand round.
- Trust-wide we were provided with information that 10 staff were provided with training, such as 'compassion training', undertaken with the local hospice between January and June 2015.
- Palliative care consultants contributed to Grand Rounds, Schwartz Rounds and In Your Shoes run by the trust.
- Staff on Kent and Marlowe wards told us they had attended study days at the local hospice but were unable to provide evidence of this.
- We saw an example of bimonthly ward minutes where care after death had been discussed with regard to the person's valuables and to ensure the person has a wrist band on with their identity.
- We were provided with one elderly care ward training record that showed that no staff had attended either adult safeguarding or dementia training with generally very low numbers of staff having completed any of the training on the matrix.
- Staff confirmed that if they needed assistance with syringe drivers out of hours, they would contact the hospice for medical advice and other wards for assistance with equipment.
- We were provided with evidence that 20 KCH nurses were trained on the syringe drivers in January 2014. These were advanced users, trained to be experts in their ward areas. We were told it was the responsibility of each ward manager to ensure that their staff were trained and competent. Not all ward managers were able to provide evidence of training for staff on their ward. Staff expressed concerns when there were shifts with high numbers of agency staff on the ward.
- The first trust-wide link nurse meeting took place on 1 July 2015.
- The Relatives Support Officer (RSO) received training on the various processes and protocols from their manager.

End of life care

New staff were supported during their first week. Annual appraisals were carried out and included discussing training needs. The manager was undertaking an IT training course for a software package.

- The RSO worked alone for much of the day. There was a weekly teleconference for all three sites so they could receive updates and have a team discussion.
- Mortuary staff and porters were trained in the use of the newly installed ceiling hoists in the mortuary and all stated that this was a considerable improvement in the prevention of musculoskeletal injury, particularly with the numbers of bariatric bodies to be moved and transferred. The training matrix for porters showed that there were nine staff awaiting training with seventeen having completed the training.
- Mortuary staff and porters were also trained in the recently acquired green lift sheets used for transferring a deceased person from the bed on the ward into the concealment trolley for transfer to the mortuary, then from the trolley into the fridge. All staff we spoke with in those departments said that this was an improvement in respect of moving and handling practice. As it is such a recent change some staff were more confident than others. The porters were pleased with the change but said that each transfer took longer than the previous process. This extra time had not been reflected in the task time allowance which remained the same at 20 minutes per transfer.
- On the wards we were told of instances when there was confusion amongst the nursing staff with the new Last Rights policy and use of the green lift sheets. We were told of occasions when the deceased was not fully covered and difficulties transferring to the concealment trolley as a result of the confusion.
- Nursing staff at the focus groups held the week before the inspection visit told us that the Last Offices procedure had changed recently. Many of them said they had not been informed in advance of the changes and had not been trained. Some present in the focus groups were not aware of the changes at that time. This meant that dignity was not always protected and caused distress to nurses, porters and mortuary staff when it occurred.
- We saw an example where the ward manager was well informed and the guidance was visible with the process said to be working well.

- The concerns were not always with the changes in practice but were always regarding the staff not feeling informed, confident or competent in the new ways.

Multidisciplinary working

- A weekly multi-disciplinary meeting between the three acute hospitals was held via video link. We attended a meeting on the WHH site. Consultants, palliative care team and a social worker attended. Each hospital had brought patients for discussion regarding their care and treatment. Whilst most were cancer patients, patients with non-malignant life threatening conditions were also discussed. We observed good exchange of information and the opportunity to build relationships across the Trust.
- Once the video link part of the meeting concluded, each site continued discussing patients in their hospital. Patients' management plans were reviewed with changes noted on the medical records.
- The Specialist Palliative Care Teams worked closely with the local hospices to discharge patients who wished to die in their own homes. We were told of very good working relationships with the hospices.
- They also worked closely with the tumour site specialist nurses, dementia nurse and care of the elderly team. We spoke with the Motor Neurone Disease (MND) specialist nurse. This was a trust wide appointment. We were told the MND nurse was involved with the patient from diagnosis to end of live care, providing advance care planning as well as family and bereavement support.
- Porters (employed by a contracted company), mortuary, patient experience staff and ward staff all described good working relationships. However we did not find evidence of opportunities for joint discussions, particularly where there were changes in such a sensitive area as last rights and transfer of the deceased.

Seven-day services

- The SPC team worked from 9am to 5pm, Monday to Friday. There were insufficient numbers of staff to provide a seven-day service. Outside these hours and at the weekend the local hospice provided telephone advice and support. Wards were also able to access support from the Care of the Elderly Team.
- The mortuary was open 8am to 4pm Monday to Friday. However staff provided a 24 hour on call service seven days a week. Identifying the deceased was available at all times on an as required basis.

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- Relatives were supported when attending for a viewing by the Relative Support Officer (RSO) between 10am and 4pm. Outside these hours this service was provided by the Site Coordinator with the support of porters transferring the body from the ward to the mortuary.
- The Chaplaincy service was available 9am to 5pm Monday to Friday with an on-call service from 6pm to 6am for emergencies only. There were two Chaplains on-call at the weekends for the three acute hospital sites.

Access to information

- The trust had access, with patient consent, to GP records through the Medical Interoperability Gateway (MiG) system. They were one of the first trusts in England to have access to this information 24/7. This meant that when a patient arrived in A&E the system automatically flagged up if they were at end of life. The palliative care team monitored the system and the local hospice was informed if the patient was known to them.
- Records for patients identified as end of life contained care plans, anticipatory medications and evidence of multidisciplinary input into care and treatment.
- The end of life care resource folder contained current information and trust documentation. Ward staff told us that they referred to this information. However, not all wards had an up-to-date version and we found some staff unaware of the resource folder.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Medical staff we spoke with understood the DNACPR decision making process and described discussions with patients and families. They tried to provide clear explanations to ensure that the decision making was understood.
- Medical staff understood the Mental Capacity Act and we were shown examples of mental capacity assessments on the clerking documentation.
- We saw doctors discussing mental capacity assessment on the Clinical Decision Unit.
- However, on reviewing the medical records of six patients we found that two patients were described as lacking capacity to make decisions and did not have the necessary Mental Capacity Act assessments in place.

- One of the patients discussed at the weekly multidisciplinary video link meeting with the three acute hospitals required support from the advocacy service and this was arranged.
- Medical staff were not always clear on the terminology of the Duty of Candour but they all told us they would always inform the patient if something had gone wrong and understood the importance of being open with patients and their families.

Are end of life care services caring?

Good



We found a very high level of care, pride and attention to detail in the provision of a good quality service for patients identified as end of life. Staff respect for the deceased in their care was abundantly clear in all parts of the service they provided.

Patients and families we spoke with reflected the good care provided. We were told that they felt included and informed in decisions.

Compassionate care

- Patients we spoke with told us that the care was excellent. The nurses were kind and responsive. They felt their dignity was respected.
- The trust had opened a suite on all three sites specifically for relatives of patients receiving end of life care. They consisted of sitting rooms, a shower and a kitchen with access to a garden. These had been agreed by the clinical management board. They provided a place of quiet and peace for relatives to rest and make themselves drinks.
- We saw where on Invicta ward staff had considered the preferred place of care and death for a patient at end of life.
- An EOLC patient on the critical care ward was peaceful and did not want to be moved to a side room. Their family were provided with support and given the option of staying. There was evidence of communication involved and the consultant knew the patient's history well. The patient did not want the palliative team involved, although the team were aware and could be called upon if required.

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- There were open visiting hours for families of patients on EOLC.
- The viewing area in the mortuary was clean and of a neutral décor. Staff had added some items to make the area more homely. Between the hours of 10am and 4pm Monday to Friday the Relatives Support Officer (RSO) would accompany relatives to the viewing room and described the support they provided. This was led by the relatives and if they wished to be left alone this was facilitated by both the RSO and mortuary staff. Out of hours the site coordinator would accompany relatives.
- We found a very high level of care, pride and attention to detail in the provision of a good quality service. Staff respect for the deceased in their care was abundantly clear in all parts of the service they provided. This was also reflected in their support of the viewing process for relatives.
- Whilst needing to manage capacity in the mortuary we saw evidence that when families needed extra time to make arrangements this was facilitated.
- The same high level of care, pride and attention to detail was also evident when speaking with nurses on the wards and with porters who transferred the bodies. All staff were committed to providing a high quality service that respected the dignity of the deceased.
- We were told of a new process for preparing the deceased for transfer and the actual transfer. We received varied reports on whether the deceased's dignity was fully maintained at all times. Where staff fully understood the changes no issues were raised.

Understanding and involvement of patients and those close to them

- We observed several occasions during the visit where patients and relatives were provided with clear and comprehensive information and support. Examples included patient reassurance and explanation regarding discharge planning as well as advice and support for those recently bereaved.
- Patients we spoke with told us that they felt well informed and involved in their care and treatment.
- We spoke with a patient who had asked to speak to the CQC. They had been on the ward for three months and had received very good care and been fully involved in discussions about their care. Their family were kept well informed and had open visiting hours.

- We saw examples of the bereavement booklet provided to families on the wards we visited. We were told that families could stay on the ward to give them time following the death of a relative.
- We saw "You said – We did" boards on the wards we visited which provided feedback to patients and others who had raised concerns.

Emotional support

- Two counsellors and one social worker were employed across the Trust.
- There was a cancer survivor's forum facilitated for patients given a limited prognosis. Group support was considered a large part of the care provided to patients and carers.
- Trust counsellors and social worker linked closely with the local hospices. This enabled them to signpost patients towards community support from hospital. These included bereavement counselling and groups as well as local site specific tumour groups.
- We saw examples of Trust leaflets such as "Help for the Bereaved" that were available for families and provided information and guidance.
- The Chapel was available for all patients, visitors and staff. The chapel was open at all times of the day and night.
- We saw facilities for Christians as well as what was required for Muslim prayers, including washing facilities. There were links with all the main faiths in the areas and a clear philosophy to support all people of any faith or no faith. There were information leaflets on the service provided, bereavement, death of a child and support groups.
- There were two chaplains and they also covered the Queen Elizabeth the Queen Mother Hospital. There were trained volunteer chaplains who provided further support to patients and staff.
- The Chaplaincy supported bereaved families and staff and conducted funerals when requested.
- We saw that prayers had been collected from patients on the wards.
- The viewing room in the mortuary did not have religious symbols but there was a cross available should this be required. Staff demonstrated full understanding of other religions and cultures and worked hard to accommodate and facilitate practices as and when requested.

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Are end of life care services responsive?

Requires improvement



The specialist palliative care team were easily accessed by a referral form and responded in a timely manner. Individual, holistic care was provided to end of life care patients with complex symptoms and needs. The team were not resourced to support the less complex end of life care patients. Development and improvement work was underway in line with the East Kent regional work.

Staff worked to address issues and concerns promptly and the small number of formal complaints were monitored and actioned.

Service planning and delivery to meet the needs of local people

- The SPC team were described by all staff we spoke with as professional, responsive and supportive with specialised advice and knowledge. Where a patient was referred to the team they were prompt in responding, assessing the patient and planning care and other required referrals to, for example, therapists. Referred patients were entered on the trust system as end of life care.
- Patients with the most complex needs were referred to the SPC team. However, the SPC team acknowledged that they did not have sufficient resources to support generalist staff to have the skills and confidence to care for patients at the end of life with less complex needs. This also impacted on audit and quality measurement.
- The palliative care team and the End of Life Care Steering Group worked closely with the East Kent CCGs to ensure service provision that will meet the needs of local people. However, much of this work was embryonic and under development at the time of the inspection visit.
- Where the preferred place of death was known staff endeavoured to facilitate this. The trust did not collect information on whether patients died in their preferred place.
- In addition, rapid discharge for patients who wished to die at home was sometimes delayed and therefore did not always happen. We were told that this was

sometimes due to hospital processes and sometimes to external delays with funding and care packages for complex needs. An audit of discharge home to die was proposed.

- Mortuary staff provided the required information to the William Harvey Hospital mortuary staff who undertook a daily track of the mortuary spaces available for the three hospitals.
- The mortuary had fridges that could accommodate bariatric bodies. The recent installation of an overhead hoist system meant that bariatric bodies could be transferred more easily.
- There were concerns raised regarding forward planning for the impact of winter with increased admissions and deaths at that time of year.

