East Kent Hospitals University NHS Foundation Trust

# Queen Elizabeth The Queen Mother 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 |
| Urgent and emergency services | Requires improvement |
| Medical care | Requires improvement |
| Surgery | Requires improvement |
| Critical care | Good |
| Maternity and gynaecology | Requires improvement |
| Services for children and young people | Requires improvement |
| End of life care | Requires improvement |
| Outpatients and diagnostic imaging | Good |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Queen Elizabeth the Queen Mother Hospital (QEQM) 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.

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

The QEQM hospital has a total of 388 beds, providing a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric services.

Following our last inspection of the Trust in March 2014 when we found many of the services provided to be inadequate, EKUHFT 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 EKUHFT 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:

**Safe**

- At the last inspection we told the Trust they must ensure there were appropriate levels and skills mix of staffing to meet the needs of all patients. At this inspection we found that although staffing overall had improved through a sustained recruitment initiative and the use of agency and bank staff, recruitment continued to be a problem for the hospital. The numbers, skills and qualifications of staff did not always reflect the needs of patients.
- Although the Trust had revised the adverse incident and serious incident policy and had trained more staff in incident investigation and Root Cause Analysis, patients were not always protected from inappropriate or unsafe care because staff were not always reporting incidents. Where incidents were reported there was good evidence that learning was shared and actions taken to prevent reoccurrence.
- The environment was not always a safe place to care for patients. For example there was only one obstetric operating theatre for both emergency and elective procedures; the flooring in the corridor areas on St. Augustine's ward was uneven, dirty and badly worn with tears in the covering. The toilets did not always conform to requirements under the Disability Discrimination Act (DDA) and were unable to accommodate patients with walking aids. Shower and bathrooms were used as storage facilities and cluttered making them unfit for patient use. The layout of the day care unit did not meet best practice in infection control and presented a contamination risk; Fire safety concerns were raised in both the midwifery wards, theatres and on St Augustine Ward. The poor state of the environment was an issue raised at the previous inspection.
- Access to and availability of equipment had improved since our last inspection through the implementation of an equipment library. However equipment was not always cleaned and checked in line with trust policy and there areas in the hospital where appropriate equipment was not readily available. For example there were insufficient fetal monitoring machines in the maternity department, a weighing machine and stand aid on St Augustine Ward had not been serviced and decommissioned autoclaves remained in theatres.
- We found that the theatres did not comply with national guidance in relation to risk assessment; the environment, and staff training.
- Staff were aware of the policies for infection prevention and control and adhered to them. The majority of clinical areas we visited were visibly clean and tidy.
- We found that attendance at mandatory training had improved along with the system for recording and monitoring attendance although the mandatory training targets and agreed actions had not been achieved.

# Summary of findings

- The recording of patient assessments and the documentation and monitoring of patients' treatment, needs and observations had improved since our last inspection. Patient observations were undertaken electronically and regular audits were undertaken to check that information was recorded appropriately.

**Effective**

- Most of the services we inspected provided effective care. National guidance was used to inform the care and treatment of patients and services participated in national and local audits.
- At the last inspection we found that the paper and electronic policies, procedures and guidance that staff referred to when providing care and treatment to patients were out of date. The Trust had undertaken a major review of the Trusts policies and procedures and apart from the emergency department and medication policies, the majority were now current and reflected best practice.
- We found that although the wards and consultants offered a seven day service they were not always supported by other services. This limited the responsiveness and effectiveness of the service the hospital was able to offer and on occasions delayed discharge. For example there was no access to therapy staff, dieticians or speech and language therapists (SALT) at weekends on the stroke ward. Pharmacy services only available until midday at weekends, which impeded timely discharge for patients who were unable to obtain their discharge medication.
- We found that patients were always asked for their consent before any intervention and this was always appropriately recorded.
- There was good multidisciplinary working throughout the hospital.
- In general patients received timely effective pain relief and their nutritional needs were being met.

**Caring**

- Patients throughout the hospital commented positively on their experiences. They told us they received kind and compassionate care, which maintained their dignity and respected them as individuals.
- We saw caring and compassionate care being delivered throughout the hospital but in particular we observed staff in the outpatients and diagnostic and imaging department treating patients, relatives and visitors with respect and thoughtfulness.

**Responsive**

- We found that the hospital did not always have sufficient bed capacity to meet the needs of the patients admitted. This meant that patients were often moved between wards during their stay, they were admitted to non-specialty beds where their own doctors were difficult to contact and consultant reviews less likely to occur. The lack of capacity had negative implications for the safe care and treatment patients.
- Patient flow through the surgical services was limited by availability of beds at times, caused by delayed discharges. In turn delayed discharges associated with provision of on-going support, rehabilitation and delays in take home medication adversely impacted on the hospital's bed capacity. This was raised as a concern at the last inspection.
- In the emergency department there was no emergency assessment room for patients with acute mental health needs.
- Surgical referral to treatment times were not being met over consecutive months for surgical specialties. Theatres were not always effectively utilised and this affected performance.
- Improvements were needed for the day-care environment, as this did not provide sufficient privacy.
- Arrangements were in place to support people with disabilities and cognitive impairments, such as dementia. Translation services were available and information in alternative languages could be provided on request.
- The complaints process was understood by staff and patients had access to information to support them in raising concerns. Where complaints were raised, these were investigated and responded to. Where improvements were identified, these were communicated to staff through a range of methods.