Meeting people's individual needs

- Once a patient was referred to the palliative care team there was a plan for treatment and care in place that took account of each patient's individual needs. This could be working in conjunction with other specialist nurses to support patients with complex symptoms as well as those with complex needs being cared for by generalist teams.
- The SPC team and other nursing staff we spoke with told us that all communication would include the patient and those people who were important to them. We saw evidence of discussions and planning in the patient records we reviewed.
- Once a patient was for end of life care there was open visiting for families and they could sleep in the side room on a mattress if they wished.
- Where the preferred place of death was known staff endeavoured to facilitate this. The trust did not collect information on whether patients died in their preferred place.
- We saw good practice on CDU where fast track continuing health care paperwork had been completed for a patient with a view to them going home although the patient was not fit for discharge.
- We saw on Invicta ward that staff were responsive to patient and family needs as the patient wanted to go home for a day. There was consideration of preferred place of care/ death.
- Telephone translation services were available where required.
- The Chaplaincy staff were available to support patients, relatives and staff when called upon and in a manner

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according to each individual person's needs. For example, they conducted weddings for patients at the end of life if requested. Staff referred patients to the service.

- The relative support service facilitated people's wishes after the death of a relative.

Access and flow

- Access to the palliative care team was by referral form. Records we looked at showed that the team visited patients generally within 24 hours as many patients were referred in the last days of life.
- We attended the weekly multidisciplinary meeting across the three acute hospitals and heard that there was good access to the hospices. However, there were some delays for patients requiring fast track discharge. We were told that this was not working so further work was planned to try and improve the service.
- We heard and observed that the meetings were very productive.
- The Relative Support Office was open from 10am to 4pm Monday to Friday. The RSO booked all appointments for families following a death, liaised with funeral directors and ensured that the medical records and all documentation was in place for the doctors to complete the MCCDs. They also saw anyone who had a query or a concern.
- Families attending for appointments were escorted to a quiet room for discussion, advice and information. Patient belongings were stored there.
- The Chaplain was available on site from 9am to 5pm Monday to Friday. An on-call service was provided for out of hours.
- Foetuses less than 16 weeks were prepared for cremation once a month.
- We saw the daily tracking system in place regarding mortuary spaces across the three hospitals (WHH, KCH and QEOM) that was coordinated by WHH mortuary staff. This ensured that arrangements could be made for requesting extra spaces if this was required.

Learning from complaints and concerns

- The patient experience department was restructured 18 months ago and also included Patient Advocate and Liaison Service (PALS) and the Relative Support Officers (RSO).
- Should a query or concern be raised the person would be directed to the RSO office in the first instance. PALS

staff supported when required and would liaise with the ward, nursing staff or consultant as appropriate. All efforts were made to resolve issues as quickly as possible for patients and their relatives.

- Out of hours there were complaint forms that could be completed and a telephone number to leave a voicemail. The hospital web site also provided anyone with the opportunity to make a comment, raise a concern or make a formal complaint.
- All contacts were logged on an electronic system including queries and advice, concerns and formal complaints.
- Staff felt the structure was an improvement and the team worked well together.
- The end of life care and palliative care service did not receive a high number of complaints. We were provided with the complaints log for the period April 2014 to March 2015. There were a total of 17 complaints of which three concerned KCH. One of the three complaints was not upheld following investigation. The issues were raised in different areas of the hospital and there were no obvious themes identified.

Are end of life care services well-led?

Requires improvement



The trust worked in line with the East Kent CCGs' end of life care strategy. This was developing. Since the last inspection there remained a lack of Trust Board direction for end of life care. There remained a non-unified approach across the wards and departments.

We found improvements in governance arrangements, staff communication and the culture within the trust.

There remained concerns that the specialist palliative care service was sustainable and that the proposed improvements could not be implemented without further resources.

Vision and strategy for this service

- End of life care (EOLC) sits in the Specialist Services Division and there was a Trust-wide End of Life Care Board that met bi-monthly. The Consultant Nurse for Palliative Care attended this board. The four East Kent Clinical Commissioning Groups (CCGs) had an end of life work stream group and was setting the EOLC strategy for

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the area. The Consultant Nurse for Palliative Care attended the East Kent CCG work stream in order to feed back into the EOLC Board at the Trust. The strategy had been circulated prior to the 25 June 2015 EOLC Board. The trust will then develop their strategy in line with the CCG strategy.

- The East Kent End of Life Strategy was in final draft form. The strategy stated a commitment to improving the end of life experience for patients and their relatives and that this involved all parties working closely together. It considered the expected increase in demand for both cancer and non-cancer end of life care in the region.
- We were provided with a copy of the East Kent draft improvement plan based on the NICE quality standard for end of life care. The leads and timescales were not yet completed on the document.
- We were provided with a copy of the trust-wide 'End of Life Work Plan 15/16' that included raising staff awareness, training and education, audit and development of personalised care plans for end of life.
- There was as yet no replacement for the Liverpool Care Pathway that was phased out from July 2013.
- In the absence of a national pathway, there was continued work underway to develop trust wide personalised care plan documentation to support the use of the five priorities for care following the discontinuation of the Liverpool Care Pathway (LCP). This was based on current evidence and staff had obtained other NHS trust versions for consideration. This work would be rolled out by the palliative care link nurses.

Governance, risk management and quality measurement

- There had been considerable work done to improve communication between the board and the ward. We were told the EOL Board now has matron support for end of life care as a priority.
- The EOL Board minutes fed into the Patient Safety Board and into the Specialist Palliative Care meetings for decision making and implementation.
- We were told that the Specialist Palliative Care Teams oversaw the whole end of life care agenda trust-wide. Staff said that for implementation additional resources would be required.
- There was no contract or service level agreement in place between the trust and the local hospice.

- There was a trust wide Hospital Palliative Care Team Annual Report for 2013-2014 that described the staffing, role and training provided by the team. We were told that the information for the 2014-2015 report had not yet been collated.
- We were told that staff would like to undertake more audit and quality monitoring. However, with the current resources this was not possible. They wanted to audit knowledge of the five priorities of end of life care as they were aware that these were not embedded everywhere in the hospital.
- An EOLC conversation form was introduced to ensure conversations and good communication was maintained with patients and their families. An audit of use of the forms showed that there was limited take up of the forms with variable understanding and knowledge on the wards. Further work was underway to raise awareness and a re-audit proposed.

Leadership of service

- The Medical Director was the nominated lead for end of life care at Trust Board level.
- At the last inspection in March 2014, we noted that there was a lack of Trust Board direction and that this was evident in a non-unified approach to end of life care across the wards and departments. We have found the same lack of direction and non-unified approach at this inspection.
- Individual staff, both clinical and non-clinical, were passionate and committed to delivering quality care to patients and their families at this difficult time. However this was still frequently managed in an ad hoc and reactive manner as need was recognised. The early identification and resourcing referred to in the draft East Kent End of Life Care Strategy were not in place.
- The consultant orthogeriatricians took a lead on supporting end of life care on the hospital's trauma and orthopaedic wards. They described on-going collaborative work with the CCGs and nursing homes in the region. These included work on a frailty pathway, anticipatory care plans (PEACE) and shared governance meetings with the CCGs.
- The leadership and team working within the palliative care team was of a high standard and this was confirmed by all staff we spoke with.
- The Trust closely monitored times to issue of the Medical Certificates of Cause of Death (MCCD) across the three acute hospital sites and demonstrated awareness

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of the causes of any delays. One cause cited was the winter pressures period due to the increased volume of admissions and deaths. This was confirmed by patient experience staff we spoke with. They were responsible for supporting the process in ensuring that the patient records and all necessary forms and documentation were available for the medical staff completing the certificates. Despite this being a known annual occurrence we did not find evidence of forward planning to mitigate the impact to reduce delays and provide resources and support for staff. We were told that this had been raised with management following significant difficulties during last winter.

- An external company was contracted to provide the portering service. We were told of good working relationships between the company and the Trust management. However, despite staff reporting difficulties with the newly changed Last Rights process and new equipment for transferring the deceased from the ward, there did not appear to be effective joint management to increase staff understanding, confidence and competence. This impacted on the deceased's dignity being protected at all times and on staff welfare as non-clinical staff were witnessing more than they expected or were trained for. All staff were distressed when dignity was compromised.
- The new processes and equipment were purchased in response to health and safety concerns regarding manual handling as well as to reduce the possibility of damage to deceased people. However, there was a lack of consultation, education and information provided to staff in advance of implementing the changes.

Culture within the service

- All staff we spoke with described an improving culture since the interim Chief Executive Officer and other changes in the senior management team had taken place. These were quite recent but staff already felt an impact in a drive to be a more open organisation. They also felt that communication had improved.
- Consultants we spoke with felt more able to engage with senior management recently.
- There remained areas where staff felt change was not occurring but they understood that change does not happen quickly when involving culture and behaviours.
- We heard from staff that the buddy system in place was helpful, as was the external counselling service provided by the Trust.

- We heard varied comments regarding processes such as the incident reporting system. Some staff felt that it was a good learning process. Some felt it was used to point out errors in other departments but was not used to self-report in the same way.

Public and staff engagement

- The end of life care service had not undertaken a patient, relative or carer survey at this hospital.
- The 'In my shoes' project was a trust initiative that involved patients/relatives giving an account of their experience of being treated in the trust.
- Staff spoke highly of the Quality Improvement and Innovation Hub. This was an area where staff could come with suggestions for improvement. There was an end of life care stand that included a recording by a relative of a deceased patient talking about what went wrong with their end of life care. It was manned once a week from 8am to 6pm and staff told us that many ideas were generated. We saw trust responses to issues raised.

Innovation, improvement and sustainability







- Some of the reviews that were underway at the previous inspection in March 2014 had been completed, including the 'amber care bundles' pilot on the renal ward. No decisions had yet been made as to what tools and documentation would be put in place.
- The reduced specialist palliative care resources mean that this service remained unsustainable and will not be in a position to implement the end of life improvement plan and strategy when they are finalised.
- There was considerable reliance on IT systems for e-learning, cascading information and, for example, the incident reporting system. Staff described ongoing difficulties with the systems that included being very slow, closing down and sometimes not allowing access. These difficulties caused a lot of wasted time for staff as well as considerable frustration when busy. One example given was that completed e-learning was not saved by the system and it therefore appeared that the member of staff had not done the training. The impact affected staff salary levels. Staff did not appear to know whether this would be improved.
- The implementation of the Medical Interoperability Gateway (MiG) system that enabled the trust to view, with consent, patients' GP records meant that this information was available 24/7. We were informed that

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version 2 was due later this year and would allow patients' care plans to be viewed and updated. Other local healthcare providers such as the ambulance

service will also be able to view the patient records. This will mean that ambulance staff would be aware if a patient was on an end of life care pathway prior to bringing the patient into A&E.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient and diagnostic imaging services are held across the Trust at six locations. We visited five of these locations during our inspection William Harvey Hospital (WHH), Queen Elizabeth Queen Mother Hospital (QEQM), Kent and Canterbury Hospital (KCH), Royal Victoria Hospital and Buckland Hospital. The centralized outpatient appointment centre was located at Kent and Canterbury Hospital. Health Records departments were located at each site.

In the last calendar year the Trust saw 1,060,985 patients in their outpatients departments 381,435 of these appointments were at KCH. Of these appointments 70% were follow up appointments, 22% were first appointments, 6% were appointments that patients did not attend, and 2% were cancelled by the patient. Diagnostic imaging services performed 132,992 examinations during the same period.

Outpatients services were undergoing an improvement strategy which included the reduction of the number of facilities used for out-patient clinics from 15 to six; WHH Ashford, KCH Canterbury, QEQM, Margate, RVH Folkestone, Buckland Hospital Dover and Estuary View Medical Centre. At the time of our inspection Buckland hospital had recently opened. Estuary View opened on the week of our inspection so on this occasion we did not inspect this site.

KCH main outpatients is located on the ground floor with four main outpatient areas A,B,C, and D. 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. Diagnostic imaging services provide X-ray, MRI, CT, obstetric and non obstetric ultrasound scans.

During our inspection we spoke with five patients, and 44 members of staff. Staff we spoke with included reception and booking staff, clerical and secretarial staff, nurses of all grades, allied health professionals, doctors, and consultants. We observed care and treatment. We reviewed performance information about the department and trust.

Outpatients and diagnostic imaging

Summary of findings

The Outpatient department was well led and had improved since implementing an outpatient improvement strategy. Despite the strategy being relatively new, through structured audit and review the department was able to evidence improvements in health records management, call centre management, Referral to Treatment processes, increased opening hours, clinic capacity and improved patient experience.