# Summary of findings

**Well Led**

- 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.
- We found that the Trust had taken action to refocus its vision and mission strategy. Staff at QEQM were articulate in understanding the Trust's vision and 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.
- 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 directorate strategic aims and principles. Although there was now a clear direction of focus in many of the services, others such as the midwifery unit lacked a clear strategy and strategic direction.
- However many of the leadership, organisational and developmental changes were in their infancy and had not had time to deliver the necessary changes to the patient experience.
- Some services such as the midwifery service had been through a period of instability of leadership which led to a great deal of staff dissatisfaction and unrest. Although progress was being made to stabilise the midwifery service with appointments to a number of interim, acting and substantive posts, a number of staff remained unhappy.
- The Trust had identified there had been a culture of bullying and harassment within the trust. We found at QEQM there were still pockets where staff felt intimidated and were not confident to speak out. The Trust told us of the actions and initiatives that were taking place to address these concerns.
- Governance arrangements throughout the hospital had been strengthened and were starting to provide more robust information to staff at all levels and to the Trust Board.

We saw several areas of outstanding practice including:

- Outpatients where substantial changes had taken place since our last inspection and the service offered was focused on ensuring that patients received a positive experience when attending the hospital.
- The pre-operative joint clinic is recognised as enhancing patient outcomes.
- 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 inspiring support to staff working hard to maintain and improve the service.
- The care pathway for patient discharged with ridged cervical collar in place is acknowledged for contributing to on-going response care to individuals.

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

Importantly, the trust must:

- The trust must take action to ensure that HTM 05-01 is complied with in operating theatres, particularly with respect to; risk assessment; the environment, and staff training.
- The trust must take action to remove the decommissioned autoclave from theatres.
- There must be sufficient numbers of suitably qualified, skilled, and experienced midwifery staff available to deliver safe patient care in a timely manner.
- The environment and facilities in which patients are cared for must be safe, well maintained, fit for purpose and meet with current best practice standards.
- There must be sufficient equipment in place to enable the safe delivery of care and treatment, that the equipment is regularly maintained and fit for purpose to reduce the risk to patients and staff.
- The Trust must ensure the hospital has sufficient capacity to cope with the number of women in labour and new born babies on a day to day basis.
- The wards must be supported in providing a full seven day service by appropriate numbers of support services such as radiology, physiotherapy and pharmacy.

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- There must be robust systems in place to monitor the safe management of medicines to ensure that national guidelines are reviewed appropriately and their implementation monitored.
- Ensure that required signatures are included in CD registers.
- Ensure that temperature checks are monitored and recorded on fridges used to store medicines and food supplements.

In addition the trust should:

- The trust should ensure that the mandatory training targets and agreed actions are achieved.
- Consider how it can address staffs knowledge and understanding with respect to the Mental Capacity Act (2005) and deprivation of liberty safeguards.
- Ensure that all safety checks on equipment are carried out.
- Consider how it may improve the environment in the day surgical unit.
- The trust should consider how it may move forward with the implementation of the dementia care work to bring it to fruition.
- 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.
- Standardising inotropic infusions to avoid the risk of potential drug errors when staff engage in cross site working.
- There should be a formal vision and strategy for women's health services to enable the development of a modern maternity service which is woman centred, underpinned by a sound evidence base and benchmarked against best practice standards.
- Methods of maintaining the stability of leadership within the maternity department should be established.
- The routine administrative burden on maternity staff at weekends and out of hours should be reduced in order to free midwifery staff to look after patients.
- Staff should be encouraged to report non-clinical incidents in order that action can be taken to protect patients from avoidable harm.
- The electronic system for allocating NHS numbers to new born babies should be functioning, in order to avoid the risk of babies missing screening tests through a manual process with insufficient printers available.
- There should be a robust system in place to measure, monitor and analyse common causes of harm to women during pregnancy and childbirth.
- Continue to work with commissioners to ensure there is adequate funding and resources for the End of Life service.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| Urgent and emergency services | Requires improvement  | The department under reported incidents as staff told us they were too busy to report incidents. Also, the use of a daily communications log by nursing staff at the end of a shift was used to share incidents which had occurred during their shift. Some of these issues should have been reported as a critical incident. However, there was evidence of learning from an incident through the trust's magazine 'Risk Wise'.<br>There were dedicated facilities for children but there was a lack of trained children's nurses. When children's nurses were in the department they could be looking after adult patients, which they were not trained to do or they were not always aware there were children in the department requiring their attention.<br>Mortality and morbidity meetings were held every month to review the care of patients who had complications or an unexpected outcome within the department. Learning points were shared with staff.<br>Adherence to infection control procedures were being followed although we did see instances of poor cleaning and unclean areas.<br>We found controlled drugs were being recorded appropriately. However drugs were not always kept securely. Mechanisms to keep a check on FP10 forms were not robust and were open to misuse.<br>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 safeguarding Level 3 training.<br>Overall there was insufficient staff observation of patients in the waiting area which may result in not detecting a deteriorating patient in a timely manner. There was no rapid assessment intervention team for patients arriving by ambulance which provided rapid assessment of 'major' patients arriving in the department by senior medical staff. |

# Summary of findings

The trust was addressing the issue of insufficient staffing levels within the department and recognised that the number of medical staff was too low although no patients were at immediate risk of harm as a consequence. The department also experienced a high use of agency nurses due to nursing staff shortages.
The department did not have a full complement of registered children's nurses. There were three children's nurses to cover the department which would not comply with the Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012)
Due to the closeness of the channel tunnel, M20 and Dungeness nuclear power station, the trusts major incident procedure was being reviewed and training to support the procedures were in place however, there was no major incident training for paediatric staff.
Staff were well supported with good access to training, supervision and development. Evidence based guidance was used across a range of conditions but these were often out of date and some staff did not know how to access them.
The department participated in national and local audits about their clinical practice. However, the 2015/16 Clinical Audit Programme for Urgent Care & Long Term Conditions Division highlighted there were a number of audits undertaken by the department where there were no action plans to improve the outcomes for patients.
Some of the college of emergency medicine CEM audits demonstrated outcomes for patients may not be as good as expected. This may mean, improvements identified via the audit process may not result in improvements being made and as such patients may not receive best care.
The pain management policy was in draft and was being developed in conjunction with the trust's medication policy. Patients in the department did not consistently receive timely pain relief.
Induction was given to new and agency nurses and to medical staff. All registered nurses were paediatric intensive life support (PILS) trained.
Patients were being asked for verbal consent to be treated and we heard doctors and nurses explaining

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the care and treatment they were receiving. We spoke with staff about the Mental Capacity Act 2005 and deprivation of liberty Standards (DoLS). Some staff understood the basic principles of the Act and could explain how the principles worked in practice in the department. However, three members of staff we spoke with did not know about DoLS.
We saw compassionate care given to children and patients in the department.
The CQCs national A&E survey showed that staff explained what was happening and had time to listen to patients.
On three occasions we saw patients' privacy and dignity being compromised.
Patients with a mental health problem experienced long delays to be seen by the mental health team and there were no dedicated facilities for them to stay in the department whilst waiting to be seen.
Trusts in England were tasked by the Government to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The department had struggled to meet this target consistently; its lowest performance was in January 2015 at 80.15%.
The management of the department was aware of the increasing demands on the department and were working on introducing new services to manage the demand.
There was an ambulatory care unit where Triage and medical staff by-pass the emergency department. This was also the case for general practitioners (GPs). Since October 2014 the ambulatory care team had seen 1,400 patients who would have gone through the department and as such reduced the number of patients in the department.
Translation/interpreter services were available at the hospital for use when patients whose first language was not English.
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 trusts '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.
Initiatives to improve the flow of patients through the emergency care pathway were underway.
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.
The directorate team were aware of the challenges the department faced and there was a senior managerial presence in the department. There was good visual clinical leadership on the major's floor which resulted in the department being calm.
We observed good leadership in the minor's area although we were told this was sometimes hampered by senior manager's interaction and interruption.
We found staff morale was improving since the last CQC inspection. However, there was a culture of acceptance where staff came to believe there was no point in escalating overcrowding as this was a daily occurrence. We asked six members of staff at what point would they escalate unsafe occupancy levels, they told us there was no limit to the number of patients that were in attendance so they would not report the levels.

## Medical care

**Requires improvement**

Overall we found medical care services at The QEQM Hospital 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. Otherwise, we found that there were good systems to report and investigate safety incidents.

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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; particularly important when there is a lack of staff or continuity of permanent staff. 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 in this regard. 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 well led was good. 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 disseminated to staff. Staff acknowledged the steps that had been taken within the organisation to improve structures, processes and systems of accountability and could discuss the trust philosophy. Individual wards developed their own strategies which staff understood. We observed a caring and positive ethos, and acknowledged developments to embed a more cohesive culture of openness between senior managers and staff. Staff reported that although the culture was improving they did not always feel actively empowered or engaged with improvement 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**

Whilst most areas in which surgical services were provided were suitable, the day-care theatre environment was not wholly safe. Fire safety arrangements within the main theatres was not sufficient, and there was a lack of risk assessment and consideration with this regard. Evacuation equipment was not available and staff had not been trained to the required standards. Some of the required safety checks were not being undertaken.
Although recruitment continued to be difficult, staffing arrangements did not always reflect the requirements, particularly when additional surgical beds were opened above the funded capacity.
Staff had not completed all the required mandatory training, which supported the delivery of safe treatment and care, and there was no formal evidence of ward staff having been trained in safeguarding vulnerable adults.
Arrangements for reporting adverse events and for learning from these had been improved.
Theatre utilisation was not always maximised and referral to treatment times were not always achieved.