Although there was still improvement required in referral to treatment pathways the outpatients department and trust demonstrated a commitment to continuing to improve the service long term.

As a part of the strategy the trust had pulled its outpatient services from fifteen locations to six. We inspected five of these locations during our visit.

Managers and staff working in the department understood the strategy and there was a real sense that staff were proud of the improvements that had been made. Progress with the strategy was monitored during weekly strategy meetings with the senior team and fed down to department staff through staff meetings and bulletins. However some staff we spoke to still felt there was a bullying culture. An action plan had been written prior to our visit to address this, but had yet to be implemented.

There were systems in place, supported by adequate resources to enable the department to provide good quality care to patients attending for appointments.

Evidence based assessment, care and treatment was delivered in line with National Institute for Health and Care Excellence (NICE) guidelines by appropriately trained and qualified staff.

A multi-disciplinary team approach was evident across all the services provided from the outpatients and diagnostic imaging department. We observed a shared responsibility for care and treatment delivery. Staff were trained and assessed as competent before using new equipment or performing aspects of their roles.

We saw caring and compassionate care delivered by all staff working at outpatients and the diagnostic imaging departments. We observed throughout the outpatients and diagnostic imaging departments that staff treated patients, relatives and visitors in a respectful manner.

Nurse management and nursing care was particularly good. Nurses were well informed, competent and went the extra mile to improve patient's journey through their department. Nurses and receptionists followed a 'Meet and Greet' protocol to ensure that patients received a consistently high level of communication and service from staff in the department.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



Diagnostic imaging services were providing appropriate and safe care. Staff within this department understood incident reporting processes and there were effective infection control systems in place. Equipment was well maintained in line with the appropriate legislation and guidance. We were informed that systems for ensuring staff had appropriate training were well embedded. However, at the time of reporting we had not received the mandatory training data that had been requested.

We found that the environment was mostly safe and the required safety checks were being completed and recorded. However, there was room for improvement around signage for fire evacuation. The department was visibly clean and well maintained. Equipment was readily available and staff were trained to use it safely. Hand gel dispensers were in situ at the entrances of the outpatient clinics along with other areas of the clinics. Although the clinics were busy, nursing staff provided good and safe care to patients. Treatment records were informative and showed a clear pathway of the care and treatment patients received at the hospital.

Health records management had been addressed as a part of the outpatient's improvement plan. We observed clear systems in place in the department which ensured that management of health records was duplicated across all outpatient locations. As a consequence audit results showed that on average the trust had 98.7% of health records available for patient outpatient appointments.

Incidents

- During the last year there had been one serious incident reported in outpatients between May 2014 and this had been around an appointment delay. There had been one serious incident reported in Histopathology during the same period. There had been no Never Events reported between the same periods. We were told that all incidents were investigated and were given evidence of that including action plans and learning from incidents.

- The matrons of outpatients and diagnostic imaging services told us they received regular reports of incidents and this enabled them to identify themes and trends and take corrective actions accordingly.
- Incidents were reported as per trust policy via an electronic incident reporting system. They were reviewed at the clinical risk meeting and clinical governance meetings, and also at departmental level. Incidents were also documented in the annual clinical governance report.
- Nursing staff and allied health professionals informed us they were encouraged to report incidents which occurred in their working area. All of the staff we spoke with was confident to report incidents via the trusts electronic reporting system.
- We were given examples of incidents which had been reported by various outpatient clinics and diagnostic and imaging departments, staff were able to inform us of the changes which had happened as a result of their report.
- The matrons of outpatients and diagnostic imaging wrote a monthly report for staff outlining what incidents had been reported and any mitigation that had been put in place as a result. Staff understood that incidents were monitored, and felt that they consistently received feedback on the outcomes and action taken as a result of their report. We were shown copies of the reports and evidence of learning as a result of an incident reported and investigated by the department.
- We saw a breakdown of incidents by category and date that allowed trends to be identified and action taken to address any concerns in a timely manner.
- The matrons demonstrated knowledge of duty of candour and their responsibilities around this.
- The matron told us they received regular reports of incidents and this enabled them to identify themes and trends and take corrective actions accordingly.
- Radiology staff told us that they had received training in reporting incidents. Staff were aware of how to record and report incidents on the electronic reporting system. Staff demonstrated an awareness of what types of incidents needed to be recorded and who they needed to be reported to for example, the Radiation Protection Advisor (RPA) or CQC as appropriate.

Cleanliness, infection control and hygiene

- The overwhelming majority of staff we observed in the outpatient clinics and diagnostic imaging department

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were complying with the trust policies and guidance on the use of personal protective equipment (PPE) and were seen to be bare below the elbow. However, we did see one Doctor who was not bare below the elbows in clinic room 42 during our inspection. It is essential for good hand hygiene and the prevention of the spread of infection that hospital staff are bare below the elbows whilst in clinical areas.

- We observed staff in the outpatient clinics and diagnostic imaging departments undertaking hand washing when attending patients and in-between patients. Staff working in the outpatient clinics had a good understanding of their responsibilities in relation to cleaning and infection prevention and control.
- The clinic areas and imaging departments were visibly clean and tidy. We saw staff cleaning the areas between use by patients using appropriate wipes, thus reducing the risk of cross-infection or cross-contamination between patients. Within the imaging department staff took active measures to ensure that infection control issues were appropriately dealt with.
- Toilet facilities were located throughout the outpatient and diagnostic imaging departments and these were clearly signposted. We looked at a sample of these and saw they were regularly cleaned with records showing when they were last cleaned. Clinical areas were monitored for cleanliness by the facilities team. Housekeeping staff could be called to carry out additional cleaning, where staff felt it was necessary.
- Nursing staff and allied health professionals were responsible for cleaning clinical equipment. We saw that there were checklists in place in each clinic room and observed that these had been completed to provide assurance that equipment and rooms had been cleaned. The equipment that we saw was in good repair and we noted that green labels were placed on the equipment that had been cleaned.
- The department audited Sharps bins monthly to ensure that they complied with best practice. Where issues were raised during audit they would be dealt with directly by the nurse managing the audit.
- We checked four sharps boxes and all four were labelled as they should be with the start date and the signature of the member of staff that had assembled the box. We were told that sharps boxes were removed when they were 75% full or three months old. We saw none that were over filled and all were within this date range.

- In Area A we saw a cleaner using a red mop to clear a spillage, the national specification for cleanliness colour coding denotes blue mops for general areas and red mops for toilets and bathrooms. This means that potentially the mop could have been used in a toilet and then in the general waiting area with a chance of cross infection/contamination.
- The diagnostic imaging areas we visited were found to be clean. We were shown a cleaning log which had been completed every day since the hospital opened. The log was divided into specific areas and was completed by the radiographer working in that area on that specific day.
- We noted that all staff in clinical areas complied with the 'bare below the elbows' guidance and adhered to the hospital's infection control guidance. We observed staff adopting hand hygiene techniques in the areas we visited.

Environment and equipment

- We found that, the outpatient and diagnostic imaging department had resuscitation equipment, with appropriate signage directing staff to its location. All resuscitation equipment was checked during our inspection and found to contain automated external defibrillator, suction equipment, and oxygen along with the appropriate emergency drug and medical supplies. The resuscitation equipment located in near CT had daily checklists for both paediatric and adult equipment. We observed that over a three month period there were eight days when checks hadn't been documented for the adult equipment and 35 days when checks hadn't been documented on the paediatric equipment. Other equipment was visibly clean, regularly checked and ready for use.
- Audits of Resuscitation trollies were completed monthly across outpatients and radiology. Review of these audits evidenced that staff took mitigating action where they found issues during these audits.
- The trust had recently changed its management of equipment and staff now accessed equipment through an equipment library. Staff told us that although there had been some initial teething problems the service worked well and they were able to access equipment when it was required.
- The matron and sister completed a monthly environmental audit where they inspected the

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outpatient's environment for suitability and cleanliness. Areas were RAG rated and either given a pass or fail mark. Where areas had failed this audit action plans were in place to drive improvement.

- Outpatients had a separate entrance with a reception area, and facilities for buying food and beverages. The reception desk was designed to give patients privacy when they were discussing their details. Behind the reception desk was the call centre which managed calls and referrals for all of the trusts outpatient locations.
- Once checked in at reception patients were directed to a clinic area. There were four clinic areas Clinic A,B,C, and D. Each area had its own waiting area.
- Ophthalmology clinics were run at the hospital in a separate area which was a cramped environment. Wheelchair access to the department was limited. The Optical Coherence Tomography (OCT) room was also too small and did not allow for 360 degree access for staff or patients.
- We noted that the ambient temperature in the phlebotomy clinic areas felt hot. Staff had kept a log of room temperatures and had made estates team aware that this was an issue. Due to this staff had to store blood collection tubes in a separate area as the ambient temperature made the storage of these tubes unsafe.
- The fire escapes from main outpatients were highlighted as a concern in our last report and changes had been made so as there is easy access out of the fire escape doors and onto a ramp. However, where you exit the building there was no 'green running man' signage or any other sign for pointing people in the direction of travel once you exit the building. There was a potential from both fire escapes to go either right or left and the escape route is to the left. Without signage there was the potential to take the wrong route which would block your escape in the event of a fire. HTM 05-03 5.95 states that: Fire signs should be provided where appropriate in conspicuous positions. Fire signs should be recognisable, readable and informative. They should convey essential information to regular and infrequent users of the premises and the fire-and rescue services. The visibility, illumination and height of display should be carefully considered.
- The radiation protection service within the medical physics department, had recently been reaccredited with Quality Management Standards Kite Mark ISO 9001, which rates governance standards. The medical physics department provided the radiation protection service to the whole of the East Kent Hospitals. It carried out the annual equipment checks of all radiology equipment. An environment agency visit for regulatory checks of the environmental permitting regulations had been completed in the last 6 months and there were no outstanding recommendations from this.
- In the diagnostic imaging department, quality assurance checks were in place for equipment used. We saw examples of recent audits for the certification for medical devices and quality management systems. These mandatory checks were based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000).
- We observed good practice for reducing exposure to radiation in the department of nuclear medicine. There were separate waiting areas for patients that had been injected with radioactive substance and those that had not.
- Staff told us that the change in computer systems in June 2014 meant that they were without computer records for three weeks. This consequently caused disruption to the diagnostic imaging departments throughout the whole trust and the manager told us that the department had taken nine months to recover from this. We were told that staff still experienced and reported difficulties with the computer system, which was being dealt with at an operational level.
- From observation in the outpatient clinic we saw that there was adequate equipment. Staff told us that there was not a problem with the quantity or quality of equipment that was needed at the clinic.
- Equipment was maintained, checked regularly and given a portable appliance test (PAT) in line with the trust's policy. Labels on equipment stated when the equipment was last checked. All equipment we saw had been checked within the last year.
- Main outpatients audited the number of maintenance requests that had been addressed by the estates team with seven working days. Between March 2014 and April 2015 100% of maintenance requests had been completed within seven days against a target of 80%.
- The radiology reception desk was isolated and removed from the radiology waiting area and examination rooms. Patients initially arriving were observed knocking on examination doors, whilst an examination was in progress. There was not always a member of staff in the reception area to provide guidance to patients.

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- The radiology waiting area had some facilities for children. The toilet facilities and changing areas available to people were clean with a patient call bell available in both.
- Equipment was new and serviced in accordance with the trusts medical devices contract. We saw that service reports were stored electronically for each piece of equipment in Radiology. Equipment was serviced annually and the last service had been within the last 6 months.
- In diagnostic imaging, quality assurance checks were in place for equipment. We saw examples of recent audits for medical devices certification and quality management systems certification. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000).
- Specialised personal protective equipment such as lead aprons for staff and lead shields for people were available in the radiology department.
- We saw that the resuscitation trolley checks were complete and recorded.
- Staff told us that at weekends they work alone in the department. There is an emergency bell in the general x-ray room, but not in the ultrasound rooms. This could be an issue if an emergency situation arose, though there are security staff available in the hospital.

Medicines

- Medicines were stored in locked cupboards in the outpatients and diagnostic imaging departments. Nursing staff ordered all medicines through the hospital pharmacy. Pharmacy monitored stock levels once a week. Nurses told us that the level of support that they received from pharmacy was satisfactory.
- A lockable medicines fridge was in place, and daily temperature checks were recorded. Temperature records that we looked at were completed and contained minimum and maximum temperatures to alert staff when they were not within the required range. We also found evidence of prompt and appropriate action that had been taken when the Fridge had been found to be outside of the recommended temperature range.
- The ambient room temperature was also monitored in the room where medications were stored. This ensured the efficacy of the medications stored. We found the medications stored in the department were within their expiry date and stored securely.
- Prescription pads were stored in a locked cabinet. When clinicians wrote patient prescriptions the clinic kept a log which identified the patient, the doctor prescribing and the serial number of the prescription sheet used. This ensured the safe use of prescription pads.
- Rigorous checking procedures had alerted staff quickly where a prescription pad had gone missing. Staff demonstrated that they had followed correct procedures where this had occurred.
- Outpatients audited prescription pads monthly to ensure that processes were being followed. Audit results showed 100% compliance.

Records

- All staff reported a marked improvement in the availability and quality of patient health records. Following our last inspection where this had been highlighted as a problem within the department the trust had rolled out a 'Your Responsibility' campaign. The campaign targeted all staff and made them responsible for looking after, correcting errors and tracking notes to the right departments.
- Staff within the health records departments were very proud of what they had achieved since our last inspection. The departments were fast paced but calm and organised. Staff were able to work at short notice where needed to source health records for clinic. They spoke about their sense of achievement when they managed this when time was against them. They told us that they worked well in their teams and supported each other when it got busy.
- Between May 2014 and April 2015 audit results showed that on average the trust had 98.7% of health records available for patient outpatient appointments. This figure excluded availability for short notice clinics. The trust had a target for availability of health records set at 98%. They had met or exceeded this target for every month in that period.
- The latest audits of health records which covered the three month period of April, May and June 2015 showed that over this three month period health records had supplied 5588 health records for clinics, with 174 of this total being temporary records.

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- The department audited the reason why temporary notes had been used in clinic. Over this period 18 were set up because the appointment was at another site, 12 had been requested but not sent, 29 already had a temporary set of notes which were used again, and 46 were for late appointments (less than 48hr notice).
- The Health record management team managed the health records for all the hospitals in the trust. They used identical systems in each hospital. They had a dedicated van that makes two trips to each location including the off-site facility every day. We asked what happened if there were too many notes for the van to take and we were told that they are then sent by taxi if needed before the van made its second trip. On the day of our inspection we were told that funding had just been given for a second van. We asked if operation stack (where lorries were parked on the M20, effectively closing the motorway) had any effect on delivery times. We were told the drivers always seem to be able to find other routes.
- The trust had a Health Records manager responsible for Health records trust wide and then three site leads that covered the individual sites.
- The Health Records team picked and tracked all notes. There were processes in place to do this which started eight days before clinics which ensured that notes were available for clinic. If having followed these processes health records were unavailable for clinics temporary health records were compiled. If notes were off the site the trust had a facility to scan notes 24 hours a day and within 15 minutes the person requesting could read the health records.
- The Health Records team does all the picking and tracking out of all notes. They initially get the clinic list eight days before a clinic where they can pick the notes, highlight any missing, notes that are in other clinics and start searching for missing notes. The staff then pick any further notes three days before and highlight notes still missing. They will start to make temporary files based on the clinic the patient is attending and what information they have in the way of results and letters. Within 24 hours they will revisit to see if they can complete the list of notes, if they can't then the temporary set is used.
- If these notes were off the site the trust had a facility to scan the notes 24 hours a day and within 15 minutes the

person requesting could read the notes. They had a system where by temporary notes were highlighted on the system and when the originals were found they were merged and duplicates destroyed.

- The department were in the process of procuring another off-site storage facility which would store inactive notes. These were notes that have not been used for two years.
- Examination results and reports are stored securely on a picture archiving communication system (PACS). Staff can access previous examination results on this system which enables them to identify and prevent recurrent exposure to radiation in accordance with IR(ME)R regulations.

Safeguarding

- Staff we spoke with were aware of their responsibilities and understood their role in protecting children and vulnerable adults. They demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. The trust had a whistleblowing and safeguarding policy that was known to staff working in the outpatient and diagnostic imaging department. They told us that they would feel happy using this policy to raise concerns if they felt it was necessary.
- There was a safeguarding lead at the hospital and the outpatient and diagnostic imaging staff were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff assured us they knew who the trust's safeguarding lead was and how to contact them.
- Each outpatient site had a safeguarding link nurse. The link nurse had a special interest in safeguarding and attended regular meetings to ensure they were updated with most recent best practice guidance. They shared their learning with the rest of their team and operated as a resource for the department where questions around safeguarding decisions were made.
- Staff in the outpatient and diagnostic imaging department had completed mandatory safeguarding training to level 3, and child protection level 3 training. They were able to talk to us about the insight and knowledge gained from this training. An outpatient's staff nurse was able to give us an example of when staff in the department had followed the trust safeguarding policy and made an appropriate referral.
- Staff in radiology told us that there had been no safeguarding incidents to date, and policies were

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accessible in both paper copy and online. We were able to see that staff knew where to find both. Staff demonstrated a good knowledge of what to do if a safeguarding issue arose.

- Staff had completed safeguarding training to the required level as part of their mandatory training.

Mandatory training

- Staff knew how their training was monitored and confirmed that managers reminded them when training was overdue and needed to be completed.
- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if requested.
- Across all staff groups including both clinical and administration staff the percentage of outpatients staff who had had completed mandatory training was Equality and Diversity 92.5%, Fire Safety 90.1%, Health and Safety 77.5%, Infection Control 88.6%, Information Governance 82.5%, Moving and Handling 92.2% and Safeguarding 93.2%.

Across all staff groups including both clinical and administration staff the percentage of radiology staff who had had completed mandatory training was Equality and Diversity 84.2%, Fire Safety 76.0, Health and Safety 78.4%, Infection Control 81.3%, Information Governance 63.0%, Moving and Handling 81.3% and Safeguarding 64.8%.

Across all staff groups including both clinical and administration staff the percentage of pathology staff who had had completed mandatory training was Equality and Diversity 88.3%, Fire Safety 80.8%, Health and Safety 74.9%, Infection Control 83.0%, Information Governance 77.1%, Moving and Handling 84.7% and Safeguarding 84.3%

- Corporate induction training was provided for all staff and was compulsory for all staff to attend. There was also a service specific induction; this was specific to the department staff worked in and their role. We saw records held within the outpatients and diagnostic imaging department which showed the induction records for new staff were comprehensive and up to date. All of the staff we spoke with confirmed that they had received their mandatory training in line with the Trust's policy.

- Staff told us they were given time to undertake mandatory training which was offered in a format of e-learning with some face to face training for training such as manual handling.
- We saw examples of staff training records showing completed training. We also saw examples of the monitoring that showed that staff had undertaken all mandatory training, such as health and safety, infection prevention and control, moving and handling, safeguarding and basic life support.

Assessing and responding to patient risk

- The hospital had systems and processes in place for responding to patient risk. Staff were noted to be available in all the waiting areas of the clinics so that they would notice patients who appeared unwell and needed assistance. Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for people living with dementia or learning disability, and elderly or frail patients with more than one medical condition.
- There were clear procedures in place for the care of patients who became unwell. Staff we spoke with told us about emergency procedures and escalation process for un-well patients. However they stated these had not been used often as the department did not often have acutely unwell patients.
- There were emergency assistance call bells in all patient areas including consultation rooms, treatment rooms and the x-ray suite. Staff we spoke with told us when the call bells were used they were answered immediately. Staff we spoke with were aware of their role in a medical emergency. Staff provided an example of a patient who had become acutely unwell during a clinic appointment where a cardio-respiratory resuscitation (CPR) team had been called to assist the patient.
- We observed good radiation compliance as per policy and guidelines during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. We saw radiographers referring to IR(ME)R (medical exposure) regulations for a patients examination.

Nursing staffing

- The outpatient clinics were staffed by registered nurses and health care assistants. Each clinic was run by registered nurses and was supported by health care assistants.

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- Where areas required a trained nurse to be available for clinics, for example breast clinics, they would be provided.
- Doctors that we spoke with told us that they were able to be supported by chaperones where required.
- The main outpatients had 2.44 whole time equivalent health care assistant posts out for recruitment at the time of our inspection. They had increased the recruitment template to accommodate the extended opening hours of the clinics at the hospital.

Medical staffing

- Medical staffing was provided by the relevant specialty running the clinics in the outpatient department. Medical staff were of mixed grades, from consultants to junior doctors. There was always a consultant to oversee the clinics, and junior doctors felt supported by the consultants.
- Doctors we spoke with thought they had a good relationship with outpatient nursing and clerical staff. They said they felt well supported and could discuss issues with them.
- The trust's policy stated that medical staff must give eight weeks' notice of any leave in order that clinics could be adjusted in a timely manner. The outpatient department audited compliance with this policy. Where doctors had not followed the policy staff escalated this to divisional leads to be investigated.
- Consultants and registrars provided cover for each other at times of annual leave or sickness whenever possible. All medical staff we spoke with confirmed that cancellation of a clinic was a last resort.
- Where data in the main outpatients departments indicated that clinic templates were not meeting with patient demand, for example clinics that were consistently overrunning, matron used this data to discuss changing the templates to reflect this demand with divisional leads and consultants.
- Matron in main outpatients produced an annual survey for consultants and doctors asking how they felt about the service and any service improvements they felt could be made. In this year's survey they had included questions about working out of normal clinic hours in order to get a gauge on which consultants may be prepared to manage clinics outside of outpatient hours.
- The results of the 2015 Consultants survey showed that 124 consultants responded to the survey trust wide. 98.3% were satisfied with nursing support in the

department, 95.1% were satisfied with nursing investigations prior to clinic, 67.4% were satisfied with their clinic template, with 42.7% being prepared to work extended hours to assist with capacity issues such as overbooking of clinic templates.

- According to the Royal College of Radiologists and the British Society of Interventional Radiologists a Trust of this size should employ six interventional radiologists. At the time of our inspection there were 2 interventional radiologists and we were informed that a third was currently being recruited.

Major incident awareness and training

- The trust had a business continuity management plan which had been approved by the management team. The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- The hospital major incident plan covered major incidents such as winter pressures, fire safety, loss of electricity, loss of frontline system for patient information, loss of information technology systems and internet access, loss of staffing, and loss of water supply.
- Most staff we spoke with were aware of the hospital's major incident plan such as winter pressures and fire safety incidents, and they understood what actions to take in the event of an incident such as a fire. The matron and sister demonstrated an in-depth knowledge of this plan and how they would implement it.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence based assessment, care and treatment was delivered in line with National Institute for Health and Care Excellence (NICE) guidelines by appropriately trained and qualified staff. Diagnostic imaging staff were meeting the requirements of Ionising Radiation regulations 1999, IR(ME)R regulations 2000 and demonstrated regular environmental health audits.

A multi-disciplinary team approach was evident across all the services provided from the outpatients and diagnostic imaging department. We observed a shared responsibility

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for care and treatment delivery. We observed patients received effective care and treatment in line with national guidelines. Patients were provided with sufficient information about their treatments and had the opportunity to discuss any concerns. KCH ran a one stop clinic for Breast, Dermatology and Urgent Skin Cancers and Rheumatology. Other one stop clinics ran across other outpatient locations in the trust. Outpatient managers were working with divisions to increase the numbers of one stop clinics as part of the outpatient's strategy.

Staff working in the clinic told us their managers encouraged their professional development and supported them to complete training. Appraisals were undertaken annually. Nursing staff and allied health professionals completed competency assessments which related to the work that they undertook in each clinic area.

We saw evidence from staff training records that clinical staff had completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff undertaking procedures were aware of the need to obtain patients' consent and completed appropriate consent documentation.

Diagnostic imaging staff were meeting the requirements with Ionising Radiation regulations 1999, IR(ME)R regulations 2000 and had regular environmental health audits.

Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance and the trust's treatment protocols and guidelines were available on the trust's intranet. Staff told us that guidance was easily accessible and was clear and comprehensive. We saw that the outpatients and diagnostic imaging department was operating to NICE guidance and local protocols and procedures. Staff we spoke with were aware of how this guidance had an impact on the care they delivered.
- We noted that NICE guidelines were in use in most clinics. Staff we spoke with described how they ensured that the care they provided was in line with best practice and national guidance. Adherence with NICE guidelines was monitored by the relevant directorates' clinical governance committees.
- National Institute for Health and Care Excellence (NICE) guidance for smoking cessation had been met within the department. The outpatient 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. These assessments had recently been updated to include the use of E Cigarettes.