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Patient flow through the surgical services was adversely affected by availability of beds. This was linked to delayed discharges associated with provision of on-going support, rehabilitation and delays in take home medication.
Consent was sought from patients prior to treatment and care delivery. Consultants led on patient care and specialist staff and allied healthcare professionals participated in the delivery of treatment and care.
Procedures were in place to continuously monitor patient safety and surgical practices and patient care reflected professional guidance. Surgical outcomes were generally good and results were communicated through the governance structure to the Trust Board.
Patients commented positively on their experiences. They said they received kind and compassionate care, which maintained their dignity and respected them as individuals.
The surgical staff spoke positively about the leadership at departmental level and felt respected and valued. Staff understood the trust's values and recognised that there had been many changes, which had contributed positively to the change in culture they now experienced.
The governance arrangements supported effective communication to staff and the Trust Board. Identified risks were continuously reviewed and discussed and information was communicated with respect to service delivery and performance. The views of the patients and staff were sought with a view to improving and developing the services.

## Critical care

**Good**

We found appropriate and effective reporting and learning from incidents and Morbidity and Mortality (M&M) meetings. Patients were cared for in a clean, well maintained and safe environment. Staff demonstrated good awareness of infection control and there were systems in place to minimise the risk of health acquired infections.
Staffing levels were sufficient to meet people's needs and consultants provided cover in line with the national recommendations. There was also adequate access to diagnostic and screening services out of hours. The care delivered in the unit reflected best practice and national guidance.

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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. The CCU had procedures in place to ensure the safe storage, handling and management of medicines. Documentary evidence demonstrated that patients received their medicines in a timely manner and reasons for omission were clearly documented. Pharmacy support was provided as well as regular reviews and internal audits. Safety thermometer data was collected and collated and used to improve and drive service change. Data was displayed in a public area which meant it could be accessed by those who wished to view it. We found an adequate supply of serviced equipment to enable staff to care for their patients.
Staff demonstrated an established approach to multidisciplinary working with other specialists in the Trust and showed us how they could obtain treatment and care for patients with complex needs, including psychology assessments. The needs of people with delirium or dementia were met by well-educated staff but the Confusion Assessment Method for ICU (CAM-ICU) was not routinely used as an assessment tool. Training was provided on a rolling basis for nursing staff and a dedicated team ensured that trainees and new students were well supported and had the opportunity to develop. Leadership on the unit was found to be strong and effective.

## Maternity and gynaecology

**Requires improvement**

We found the maternity and gynaecology services at Queen Elizabeth the Queen Mother Hospital (QEQM) required improvement, because the majority of issues identified in the previous report had not been addressed.
Since the last inspection the midwifery service had been through a period of instability of leadership which led to a great deal of staff dissatisfaction and unrest. The Trust had identified there had been a culture of bullying and harassment within the trust. The lack of leadership, the culture of bullying and lack of strategic direction was felt throughout the midwifery service and had resulted in a lack of focus and direction for the obstetric service at the QEQM Hospital for several months. However since

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April 2015 a number of interim, acting and substantive posts had been filled and although a number of staff remained unhappy, progress was being made to stabilise the midwifery service.
There remained a problem with understaffing. Although there had been some improvements; with the Trust now actively recruiting to the vacancies, agency and bank staff were now being used and the midwife to patient birth ratio had improved to 1:28. However we found it was still routine practice for staff to go without meal breaks or work over the end of their shift in order to ensure the ward was covered, to catch up on documentation and to keep women safe.
At the previous inspection we found there was a lack of capacity with the maternity units across the Trust closing on many occasions. There had been no change in this situation with over 88 closures or diverts happening in the past year. This reduced the choice available and meant that women in labour had to travel more than 30 miles to the next available hospital.
We found that there remained issues with the general environment and lack of equipment across the obstetric department. The general environment was tired and cramped with a lack of storage facilities. There was a shortage of basic medical equipment from medical devices such as resuscitation equipment, fetal monitoring equipment and cardiotocography (CTG) devices to broken printers and photocopiers. At the QEQM Hospital we found there was a lack of en-suite facilities for women in labour and only one obstetric operating theatre for both emergency and elective procedures.
We found there was under reporting across the maternity service. Although staff were good at recording any clinical incident, non-clinical events were not being recorded. The Trust was aware of the issue of under reporting and had strengthened the governance system and improved training and development in reporting and managing incidents and complaints.
The majority of the obstetric records and medical notes we reviewed were well completed. However there was a risk that babies could miss the new-born screening test as NHS numbers were

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allocated manually with insufficient printers in place. The hospital had systems in place to identify when patients who were becoming increasingly unwell, and provide increased support. Recognised tools were used for assessing and responding to patients' risk.

However regardless of problems with leadership and staff unrest during the year we noted that staff had continued to provide women with positive pregnancy and birth experiences. Women told us that staff involved them in their care and kept them informed. Emotional support was provided by staff in their interactions with patients, together with support from specialist lead midwives. The majority of feedback received was positive and the kind and caring attitude of the staff praised. There were few exceptions where women felt unsupported during labour or told us of individual members of staff who had not responded appropriately. We saw that generally patients were treated with dignity and respect.