- Main Outpatients audited the number of patients who had been assessed for their smoking status and offered advice. Between March 2014 and April 2015 90.3% of patients had been offered this service against a target of 100%.
- Staff in the department demonstrated a working knowledge of NICE Guidance for recognising and responding to acute illness in adults in hospital. The department used a multiple parameter scoring system to allow a graded response to patients who became unwell in the department.
- During our visit we saw that local rules were displayed, reviewed and within date in controlled X ray rooms in compliance with Ionising Radiation Regulations.
- Staff demonstrated the use of IR(ME)R regulations and guidance relating to the examination of patients.
- The trust had a radiation protection advisor who leads on the development, implementation, monitoring and review of policies and procedures in order to comply with IR(ME)R regulations.

Pain relief

- The imaging department had a stock of pain relief and local anaesthetic for use when invasive procedures were been carried out. We saw that pain relief was discussed with patients during their consultation or treatment and analgesia was prescribed as necessary and dispensed by the hospital pharmacy.
- Patients at the outpatients department had access to pain relief when it was needed. Clinical staff reported that patients' pain was assessed and monitored to ensure they received the appropriate amount of pain relief when in clinic. Staff told us that they could give paracetamol to patients if they were in pain, but all other analgesics had to be prescribed before being administered to patients.
- Staff in pain clinic told us prescribed pain relief was monitored for efficacy and where necessary changed to meet patients' needs. This is discussed with patients as part of their ongoing management of pain.
- Pain clinics were managed by specialist nurses and consultants. Following a 'We Care Survey' in the trust where pain relief was raised as an area for improvement

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the trust had completed some work around making improvements. Pain clinics were held at the three main outpatient sites (WH/QEQM/KCH). Patients were seen prior to their appointment where they were assisted to complete a pain scoring tool. This allowed patient outcomes to be monitored robustly.

Facilities

- The hospital had a large reception area with a manned desk and automated check in machines. The automated check in service was a new initiative being trailed at the Buckland site. Staff were hopeful that the system would be rolled out to the other outpatient's sites in the Trust.
- Once seated in the waiting areas patients would be called through to their clinic via a television screen and audio system. Important messages were also displayed on the screen for patients such as clinic delays.
- Signage was poor in the hospital. Staff were aware signage was inadequate but had been told that they needed to give the walls time to settle before signs could be erected. We saw that signs had been purchased and were ready to be displayed once staff were given permission to do so.
- There had been some snagging issues with the new building but these had been reported by staff and were awaiting rectification. There was a steering group which included patient representatives which met monthly and took forward snagging issues around the new build.
- There were vending machines and a shop on the ground floor of the hospital where patients could buy food and beverages.

Competent staff

- Corporate induction training was provided for all staff and was compulsory for all staff to attend. There was also a service specific induction; this was specific to the department staff worked in and their role. We saw records held within the outpatients and diagnostic imaging department which showed the induction records for new staff were comprehensive and up to date. All of the staff we spoke with confirmed that they had received their mandatory training in line with the Trust's policy
- We spoke with a selection of staff in all departments who told us that they had participated in the annual

trust appraisal system. All staff we spoke with told us they were well supported by colleagues and by their managers. 90.19% of nursing staff across outpatients were up to date with their annual appraisal.

- Staff throughout the main outpatient and diagnostic imaging departments were required to obtain competencies that were relevant to their role. Competencies were in place for clinical tasks, supporting patients, and use of equipment. Competencies included the knowledge and theory which supported the practice. The department had an education lead that ensured that competencies were in place and up to date for all staff.
- Staff received mandatory training such as infection control, safeguarding and health and safety. They were also provided with training relevant to their specialty such as general surgery, orthopaedics, cardiology.
- We spoke with staff throughout the outpatients who told us there were many development opportunities available for them and that the trust supported staff to broaden their competencies.
- We spoke with HCA's, sisters, link nurses, and nursing staff who described how the intranet published courses available and contained good information for them to access.
- Of the trust wide band four training places offered to band two nurses, four of the seven trust wide positions were given to outpatient nurses. Matron was extremely proud of this as the feedback showed that the applicants were of a high standard. The band four training gave opportunities for nurses to tag on modules that were specific to their own working environment. Matron was ensuring that these modules would assist with the departments plans to increase the numbers of one stop clinics across all outpatient sites.
- The matron was working alongside divisional leads to establish and train staff in competencies to improve pre-assessment clinics. This was where a patient was identified for surgery in outpatient's clinics a nurse would be able to take the patient through pre-assessment so that the patient can be prepared for surgery in the same appointment reducing the need for separate appointment in the hospital.
- We spoke with two phlebotomists who were trained for their roles in house, where they were supervised and signed off as competent by their managers. Staff in this department also had a role in training medical students and nursing students in intravenous access.

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- We saw an equipment competency log for all staff working within the radiology department. This had been completed for all staff in the team within the last month.
- All radiographers working in the NHS are required to be registered with the Health Care Profession Council (HCPC). The registration of radiology staff is checked each year along with an assessment of their skills.
- Outpatient audited the checking process for trained nurses being updated with the nursing and midwifery council (NMC) registration requirements. They had a 100% target on these checks and had met this target each month over the period May 2014 to April 2015.

Multidisciplinary working

- KCH ran a one stop clinic for Breast, Dermatology and Urgent Skin Cancers and Rheumatology. Other one stop clinics ran across other outpatient locations in the trust. Outpatient managers were working with divisions to increase the numbers of one stop clinics as part of the outpatient's strategy.
- There was evidence of multidisciplinary working in the outpatients department. We were told about a number of examples of where joint clinics were provided e.g. breast clinic, dermatology clinic, ophthalmology, older person's clinic and oncology clinics.
- Many clinics had multi-disciplinary (MDT) meetings, particularly the cancer related specialties, where the team agreed and planned the care for patients and decided which clinician would be seeing the patient in clinic to explain the plan to them. We saw, for example that a member of staff from the outpatient's clinic and breast radiology attended the breast care MDT.
- Specialist nurses ran clinics for some specialties, such as a pain clinic, breast clinic, heart failure clinic and diabetic clinic, among others. We spoke with some of the specialist nurses, who described how their clinics fitted into patient treatment pathways. Nursing staff and healthcare assistants we spoke with in clinics such as orthopaedic and gynaecology clinics told us that teamwork and multidisciplinary working were effective and professional.
- We saw that patients were regularly referred to community-based services such as community nursing services and GP services.

- Good internal team working was reported in radiology between services. For example, between the minor injuries unit and diagnostic imaging services. The staff reported that they had good relationships with the local GP's and were able to discuss a person's care if needed.

Seven-day services

- Part of the public consultation process around the new outpatient strategy along with a need for increased capacity to meet with the increasing workload outpatients had recently increased its opening hours.
- Outpatients across all sites was now opened between 7.30am and 8pm Monday through Friday and on a Saturday morning.
- Two extra nurses had been employed on the three main sites (WHH, QEQM, KCH) and one extra nurse on the two smaller sites.
- Opening hours were supported by radiology, pharmacy, and therapy staff.
- The service ran Monday to Friday from 8.30am to 5.30pm. We were told there were no evening or weekend clinics. The fracture and orthopaedic clinic provided Sunday service from 8:30 – 1pm.
- The diagnostic and imaging department offered seven-day services for inpatients and those who attended the emergency department.

Access to information

- We found patient information leaflets throughout all areas of outpatients and diagnostic imaging departments. The department was able to obtain leaflets in other languages and in large print format when required.
- Staff in radiology were able to access a person's previous diagnostic imaging examinations via PACS. This is important to ensure that people did not receive an overexposure to radiation following IR(ME)R guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence from staff training records that clinical staff had completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with confirmed they had completed training and undertaken regular updates. However we noted that their knowledge of MCA and DoLS was variable with some staff demonstrating clear knowledge of the act and its implications.

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- Patients we spoke with said that they completed consent forms before their treatment, when this had been appropriate. We were told that clinicians asked for consent before commencing any examination and explained the procedure that was to take place. Staff undertaking procedures were aware of the need to obtain patients' consent and completed appropriate consent documentation.
- Where required mental capacity was assessed by consultants and doctors in clinic. Doctors had access to mental capacity assessments, best interest decision checklists, decision making flowcharts, and information on the process including a two stage capacity test.
- Outpatients had leaflets displayed in all outpatient areas which explained decisions around consent for patients. They explained the need for healthcare professionals to gain consent, forms of consent, and commonly asked questions around the consent processes.

Are outpatient and diagnostic imaging services caring?

Good



We saw caring and compassionate care delivered by all staff working at outpatients and diagnostic imaging department. We observed throughout the outpatients department that staff treated patients, relatives and visitors in a respectful manner. Staff offered assistance without waiting to be asked.

Clinical room doors were kept closed, and staff knocked before entering clinic rooms to maintain patients' privacy. Patients and relatives commented positively about the care provided to them by the staff from all the clinics visited. Staff ensured that patients understood what their appointment and treatment involved.

Patients told us they felt involved in their care and treatment, and they thought that staff supported them in making difficult decisions. Patients told us they were given sufficient information about their care and treatment and were fully involved in making decisions about their care and treatment. All the patients we spoke with told us the

staff were caring and polite. Patients we spoke with were satisfied with the services provided and stated that doctors and nurses had time to discuss with them their care and treatment.

Compassionate care

- We observed most staff interactions with patients as being friendly and welcoming. We observed some instances where patients that attended clinic regularly had built relationships with the staff that worked there. We saw examples of caring interactions by healthcare assistants. For example, friendly greetings, getting down to a patient level to interact with them and maintaining eye contact.
- We saw that staff always knocked and waited for permission before entering clinic rooms. We also saw that clinic rooms had signage instructing people to knock and wait for an answer before entering to maintain people's dignity.
- One patient explained how the consultant had explained in detail their treatment options and ensured they had all the information they required. We observed a nurse explaining paperwork to a patient attending their first appointment, following a diagnosis of their illness. Everything was explained very calmly and they also ensured the patient and their partner had the correct phone numbers should they need to ring for more information.
- People we spoke with told us they felt listened to and were given sufficient information about their treatment. Patient's confidentiality was respected. Patients and staff told us there were always rooms available to speak to people privately and confidentially.
- Notices were displayed for patients informing them that chaperones were available and offering them the right to have treatment and consultation from same sex staff. An example of this was in the cardiac clinic where information was displayed explaining that patients would be required to remove their clothing to the waist.
- Throughout the two days we visited the outpatient department, we observed nursing, healthcare and receptionist staff interacting in a positive and caring manner with patients. We saw that enquiries made at the reception desks were responded to in a polite and helpful manner. We saw patients being redirected to other clinic locations with a clear and reassuring approach.

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- Reception staff told us when patients arrived for appointments their name, date of birth, address, and telephone number were checked with them at this desk. Patients waiting to be seen were signposted to stand back from the desk in order that conversations could be had in private.
- Matron had rolled out a customer service training course for all main outpatients' staff. All nursing staff and reception staff had attended this course which helped staff to deliver a patient centred service, and taught staff how to deal with difficult conversations and challenging situations in the department.
- Main outpatients gathered patient views and reported monthly on the findings. As a part of this survey patients were asked 'Overall, did you feel you were treated with respect and dignity while you were at the Outpatient department?'. The response on this question in 2014 surveys was that 100% of patients felt that they had been treated with respect in the department.
- Outpatients had leaflets to inform patients about what to expect with regards to privacy and dignity. We saw that these leaflets were displayed in all outpatients' areas.
- In radiology we saw examples of staff being friendly, approachable and professional. We witnessed people being spoken to with respect at all times.
- Staff made sure that patient privacy and dignity was respected at all times. During intimate examinations staff reported that they always lock the door, however chaperone's were not always available. This led to staff feeling that both themselves and patients were left in a vulnerable position.
- We saw that there was a secure viewing area for staff looking at a persons examination details. This ensured confidentiality and allowed staff to discuss findings with colleagues without being overheard

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved and informed about their care. Patients told us they were given sufficient information to help them make any decisions they needed to make. We were told that treatment options were clearly explained.
- Staff were expected to use the departments 'Meet and Greet' protocol and competencies related to this protocol were assessed for all staff. This meant that

patients were all treated with respect by staff and were kept informed of any clinic delays and the reasons for these. The department audited compliance with these competencies.

- Between May 2014 and April 2015 'Meet and Greet' competencies had been completed by 99.2% of reception staff and 99.71% of nursing staff. The trust target for completion of these competencies was 90%. Both staff groups had exceeded this target every month.
- Main outpatients gathered patient views and reported monthly on the findings. As a part of this survey patients were asked 'Did the doctor explain the reasons for any treatment or action in a way that you could understand?'. The response on this question in 2014 surveys was that 99% of patients felt that this was the case in the outpatients department.
- In radiology we saw staff giving clear explanations to people about the examinations they were going to receive. However there were no patient advice leaflets available in the radiology patient waiting area.

Emotional support

- Staff explained how they tried to provide support to patients who were given distressing news. One nurse explained how they ensured they were with the patient when the consultant spoke with the person. They would also make sure they stayed with the person afterwards to ensure there was no delayed reaction.
- Patients and relatives we spoke with confirmed that they had been supported when they were given bad news about their condition. Staff explained how they ensured patients were in a suitably private area or room before breaking bad news with them. We were told that it was always possible to locate a suitable room for these discussions. Nurses were always available to help and support patients with information when they were in clinic.
- In main outpatients some band 5 staff nurses had completed extra training to support patients when they had received bad news. Where bad news was being shared with patients the nurse would sit through the consultation with the patient, be responsible for documenting what was said and how the patient had reacted, and be responsible for supporting the patient through the process. The nurse would take the person to a private room where they would check that the patient understood what they had been told, and establish with them the level of support they required.

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- This role had been established as the department recognised that although patients were being supported by the Clinical Nurse Specialist (CNS) some patients required further support through the pathway and the band 5 nurse was able to offer this extra help and guidance.
- In radiology during obstetric examinations partners were encouraged to be in attendance. However, we noted that there was no separate room available should bad news need to be broken.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



The outpatient service was not always responsive to patients' individual needs. Overall, not all patients were seen within the national waiting time target for waiting to be seen in a clinic. The department had in place an improvement plan which was designed to improve on the referral to treatment times (RTT), however this had been in place for a short time and the long term impact on RTT figures across the trust could not be evidenced at the time of our inspection. However, the trust were able to demonstrate that they were making inroads on the backlog of appointments in most specialities.

Ophthalmology had a backlog of follow up appointments which they had a strategic plan in place to address. Follow up appointments were rated by clinicians for urgency, these appointments were then managed through partial bookings and monitored for risk through weekly governance meetings.

We observed some delays in patients being seen at their appointed time throughout the time we were onsite at the hospital in some clinics. Delays in clinics were explained to patients, with staff following a protocol which ensured that they told patients about clinic delays and the reasons for these. They were kept informed and comfortable with beverages, and when required food. The department audited staff compliance with this protocol.

The centralised call centre which managed referrals across all outpatient locations had been vastly improved since our last inspection. Telephone systems had been updated and improved and staffing increased. The managers in this

department were constantly reviewing performance data and had overhauled the referral to treatment pathway management to ensure a fairer system for patients who were now all given appointments in chronological order. The department was rolling out new procedures for the booking of follow up appointments through a partial booking process. The trust had so far rolled this out in Ophthalmology and Cardiology but planned to roll it out to all other specialities by the end of March 2017.

The radiology manager told us there had recently been an external review of the Trust radiology services by Nottingham NHS Trust, to assess equipment and staffing levels.

Complaints were being managed in line with trust policy and staff were able to tell us how they had made service improvements as a result of complaints analysis.

Service planning and delivery to meet the needs of local people

- During our inspection we observed the phlebotomy clinic in operation. This was a "walk in" clinic meaning that patients did not make an appointment. Patients were seen in a timely manner and not kept waiting long for the service. We observed that the area was bright and comfortable with plenty of patient seating.
- Phlebotomy told us that they had support from the vascular team to assist them where they had difficulty with venous access. They said that this was not required often but was a huge help when needed.
- The hospital audited the time that patients waited for their appointment and monitored trends in late running clinics. In the latest monthly audit of June 2015 at the KCH site 693 patients were seen in clinic. Of these patients 61.33% of patients were seen within 30 minutes, 13.56% were seen within 30-40 minutes, 12.12% were seen within 40-50 minutes, 3.46% were seen within 50-60 minutes, 4.62% were seen within 60 - 90 minutes, 2.31% were seen within 90-120 minutes, 1.44% were seen within 120- 180 minutes and 0.72% were seen after 240 minutes. We are unable to compare this to results nationally as this data is not collected at all trusts nationally. However across the trust KCH had the worst reported waiting times for patients.
- Staff in the department followed a 'Meet and Greet' protocol. Staff were required to pass competency assessments around this protocol before running clinics. The protocol told staff at what intervals to advise

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patients about waiting times and when to offer them refreshments or food. Matron had worked with staff who initially found it hard to go into a waiting room full of patients and explain to them the reasons for the clinic delay. The department demonstrated a commitment to keeping patients informed and comfortable during clinic delays.

- Referrals were triaged by a manager and on the day of inspection the oldest referral they had in the department was dated 21 June 2015. They adhered to the 18 week pathway but actually saw all patients within six weeks. The department had not breached the 18 week referral to treatment pathway since July 2014. They aimed to fit hearing aids within 12 to 13 weeks as an internal standard to keep the 18 week pathway unbreached. Patients were then given a follow up six to eight weeks after the fitting of the aid. If at the appointment the patient seemed fine and was well the follow up could be a phone call however if deemed necessary by the audiologist the patient will be seen in clinic. Audiologists complete the letters to GP's which were sent the same day as the appointment in clinic.
- The interventional radiology department offered treatment to patients with a diagnosis of prostate problems that enables patients to be able to attend as a day case rather than a potential longer stay.
- We observed that the radiology department had tables with adjustable heights. This offered easier access to a patient with mobility difficulties.
- The digital radiography suite was suitable for paediatric patients. Staff told us they ensured the lowest possible dose of radiation was given to obtain the correct information.
- Patients told us they were allocated enough time with the doctors when they attended their appointments, and that their appointments were not rushed. Doctors were well informed about patients' medical history, and patients' medical records were available to doctors.
- The hospital audited the time that patients waited for their appointment and monitored trends in late running clinics. However, because this hospital site had only recently opened we are unable to report on these results.
- The main outpatients completed audits which recorded how many patients were told about clinic delays. The results of this audit were published each month and fed into the governance report for outpatients. Between March 2014 and April 2015 91.9% of patients on average

had been informed about clinic delays of more than 20 minutes. In the same time period an average of 84.8% of patients had been informed of the reason why the clinic was running late.

- The matron met with divisional leads across all outpatient sites and planned capacity eight weeks in advance. They worked to ensure that all clinics were utilised as much as possible across all sites. Matron then communicated with the sisters to ensure that they can support this clinic activity with their staff and worked to ensure that staff were available for clinics that were required. Matron made it clear that their priority was to get the service delivered and to 'worry' about getting paid by the divisions at a later date.
- The audiology outpatients team managed their own referrals which came directly from GP's, internally through wards and via the Cancer pathway, the ENT Team, and GP's with a special interest in ENT (usually symptoms like glue ear are referred this way). The department also undertakes pre and post-operative hearing assessments where the operation may affect hearing. We were told there were dementia champions in all audiology clinics across the trust. The manager was very proud that the service was the largest provider in East Kent.

Access and flow

- Hospital Episode Statistics for December 2013 – December 2014 showed that 381,435 outpatient appointments were made at KCH. We noted that 70% of patients attended their follow up appointment, with 22% attending their first appointment. The data showed that the hospital's ratio of follow-up to new appointments was higher than the England average. Out of the total appointments made, 2% had been cancelled by patients and 6% by the hospital. Both these figures were below the England average of 6% and 7% respectively.
- Staff managed patients not attending clinics (DNAs) by text reminders. Between December 2014 and December 2015 6% of patients at KCH did not attend their appointments, this is lower than the England average of 7%. We were told by trust managers that the hospitals did not attend rate was continuously monitored to enable changes and adaptations to be made to minimise waste of resources. For example, texting had been used to remind patients of their appointment date and time. Measuring the non-attendance rate is

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important, because non-attendances mean that resources are not being used well and can have negative impact on patients receiving services at the hospital.

- Part of the outpatients strategy was to improve Referral to Treatment times (RTT) across the trust. This had been a problem for the Trust at our last inspection. We were shown data which demonstrated that a robust monitoring and improvement plan was in place. The trust were able to demonstrate that they were making inroads on the backlog of appointments in most specialities.
- The trust had also improved their processes to ensure that patients were being given appointments in a fairer way. Previously the system of benchmarking patient pathways had meant that patients that breached the initial pathway could be placed out of date order meaning that patients who had entered the pathway after them could have received appointments before them. The new system ensured that patients on 18 week pathways were seen in strict chronological order.
- 95% of on non-admitted patients should start consultant-led treatment within 18 weeks of referral and 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral.
- More detailed analysis showed that the following specialities were performing below the NHS operating standard of 92%. General Surgery 82.2%, Urology 90.4%, Trauma and Orthopaedics 84.4%, ENT 88.2%, Ophthalmology 90.1%, Oral Surgery 88.4%, Gastroenterology 83.8%, Dermatology 89.9%, Thoracic Medicine 91.4%, Neurology 85.5%, and Gynaecology 89.2%.
- Four specialities were performing above the NHS operating standard of 92%. These were General Medicine 98.6%, Cardiology 93.7%, Rheumatology 95.4%, and Geriatric Medicine 89.2%.
- Of these statistics 6,247 patients were on the non-admitted treatment pathway (which involved only outpatient interventions). Of these patients half of them were seen within seven weeks, with 19 out of 20 patients starting their treatment within 20 weeks. Ophthalmology was highlighted as a service which was struggling to manage the demands on the service. As part of the Ophthalmology strategy, the clinical teams put Ophthalmology forward to be the first speciality to go with partial booking. As part of this programme, recording sub speciality was implemented. This allowed the service to focus on those areas that were in most need of capacity and allow the correct recruitment strategy to be developed to address the gap in clinical skills.
- Due to historic Patient Administration System (PAS), the true follow up capacity gap was not visible. Partial booking has given transparency to the issues facing follow ups which have been included within the Ophthalmology Business Case. To date there are approximately 5,500 patients waiting for a follow up appointment outside of their required timeframe to be seen. Follow up capacity currently stands at 11,000 appointment slots from June until December 2015. Following further analysis the capacity is not within the correct sub speciality and there is now a requirement to reallocate resources within the teams. Additional weekend lists were addressing some of the capacity gap, with the recruitment of an outside company to provide additional nursing and technician support to the medical teams.
- It was anticipated that the business case would be approved in August 2015. Within this case there were 3 new consultants. Two of these will be recruited to emergency eye care, releasing the current consultants back into their sub speciality clinics. This will give an additional 2,480 appointments back to the sub speciality. In addition, the nature of the emergency eye care presentations will be addressed by consultants sub specialising in Cornea conditions which will reduce consultant to consultant referrals as they will be able to deal with the condition on presentation.
- The third consultant will specialise in glaucoma disease which is also a high volume speciality. The trust had been working in partnership with the CCG to design a pathway for stable glaucoma which will allow follow up patients to be seen in their community rather than in an acute setting. The CCG are currently working through the implications to the community services.
- With the 2 new emergency eye care consultants will be additional outpatient capacity which will equate to approximately 252 outpatient slots.
- Since the inspection the Trust has confirmed that the business case for ophthalmology has been presented to the strategic investment group by the clinical lead where it was approved to be presented at management board in November.