Both the midwife led unit and the consultant led unit had rooms with pool facilities and a variety of couches for women in labour. These were well situated and well maintained to offer women a real choice in how they wished to give birth. There was effective multidisciplinary working both within the hospital and with outside agencies.

We saw that a thorough review of all relevant policies and procedures had taken place to ensure they met with current best practice. Audits had taken place last year and with a more stable leadership in place the audit programme was planned to improve over the coming year.

There were mechanisms in place to enable staff to learn from any accident, incident or complaint. We saw that clinical governance arrangements were improving with the change in culture. Staff were now more confident at raising concerns with their managers and whistleblowing when things were not right. Staff demonstrated a good understanding of infection control procedures, with robust monitoring of their effectiveness. We found that staff attendance at mandatory training was good and staff were knowledgeable in how to safeguard and protect vulnerable women and their babies.

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## Services for children and young people

**Requires improvement**

The children's and young people's service at Queen Elizabeth The Queen Mother Hospital (QEQM) requires improvement.

We found the safe and well-led domains required improvement. We identified some potential risks to children's safety due to an insufficient number of nursing staff in Rainbow ward and in the Special Care Baby Unit (SCBU).

We noted a large number of incidents reported on Datix had not been investigated in a timely manner and there were concerns that themes from these incidents had not always been examined so that lessons could be learnt.

Paediatric early warning score charts had not always been completed correctly. This was a serious concern because these charts were used to identify patients in urgent need of medical intervention. This meant that critically ill patients might not have received appropriate care and treatment in a timely manner.

There had been no never events and two serious incidents over a one year period. The latter had been thoroughly investigated and lessons had been learnt. The second of the serious events was attributed to a rare complication of an infection and was not caused by suboptimal care.

The environment was reasonably clean and tidy. There had been no incidents of C. difficile or MRSA infection. However, the building was not always kept in a good state of repair.

Staff had received mandatory training. However not all medical staff had received level 3 training in safeguarding, which was a statutory requirement.

We found gaps on the checklist for the resuscitation trolley in June and July 2015. The trolley had not always been checked daily and this had potentially exposed patients to the risk of serious harm, if an apparatus required for resuscitation had gone missing or was not in good working order.

There was consultant cover seven days a week and all acute patients saw a consultant within 24 hours.

Staff had yearly appraisals and felt supported by their line managers, including newly qualified staff and junior doctors. Mentorship was in place for student nurses, who had good learning opportunities.

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Staff had access to trust policies and procedures, which were in line with national guidance. Some national clinical audits had been undertaken and improvements had been made in clinical practice as a result.
There was effective multidisciplinary working, both within the trust and with external services.
Patients had open access to the Child Care Unit, once they had been referred by the family doctor. This meant patients did not have to wait long to be seen and parents felt there was continuity of care on the children's ward.
Mothers of babies in the SCBU were complimentary about the medical and nursing staff and felt their baby had received appropriate care and treatment.
Staff treated patients and their family with respect and dignity and were compassionate in providing care.
In view of the various concerns raised, such as a prolonged period with insufficient staff numbers, delay in reviewing incidents reported on Datix and slow response in addressing issues raised, we considered senior managers had not acted fast enough to rectify the shortfalls and to ensure patients received safe and appropriate care at all times.

**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. Patient records demonstrated discussion with patients and families regarding care and treatment. 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, 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 through structured audit and review.
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.
As a part of the strategy, the trust had reduced 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.
Outpatients and diagnostic imaging departments at Queen Elizabeth Queen Mother Hospital were providing safe care to patients. 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.

# Summary of findings

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 the 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.

# Queen Elizabeth The Queen Mother Hospital

## Detailed findings

**Services we looked at**

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

# Detailed findings

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## Background to Queen Elizabeth The Queen Mother Hospital

The Queen Elizabeth the Queen Mother Hospital (QEQM) is one of five hospitals that form part of East Kent University Hospitals NHS Foundation Trust (EKUFT). EKUHFT 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.

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

The QEQM hospital has a total of 388 beds, providing a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric services.

Following our last inspection of the Trust in March 2014 when we found many of the services provided to be inadequate, EKUHFT 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 EKUHFT 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

# Detailed findings

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.

## 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 Queen Elizabeth The Queen Mother Hospital

**Context**

The Queen Elizabeth the Queen Mother Hospital (QEQM) is one of five hospitals operated by East Kent University Hospitals NHS Foundation Trust (EKUHFT) 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.

# Detailed findings

### 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 QEQM hospital has a total of 388 beds and provides a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric services.
- 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.

### Key intelligence indicators

### 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 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.

# Detailed findings

- 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.

**Inspection history**

- The QEQM 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 |
|---|---|---|---|---|---|---|
| Urgent and emergency services | 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 |
| Maternity and gynaecology | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| Services for children and young people | Requires improvement | Good | Good | Good | Requires improvement | Requires improvement |
| 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**

# Urgent and emergency services

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

## Information about the service

The emergency department at the Queen Elizabeth The Queen Mother Hospital at Margate provided a 24 hour service, seven days a week and was part of the urgent and long term care conditions directorate. Overall attendances were 180,019 approximately 20% of these attendances were children.