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- Part of this business case is to introduce virtual clinics for diabetic medical retina patients. The Trust have written a pathway for the CCG to transfer approximately 4000 stable glaucoma patients into the community.
- In the meantime the Trust have written a specification to go to tender for an external company to integrate with services to provide additional capacity. The department also currently have an outside company assisting with weekend capacity.
- The follow up waiting list was held on a system called EPR. The Trust are in the process of transferring the patients onto PAS and validating as part of the process. Part of this process is providing clinical validation for some of the lists such as orthoptics and contact lens patients.
- For each patient that requires a follow up appointment the clinician indicates the priority whether it is urgent, chronic or routine. The priority selection criteria was decided by the lead clinician.
- The departments governance team are monitoring the follow up list weekly with the operational team prioritising patients from the partial booking list as appropriate with risk being discussed at every governance board.
- The trust reported on cancer wait times trust wide. This data could not be broken down by hospital site. In quarter four 2014/15 93.9% of patients given an urgent referral by their GP on suspicion of cancer to the trust had their first consultation within 2 weeks of the referral as recommended. The trust was operating above the set operating standard of 93% for the 2 week cancer waiting times however it was operating slightly below the England average suggesting it was not operating as well as other trusts in England.
- In quarter four 2014/15 97.5% of patients given a decision to treat for cancer received their first treatment within 31 days of the decision. The trust was operating above the set operating standard of 96% for the two week cancer waiting times it was also operating above the England average suggesting it was operating better than other trusts in England.
- In quarter four 2014/15 75.3% of patients given an urgent referral by their GP on suspicion of cancer to the trust received their first treatment within 62 days of the referral. The trust is operating below the England average suggesting it is not operating as well as other trusts in England.
- All two week referrals went through the central booking office. Any breaches of the two week RTT went on a report that was circulated to divisional leads daily. Performance on cancer targets was also discussed at a weekly key performance indicator (KPI) meeting.
- There was an acknowledgement that endoscopy was struggling to meet with RTT targets. We were told that the trust had tightened up of the escalation process in order to address the issues. However a lack of doctors in the trust able to perform endoscopic procedures put a strain on the trusts ability to meet with the demand for this service. A national advertising campaign had meant that in June 2015 the trust had 2400 two week referrals which was an increase of 200 on previous month.
- The outpatients booking office managed calls and referrals for all of the outpatient locations in the trust and dealt with 76% of the trusts referrals with some specialities managing their own booking processes.
- The outpatients booking office had four main functions. It operated as a call centre Monday through Friday 8am until 4pm, and was about to start operating as a call centre on a Saturday 8am until 4pm. It operated as a referral and booking centre for all the outpatient sites which included 'Choose and Book' referrals. It had a rapid access team which dealt exclusively with two week and cancer referrals; and it managed the clinic maintenance team who set up clinics on the patient administration system (PAS), amended clinic templates, and cancelled and rebooked clinic appointments.
- 'Choose and Book' referrals were directly bookable by patients who could access and book appointment slots by phone or online. They could also be booked indirectly by outpatient's booking office staff. If 'Choose and Book' referrals could not be managed within the 18 week timescales the system would alert staff who would go to the referrer and obtain a paper referral that could be managed outside of the 'Choose and Book' system.
- Once paper or fax referrals were received, clerks would date stamp the referral before booking the patient onto the system and sending the referral to the relevant consultant for triage. Managers told us that the expectation was that consultants would triage referrals within 48 hours; however this was not always happening. The manager of outpatients booking was working on a service level agreement which was a draft stage at the time of our inspection. They hoped that

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once completed and agreed by specialties that this document would have clear protocols and key performance indicators (KPIs) around the timeframes for triaging referrals.

- Triage referrals would be rated for urgency and then forwarded to the outpatients booking team to make the appointment. Urgent appointments were made within two to four weeks unless they were on the cancer pathway when an appointment was given within two weeks, and routine appointments were made within 18 weeks. Central booking staff then booked appointments using the urgency scale. We were told that they would escalate to divisional leads if they could not make appointments within the agreed timescale.
- The call centre monitored the length of time it took for calls to be answered, the length of time calls took, and the number of people who ended the call before it was answered. By doing this they were able to monitor trends and ensure staffing levels in the department met with the demand. The telephone systems had recently been upgraded to improve the services. The upgrade had created some initial snagging issues but these had been resolved.
- Interventional radiology staff told us that they have the ability to provide an excellent service to vascular, renal and urology teams. However, the gastrology and trauma services were based at another site which had limited services for interventional work. This could lead to the potential transfer of unwell patients to get to the treatment they required.
- The radiology manager told us they were managing waiting times in diagnostic imaging. At the time of reporting the average wait for x-ray was less than one day, MRI, CT and non obstetric ultrasound was 20 days. Overall this was less than the wait times at the time of our inspection.
- Staff told us there was a delay in reporting CT examinations. Consultants were receiving additional pay to come in at weekends to clear the back log of reporting. However we were told some staff manipulate this system to come in at weekends, so they can increase their salary. At the time of reporting the number of diagnostic test waiting to be reported on was 628.
- Staff told us that there were sometimes delays in examinations, for inpatients, as there is no dedicated porter for radiology and there is often a considerable wait.
- At the time of our visit, the general x-ray waiting area was very quiet. We did request clinic numbers for the weeks pre, during and post inspection, but at the time of writing the report we had not received these figures.
- Latest RTT times published by NHS England published on 9th July 2015 show that overall the Trust performed below the NHS standard of 92% with 88.4% of patients who had started their treatment within 18 weeks. These statistics are reported at Trust level and are not broken down by hospital site.
- Of these statistics 6,247 patients were on the non-admitted treatment pathway (which involved only outpatient interventions). Of these patients half of them were seen within seven weeks, with 19 out of 20 patients starting their treatment within 20 weeks.
- Ophthalmology was highlighted as a service which was struggling to manage the demands on the service. As part of the Ophthalmology strategy, the Clinical teams put Ophthalmology forward to be the first speciality to go with partial booking. As part of this programme, recording sub speciality was implemented. This allowed the service to focus on those areas that were in most need of capacity and allow the correct recruitment strategy to be developed to address the gap in clinical skills.
- Urology also struggled to meet cancer pathway targets due to several issues within the four separate pathways. There were Issues with diagnostics within the pathways in particular with biopsies relating to prostate cancers. The trust had a 10 day target for biopsy which was not currently being met. This trust was currently breaching the 31 day RTT target by approximately 20 patients per month.
- Where booking staff had escalated patients who they were unable to book within the timescales required, divisional managers would steer staff on how to manage these bookings. We were told that this would be addressed by providing extra clinics, converting follow up appointment slots into new appointments, double booking clinic spots or by agreeing breaches in the RTT.
- Main outpatients audited the number of referrals that had been scanned and registered on the electronic system within five days of receipt. Between March 2014 and April 2015 100% of referrals had been processed within five days against a target of 100%.

Meeting people's individual needs

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- Staff ensured that patients who may be distressed or confused by the outpatient environment were treated appropriately. Patients living with a learning disability or diagnosis of dementia were moved to the front of the clinic list. The outpatient staff liaised where needed with ambulance transport staff to ensure that this process ran smoothly.
- We were told that translation services could be accessed through language line for people whose first language was not English.
- Patients we spoke with were positive about the outpatient services and told us they were satisfied with the treatment they received. Patients made positive comments about nursing staff, healthcare assistants, receptionists and doctors.
- From the hospital entrance towards the radiology department, signage was clear but only written in English. This included a notice asking women to inform the radiographer if there is any possibility they may be pregnant. This may put patients at risk if they did not understand the signage.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Initial complaints would be dealt with by the outpatient matron, but if the matron was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). Staff explained the complaints procedure to us.
- Complaints were discussed at departmental level and also at Directorate Clinical Governance Group meetings. There was evidence to show that lessons learned were shared with staff. Most of the staff we spoke with were able recall when actions from complaints were shared with them.
- Matron encouraged staff to contact them when a patient was complaining. They told us that they preferred this as they always got the 'whole picture' where they managed complaints like this, and that they could often resolve the problem far quicker if they could deal with it straight away. They gave a recent example of what appeared to be a simple complaint about the length of time it took to get an appointment but was in fact a far more complex complaint which matron was able to deal with within an hour of meeting with the complainant.
- As a whole the trust had received 239 outpatient and diagnostic contacts through the trusts Patient Advice

and Liaison Service (PALS) between April 2015 and June 2015, 115 of these had been at the KCH site. We looked at the reasons for these contacts but saw no apparent trend.

Are outpatient and diagnostic imaging services well-led?

Good



Outpatients had implemented an improvement strategy, and a special measures action plan following our last inspection. Managers and staff working in the department understood the strategy and there was a real sense that staff were proud of the improvements that had been made. Progress with the strategy was monitored during weekly strategy meetings with the senior team and fed down to department staff through staff meetings and bulletins.

Staff were keen to show us areas that had been improved and this was particularly evident in outpatient's central booking and the health records management team.

Staff felt that outpatients were an area that the trust board were interested and invested in. Matron described the department as a progressive and important place to work, and had leased with occupational health to ensure that nurses who were not fit to work elsewhere in the hospital were not sent to outpatients believing it to be a less strenuous department to work in. Matron said, "I only want committed nurses in this department, who want to embrace the opportunities to learn and progress, it is such an interesting place to work".

The nursing care and management of nurses in the department was exceptional. The matron and sisters were very well thought of by their staff. Nursing staff were very clear on their roles and responsibilities and the direction that the department was going in.

Matron was very proud of her staff and the outpatients department's successes, but equally keen to drive improvement in the patient experience throughout the department, and share good practice in outpatient areas that were not directly managed by them.

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There was an open culture in the outpatients department and we were given examples where band 2 HCAs had challenged doctors and stopped clinic appointments where they were not happy with an aspect of care.

The diagnostic imaging services senior management team had a clear vision and strategy for their service. At site level diagnostic imaging teams reported that they felt supported and worked well together. However there appeared to be a disconnect between the senior management team and staff delivering care. There were mixed views on the culture within the department with some staff telling us they felt there was an open and supportive culture and others reporting one of bullying.

Vision and strategy for this service

- The trust had implemented a Special Measures Action plan following our last inspection. The action plan identified where issues had been raised during inspection and outlined actions to be taken by the trust along with an agreed timescale. This action plan had been RAG rated on delivery of objectives.
- Outpatients had implemented an improvement strategy. The outpatient clinical strategy objectives as approved by the board in June 2014, following public consultation, were to reduce the number of facilities used for outpatient clinics from 15 to 6; WHH Ashford, KCH Canterbury, QEQM, Margate, RVH Folkestone, Dover and Estuary View Medical Centre. To offer a wide range of services across most specialties including diagnostic support. To extend clinic hours from 07.30 -19.00 and Saturday mornings to improve patient choice and access and make more effective use of staff time. To increase the number of people who are within a 20 minute drive of outpatient services. To invest in the clinical environment to support high quality clinical services and an improved patient experience. To develop a one-stop approach more widely than is currently seen in services. To expand the use of technology to reduce follow up appointments and support patients, monitoring their progress at home or in primary care; and to invest £455,000 in extending / modify public transport routes provided by Stagecoach.
- Progress with the strategy was monitored during weekly strategy meetings with the senior team.
- Outpatient had a business plan in place for 2015/2016. This outlined the streamlining of services from 15 outpatient locations to six, a review of 18 week and two

week pathways with a strategy for meeting a rise in demand, a review of current work streams and their purpose, a market assessment and planned developments.

- Outpatients had a Patient Administration Review Project Group whose main objectives were to review all patient administration services in order to deliver an efficient patient pathway that complied with national and trust access standards, and delivered an improved experience and access for patients. We were shown examples of improvements that had been made to the service as a result.

Governance, risk management and quality measurement

- Risk and Governance meetings were held monthly which were attended by managers throughout the outpatients departments. The outcomes from these meetings were shared with staff during staff meetings and matron devised a monthly highlight report for staff which summarised the clinical governance report and highlighted learning from incidents and complaints. This went to all departments and was pinned on staff notice boards.
- We saw local risk registers for directorates that included the outpatients and diagnostic imaging department, which enabled the Corporate Governance Group to understand the most significant risks and approve action to mitigate those risks.
- There were regular team meetings to discuss issues, concerns and complaints across the division.
- The trust undertook clinical audits such as hand hygiene, infection control, sharps, resuscitation equipment and records of the audits showed a high percentage of compliance with good practice.
- The trust also audited referral to treatment pathways, call centre statistics, meet and greet protocols and clinic waiting times in order to monitor patient experiences through the department.
- The results of these audits were fed back through leadership meetings, clinical governance meetings, staff meetings, and patient user groups to ensure that service improvements were made where indicated.

Leadership of service

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- The main outpatient's sister was new in post. Staff spoke optimistically about their appointment and felt that they were a positive role model and manager for the department.
- We found competent staff managing each of the clinical areas visited. Staff told us that they had confidence in the people managing them and that leadership within the outpatients. Staff showed a good understanding of the values and vision of the trust and felt able to raise concerns.
- The matron had worked hard to ensure that processes were identical across all main outpatient locations. This meant that nurses could work across sites as there was consistency in both processes and expectations of them. Other outpatient clinics which were run by other divisions such as Ophthalmology who had recently started to use the meet and greet competencies that had been used in main outpatients. The matron was starting to work with matrons in other clinics to share good practice and encourage joint learning.
- The matron and sisters were spoken of very highly by staff who felt well supported by them.
- There were clear lines of accountability and responsibility within the outpatients and diagnostic imaging department. Staff in all areas stated that they were well supported by their managers, that their managers were visible and provided clear leadership.
- Staff felt optimistic following the arrival of the new Chief Executive.
- Band 7 sisters had been offered places on the leadership programme. This programme assisted them in their development as managers.
- Matron took part in a 360 degree appraisal programme which they used to improve on their ability as a leader. Due to the success of this approach matron was planning to implement this style of appraisal for the band 7 sisters in the department also.
- Staff in radiology told us that members of the executive team had attended a recent team meeting and intended on making this a regular occurrence.

Culture within the service

- There was a positive culture amongst all staff in outpatients; staff were committed and proud of their work. Quality and patient experience was seen as a priority and everyone's responsibility.
- All the staff we spoke with in outpatients told us that communication between different professionals was

good and that it helped to promote a positive culture within the department. Staff described a very positive working environment. Clinical staff we spoke with told us they felt able to raise concerns and discuss issues with the managers of the department. All staff we spoke with were professional, open and honest, and were positive about working at the hospital. Staff acted in a professional manner, they were polite and honest and respectful.

- Matron was very proud of the department and the staff who worked there. They had worked hard to ensure that staff saw it as a progressive and innovative place to work and learn. Matron had worked with occupational health to ensure that nurses were not sent to the department with health related problems, wrongfully believing that it was a quieter place to work.
- We were given examples of where staff had felt able to speak out and raise concerns. We were told that a band 2 HCA had stopped two new doctors from accessing the computer systems when they didn't have identification on them. We were also given an example of a band 2 HCA stopping a clinic where they felt someone living with a learning disability did not have the understanding to consent and didn't have an advocate with them to assist with the situation.
- All staff in main outpatients had been involved in the 'Wellbeing Programme'. Staff attended sessions where they were involved in discussions around subjects such as weight loss and stress. From this staff were able to self-refer themselves for further assistance.
- Staff were aware of the confidential staff counselling service available to them.
- Matron and sisters were mindful of the stress that staff could be under in particular with the changes to the services. They had encouraged staff to complete stress awareness assessments and had referred staff to occupational health where these had established the need for further assistance.
- One module of the customer care training attended by all main outpatient staff was entitled, 'Our customer, our responsibility'. This ethos was fed in part throughout each module of the programme. The training taught staff to see all people entering the hospital as their customers and their responsibility. Staff therefore did not ignore the needs of patients or visitors attending other areas of the hospital.
- We saw evidence that this ethos was embedded in the way that staff treated people entering the department

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throughout our visit. Matron gave an example where one of the outpatient nurses had found a patient alone waiting for transport, and had stayed with them until they had been collected at 9pm. This was despite the patient not being an outpatient's patient on that visit.

- We spoke to several members of diagnostic imaging staff who told us they had experienced bullying either to themselves or others. These issues had been raised via a confidential helpline provided by the trust and to line managers. However, they felt that the issues had not been resolved. The leadership team told us they were not aware that there were bullying issues and during discussions around bullying some managers adopted a defensive attitude.
- The last trust staff survey resulted in the development of an action plan by the diagnostic imaging team. This had been written just prior to our visit and no actions had been implemented.
- All staff in main outpatients had been involved in the 'Wellbeing Programme'. Staff attended sessions where they were involved in discussions around subjects such as weight loss and stress. From this staff were able to self-refer themselves for further assistance.
- Staff were aware of the confidential staff counselling service available to them.
- Matron also described reception staff noticing an increase in patients attending the hospital because they had been unable to access the call centre. Staff had raised this and matron had contacted the call centre immediately to get the issue resolved.

Public engagement

- Outpatients held quarterly user group meetings where people who had used outpatients were able to involve themselves in improvements to services. The group had been involved for example with collecting patient views around facilities and had as a result of this obtained some higher back chairs for improved comfort of patients attending clinics.
- The current survey being managed by the group was around how long patients would wait after hearing that their appointment had been cancelled, to contacting the department if they hadn't received an appointment to replace it. From this survey the group will look at the wording in appointment letters to reflect their findings.

- Patient user group members were involved in the 'walk the floor' audit where they were able to monitor the care and environment and make suggestions for improvement.
- The users group was currently advertising for more patient representatives. Matron actively recruited patients who had made a complaint about the department to join the group, and gave an example of a patient representative living with hearing difficulties who had greatly improved the facilities and awareness in the department around this disability.
- The hospital had run a patient survey on the usage of the new electronic booking system. The survey showed that 96.3% of patients found the system easy to use, with 94.2% saying that they would use it again.

Staff engagement

- In the staff room in main outpatients sister had displayed communications to staff on a notice board which updated staff on key messages as well as having a 'you said, we did' section for staff innovation and service improvements.
- In order that staff felt included and well informed about the strategy each member of staff had received a letter which included a description of the strategy and how it affected them. Staff were able to confidently discuss their progress on service improvements along with areas that had been identified as still requiring improvement.
- Staff we spoke with said they felt engaged with the trust and could share ideas or concerns within their peer group and with their managers. Staff were given trust messages directly via email, and through bulletins and on screen savers. Staff we spoke with said they felt well informed of developments and issues within the hospital and the wider trust in general.
- In the most recent staff excellence awards the first three places were awarded to staff from the outpatients. First place was awarded to an HCA, second place to an associate practitioner, and third place to an administrator. The staff were proud of this achievement and felt that it was reflective of staff commitment within the department to deliver a high standard of patient care.

Outpatients and diagnostic imaging

- Some diagnostic imaging staff told us they felt well supported by their managers and felt engaged with the Trust. However, others reported that they were not aware of developments and issues within the hospital and did not feel engaged with the trust.
- Some radiology staff felt that a lead sonographer should be available for supervision and training. They told us they didn't feel well supported without this assistance.
- Radiology staff told us that meetings occurred twice a month at present as the service was new, in order to identify and monitor how the service was running.
- A staff room was available in the hospital for team building and training. Staff told us that this was accessible to all.

Innovation, improvement and sustainability

- Volunteers at the KCH hospital had approached matron with a suggestion on how to make the hospital maps sent in outpatient appointment letters clearer. Matron had taken on board their suggestion and encouraged them to join the service improvement group.
- Ophthalmology were a service that had been identified by the trust as experiencing difficulties meeting patient demand and requiring improvement. As a result a team was formed for each of the services who worked to develop recommendations that increased capacity, efficiency and flexibility. The overall vision for the service transformation that would be driven by the ophthalmology strategy was expressed as, "An agile service with the capability and capacity to meet demand pressures, whilst providing excellent and sustainable care for our patients".
- From the respective teams output an overall transformation strategy for the whole ophthalmology service was developed. The transformation strategy involves an increase in staff numbers and new equipment to support these staff. The strategy takes advantage in the changes to outpatient facilities being driven by the outpatient clinical strategy, and new facilities at Dover hospital and Estuary View, ensuring efficient use of these facilities and maximising patient throughput.
- The strategy also recommends the introduction of an electronic patient record system in the form of software which will drive both efficiency increases and cost savings. The system can also be rolled out to, and

integrated with, community services to support the flow of patients in and out of acute services. Ophthalmology was successful in obtaining external funding to commence this project commencing this financial year.

- In order to improve patient experience and choice the outpatient improvement team had made changes to the ways in which follow up appointments were being made in some speciality groups. The changes were made to enhanced patient experience by reducing the number of times follow up appointments are cancelled and rebooked, to optimise capacity, and improve on outpatient efficiency. On 15 December 2014 Outpatients launched partial booking within the trust with the Ophthalmology specialty. In June 2015 Cardiology started partial booking with a full evaluation and lessons learnt exercise being undertaken at the time of our inspection. The trust had set itself a target to complete roll out of partial booking by end March 2017.
- As a result Ophthalmology had started to use a partial booking system to book patients for follow up appointments. The trust had produced a flow chart for staff to follow when booking these appointments which included the escalation system where appointments could not be booked within the timescales required. Secretaries told us that the initial issues with the system were an increase in calls from regular patients who didn't understand the changes in the way that their follow up appointments were managed.
- The outpatient's improvements programme had also recently instigated changes to the follow up booking Protocol for out-patient Cardiology. Any patient leaving clinic whose clinician had requested they be seen again in outpatients within the next eight weeks would have their appointment made prior to them leaving the hospital. Any patient leaving clinic whose clinician had requested they be seen again in outpatients any time after eight weeks would be added to a waiting list. The clinician would also have to identify (via the outcome form) the category of the patient. Category 1 – Urgent Pathway, Category 3 – Routine, and Category 4 – SOS (Discharge but can ring if in problems within 6m). The protocol described the process and included a flow chart for staff to follow.
- Outpatients were piloting the accredited Ward /Department developed collaboration with the trust wide Ophthalmology matron. The programme helped staff to look critically at their service along with celebrating good patient care.

Outstanding practice and areas for improvement

Outstanding practice

- The outpatient improvement plan had improved the service for patients. The team managing these improvements had regular meetings to establish their progress whilst ensuring staff were informed about improvements being made and the reasons behind any changes to the service.
- The management of health records and the central call centre had improved at a fast pace since our last inspection and we felt assured that these improvements would continue.
- The Nurse leadership in outpatients was outstanding with staff inspired to provide a good service to patients. The main outpatient's matron provided knowledgeable and inspirational support to staff whilst working hard to maintain and improve the service.

Areas for improvement

Action the hospital **MUST** take to improve

- The trust must review its nursing establishments to ensure that numbers of registered nurses meets national guidance, and the needs of patients at all times, including throughout the night.
- The trust must review the medical establishments to ensure that the numbers of doctors is sufficient to meet the needs of patients at all times, including through the night and at weekends.
- The trust must clarify name and service provided in the ECC and provided protocols for the ambulance service about what patients can be admitted.
- The trust must review its arrangements to ensure they can be assured that medicines and intravenous fluids are stored safely and securely.
- The trust must review its arrangements for ensuring that resuscitation equipment is available and ready for use at all time.
- The trust must ensure that training for staff on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards is available for staff providing care to patients with a cognitive impairment.
- The trust must ensure that suitable arrangements are made for patients with mental health issues whilst awaiting assessment.
- The trust must ensure that staff have the knowledge and skills required to comply with the organisational systems and processes for consistent incident reporting.

- The trust must seek and act on feedback from patients, families and carers for end of life care services.
- There must be sufficient numbers of suitably qualified, competent, skilled and experienced end of life care staff to ensure the quality of service for all end of life care patients seven days a week.

Action the hospital **SHOULD** take to improve

- The trust should review its medical bed capacity to ensure that the majority of patients are cared for in the correct speciality bed for the duration of their hospital admission. It should also review its arrangements for the management of patients outlying in non-speciality beds to ensure the quality and safety of their care is not compromised.
- The trust should review the processes in place that provide assurance that equipment shared between patients is clean and ready for use.
- The trust should review the pharmacy service and how staff shortages are impacting on patient's timely discharge.
- The trust should review its care planning arrangements for summarising and recording the individual needs of patients when individual risks have been identified.
- The trust should review pain management tools to assist patients living with a disability or dementia.

Outstanding practice and areas for improvement

- The trust should ensure that all confidential patient records are fit for purpose and securely stored in clinical areas to minimise the risk of unauthorised access.
- The trust should consider the support available to people living with learning disabilities is provided when they are patients, and to its staff to ensure they can meet individual needs.
- Continue to improve referral to treatment times across all specialities to ensure that patients are treated in an acceptable timeframe following referral to the service.
- Consider how the environment in which surgical services are provided would be suitably maintained.
- Improve theatre utilisation.
- Ensure that staff are afforded the opportunity to have their performance formally reviewed.
- Ensure staff in surgical areas complete all the required mandatory training.
- Ensure that patient risk assessments were completed and acted upon.
- The trust should consider standardising inotropic infusions to avoid the risk of potential drug errors when staff engage in cross site working.
- The trust should continue to improve Referral to Treatment times across all specialities to ensure that patients are treated in an acceptable timeframe following referral to the service.
- The trust should ensure patients are identified as at end of life promptly.
- The trust should improve advance planning for end of life care patients that includes a replacement for the Liverpool Care Pathway that will reflect their needs and preferences.
- The trust should ensure that joint training with contracted services is in line with best practice and trust policies. Relevant staff should be involved and consulted.
- The trust should ensure that end of life care documentation on the wards is up to date and accurate.
- The trust should ensure clear executive leadership and trust board strategy for end of life care.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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