The main reception was staffed 24 hours a day.

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

We spoke with 10 patients, six relatives and 31 staff, including consultants, middle grade doctors, senior managers, nurses, ambulance staff, domestics, and security staff. We observed care and treatment and looked at five treatment records. We also reviewed some of the trust's own quality monitoring information and data.

## Summary of findings

The department under reported incidents as staff told us they were too busy to report incidents. Also, the use of a daily communications log by nursing staff at the end of a shift was used to share incidents which had occurred during their shift. Some of these issues should have been reported as a critical incident. However, there was evidence of learning from an incident through the trust's magazine 'Risk Wise'.

There were dedicated facilities for children but there was a lack of trained children's nurses. When children's nurses were in the department they could be looking after adult patients, which they were not trained to do or they were not always aware there were children in the department requiring their attention.

Mortality and morbidity meetings were held every month to review the care of patients who had complications or an unexpected outcome within the department. Learning points were shared with staff.

Adherence to infection control procedures were being followed although we did see instances of poor cleaning and unclean areas.

We found controlled drugs were being recorded appropriately. However drugs were not always kept securely. Mechanisms to keep a check on FP10 forms were not robust and were open to misuse.

# Urgent and emergency services

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 safeguarding Level 3 training.

Overall there was insufficient staff observation of patients in the waiting area which may result in not detecting a deteriorating patient in a timely manner. There was no rapid assessment intervention team for patients arriving by ambulance which provided rapid assessment of 'major' patients arriving in the department by senior medical staff.

The trust was addressing the issue of insufficient staffing levels within the department and recognised that the number of medical staff was too low although no patients were at immediate risk of harm as a consequence. The department also experienced a high use of agency nurses due to nursing staff shortages.

The department did not have a full complement of registered children's nurses. There were three children's nurses to cover the department which would not comply with the Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012).

Due to the closeness of the channel tunnel, M20 and Dungeness nuclear power station, the trusts major incident procedure was being reviewed and training to support the procedures were in place however, there was no major incident training for paediatric staff.

Staff were well supported with good access to training, supervision and development. Evidence based guidance was used across a range of conditions but these were often out of date and some staff did not know how to access them.

The department participated in national and local audits about their clinical practice. However, the 2015/16 Clinical Audit Programme for Urgent Care & Long Term Conditions Division highlighted there were a number of audits undertaken by the department where there were no action plans to improve the outcomes for patients.

Some of the college of emergency medicine CEM audits demonstrated outcomes for patients may not be as good as expected. This may mean, improvements identified via the audit process may not result in improvements being made and as such patients may not receive best care.

The pain management policy was in draft and was being developed in conjunction with the trust's medication policy. Patients in the department did not consistently receive timely pain relief.

Induction was given to new and agency nurses and to medical staff. All registered nurses were paediatric intensive life support (PILS) trained.

Patients were being 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). Some staff understood the basic principles of the Act and could explain how the principles worked in practice in the department. However, three members of staff we spoke with did not know about DoLS.

We saw compassionate care given to children and patients in the department.

The CQCs national A&E survey showed that staff explained what was happening and had time to listen to patients.

On three occasions we saw patients' privacy and dignity being compromised.

Patients with a mental health problem experienced long delays to be seen by the mental health team and there were no dedicated facilities for them to stay in the department whilst waiting to be seen.

Trusts in England were tasked by the Government to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The department had struggled to meet this target consistently; its lowest performance was in January 2015 at 80.15%.

The management of the department was aware of the increasing demands on the department and were working on introducing new services to manage the demand.

# Urgent and emergency services

There was an ambulatory care unit where Triage and medical staff by-pass the emergency department. This was also the case for general practitioners (GPs). Since October 2014 the ambulatory care team had seen 1,400 patients who would have gone through the department and as such reduced the number of patients in the department.

Translation/interpreter services were available at the hospital for use when patients whose first language was not English.

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 trusts '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.

Initiatives to improve the flow of patients through the emergency care pathway were underway.

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.

The directorate team were aware of the challenges the department faced and there was a senior managerial presence in the department. There was good visual clinical leadership on the major's floor which resulted in the department being calm.

We observed good leadership in the minor's area although we were told this was sometimes hampered by senior manager's interaction and interruption.

We found staff morale was improving since the last CQC inspection. However, there was a culture of acceptance where staff came to believe there was no point in escalating overcrowding as this was a daily occurrence.

We asked six members of staff at what point would they escalate unsafe occupancy levels, they told us there was no limit to the number of patients that were in attendance so they would not report the levels.

# Urgent and emergency services

## Are urgent and emergency services safe?

**Requires improvement**

We saw an under reporting of incidents as staff told us they were too busy to report incidents. Also, the use of a daily communications log by nursing staff at the end of a shift was used to share incidents which had occurred during their shift. Some of these issues should have been reported as a critical incident. However, there was evidence of learning from an incident through the trust's magazine 'Risk Wise'.

There were dedicated facilities for children but there was a lack of trained children's nurses. When children's nurses were in the department they could be looking after adult patients, which they were not trained to do or they were not always aware there were children in the department requiring their attention.

Mortality and morbidity meetings were held every month to review the care of patients who had complications or an unexpected outcome within the department. Learning points were shared with staff.

Adherence to infection control procedures were being followed although we did see instances of poor cleaning and unclean areas.

We found controlled drugs were being recorded appropriately. However drugs were not always kept securely. Mechanisms to keep a check on FP10 forms were not robust and were open to misuse.

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 safeguarding Level 3 training.

Overall there was insufficient staff observation of patients in the waiting area which may result in not detecting a deteriorating patient in a timely manner. There was no rapid assessment intervention team for patients arriving by ambulance which provided rapid assessment of 'major' patients arriving in the department by senior medical staff.

There were problems with the number of medical staff in the department. The trust was actively addressing this and recruitment of sufficient medical staff to resource the department was on-going. The department also experienced a high use of agency nurses due to nursing staff shortages.

The department did not have a full complement of registered children's nurses. There were three children's nurses to cover the department which would not comply with the Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012).

Due to the closeness of the channel tunnel, M20 and Dungeness nuclear power station, the trusts major incident procedure was being reviewed and training to support the procedures were in place however, there was no major incident training for paediatric staff.

### Incidents

- For the period January 2015 to April 2015, there were a total of 138 incidents reported in the department with 88 resulting in no harm to the patients, 36 resulting in low harm, 14 resulting in moderate harm and none needing to be reported to STEISS. STEISS is a patient safety reporting and learning framework.
- Over 35 of incidents reported were relating to patients arriving in the department with a pressure ulcer. Four members of staff told us they did not report incidents on Datix as it was too time consuming.
- Staff knew how to report an incident but there was low reporting due to nursing staff reporting their concerns via a communications log to the matron at the end of each shift. This log would record any events or issues that affected the smooth running of the unit.
- Whilst these kept the matron up to date on patient and technical issues, a number of these should have been reported as a critical incident. For example: from the notes from Monday 1st June 2015 to Sunday 19th July 2015 the log noted the ventilator in the resuscitation bay was still not working, which would indicate the ventilator had not worked for some time, fluid balance charts were not completed correctly for patients on a sepsis pathway and a specific issue relating to not following care plans was also recorded.
- Staff told us their main concerns were the department being overly busy and the lack of medical and nursing staff.

# Urgent and emergency services

- Staff told us they did not receive feedback from an incident. However, there was evidence of near misses and never events that had occurred across the organisation on the feedback board in the staff room.
- Junior doctors told us they were too busy to report incidents.
- There was evidence of learning when things go wrong through the trusts magazine 'Risk Wise'. 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.
- We saw local examples of learning when things go wrong such as; a failure to diagnose a fracture which resulted in improving assessments on these patients and a misdiagnosis of a patient's condition which resulted in improving medical staff awareness in recognising some risk factors.
- We were told by one member of medical staff that they had reported an incident where a patient had a wrong x-ray. This person had received no feedback on the incident and when we checked the incident records this had not been reported.
- Mortality and morbidity meetings were held every month to review the care of patients who had complications or an unexpected outcome within the department. Learning points were shared with staff and placed on the trusts intranet.
- We spoke with three members of staff about their knowledge of the duty of candour. None could tell us what this was.
- The Duty of Candour requires being open with patients when things go wrong and providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the norm in every organisation.
- We saw no evidence of a safeguarding flow chart which would help staff when a safeguarding issue arose.

**Cleanliness, infection control and hygiene**

- In the Care Quality Commission's (CQC) national A&E survey, 9.6 patients out of 10 described the emergency department as being clean. The department reported there were no incidents of methicillin resistant staphylococcus aureus (MRSA) or clostridium difficile (C diff) in the last twelve months.
- The department had a 'hygiene code and environmental audit' undertaken in April 2015 which showed non-compliance with eight of the 19 environmental standards such as; an accumulation of dust on equipment and mattresses needing to be changed. There was also non-compliance with one out of 12 of the trusts clinical standards. The department had an action plan in place to address the shortfalls.
- We observed all staff were 'bare below the elbow'. Protective clothing and equipment such as gloves and aprons were available and used by staff.
- We saw good hand washing in a double hand washing station which staff used frequently and saw good evidence of trolleys being cleaned before being used for the next patient.
- The children's waiting area was dirty and blood marks were found on one of the play tables. Some of the toys were also dirty. Staff told us the play specialist was normally responsible for cleaning the toys and play area but the play specialist had been off sick for two months.
- The cleaning rota showed the children's area was last cleaned on the 6th July 2015 and with no cleaning being documented at all in June 2015. Toys were last cleaned on the 1st July 2015. The cleaning schedule was seen to be up to date in the paediatric toilet
- We saw the sharps bin in the treatment room was covered in blood splashes and we saw syringes were kept in a dusty 'Daz' container.
- The alcohol gel dispenser near to the treatment room was empty.
- The medical store room which was a room off the paediatric waiting area, contained cardboard boxes which were stored on the floor. This was an infection control risk and we asked that these should be moved. The system of storing clinical equipment was confusing and not easy to identify equipment if needed in a hurry. The door to this room was open and children could walk in unattended.

- There was no clinical room to prepare intravenous drugs and infusions. We saw this procedure carried out on a portable trolley. However, we were told by one nurse this could often be carried out at the majors' computer desk. This meant this could be an infection control risk.

**Environment and equipment**

- Within the main department there were four resuscitation beds with one being allocated to the care of children, nine majors' beds and one room dedicated for gynaecological patients. There was also a minor injuries/ treatment area (minor's area).) The minor's area had four cubicles with trolleys, an eye examination room, a patient's assessment room for ECGs and examinations and two seated areas.
- Security arrangements were adequate. In the CQCs national A&E survey, 9.6 out of ten patients said they did not feel threatened in the A&E department.
- We checked a range of equipment such as resuscitation trolleys, defibrillators and trolleys. The majority were in order and checked regularly. However, there was no oxygen on one of the resuscitation trolleys; the cylinder was empty and unsecured so equipment could have been tampered with or removed. Portering staff replaced the cylinder once we had informed the nurse in charge.
- We saw needles and medicated dressings in trolley drawers near the adult suture room which were easily accessible to children as the suture room was part of the family waiting area.
- Check lists for the family waiting area had not been completed since 10th July 2015 this meant that equipment could be missing or not working and could lead to a delay in children being treated.
- We saw on one of the check lists a paediatric airway size 0 was out of date (February 2014) but had been placed back on the rack for future use. Yet on the 5th July 2015 someone had signed to say all the equipment had been checked.
- A similar issue was also noted that an endotracheal tube was out of date (April 2105) and was also placed back on the rack for further use. When asked about using out of date equipment we were told 'it was better than nothing'. The senior nurse on duty was informed about the out of date equipment.
- We saw there were no plug guards on the floor sockets and electrical flexes accessible to children in the family waiting area. These meant children may not be protected when near electrical equipment.
- Staff told us there were no problems with acquiring equipment as they had a medical library which they could access easily.
- We saw adult patients being taken through the family waiting area for treatment such as suturing and minor surgical procedures. This meant the environment was not always conducive for children.

**Medicines**

- In the CQCs national A&E survey, 9.4 patients out of ten said the purpose of new medicines was explained before they left the department. However, only 4.6 patients out of 10 said they were told about the possible side effects of those prescribed new medicines whilst in the department.
- Staff treating and prescribing medications for children used the British National Formulary (BNF) for children. This was out of date 2012-2013. These meant children may be prescribed the incorrect dose of medication.
- We saw the fridge which held the resuscitation drugs was unlocked this was brought to the attention of senior staff at the time of the inspection. We were concerned that it took the person six attempts to find the right key for the lock. This meant that in an emergency, time would be taken to unlock the fridge.
- We also saw the controlled drug cupboard lock was broken. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential misuse. It is important that controlled drugs are therefore stored securely. The emergency bay drug cupboard containing two boxes of paracetamol also had a broken lock and the door could not be locked. We raised this with staff on the inspection
- We observed the fridge for storing other drugs was locked and the temperatures had been checked daily.
- FP10s were accessible by the nurse who held the controlled drug keys and were kept in a separate cupboard above the doctors writing area. Additional FP10s were kept in the controlled drug cupboard in the emergency bay.

- FP10s are prescription forms which have individual serial numbers and anti-counterfeiting features. It is important that these forms are kept secure.
- We were told that some FP10s had gone missing recently and the person taking these had been identified. We were concerned there were no procedures in place to check this did not happen again. There was no record to track the use of FP10s and staff did not know how many were used in the department.
- We saw one nurse about to administer an intravenous infusion with an added medication; the nurse had not had the infusion checked by another nurse. We informed the nurse in charge before the infusion was administered to the patient. We checked the incident reports and this was not reported as an incident.
- Medication guidelines for children were found to be out of date some were dated 2011 and some others not dated at all. The paediatric prescribing drug infusion guidelines were also out of date (1999) dated.

**Records**

- The department used a white board to track the patient's journey through the department. This included: the patients name, time of arrival in the ED and the named nurse in charge of each patient.
- We looked at five sets of records and found incomplete record keeping with no pain scores being documented.
- An audit in 2014 was carried out to see if doctors in the department, seeing patients aged 65 years or over, who were attending A&E with a history of fall were adhering to current A&E guidelines. The results of this audit demonstrated poor documentation. An action plan was put in place to rectify this issue.

**Safeguarding**

- We looked at the processes and policies the trust had in place for safeguarding vulnerable adults and children. They provided staff with detailed information about the action they should take if they had concerns about any patients who attended the department.
- We spoke with a number of staff from all disciplines about the action they would take if they were concerned about the safety and welfare of patients. Most had a good knowledge of what they would do. However, two doctors told us they did not receive safeguarding level 3 training.
- A member of the children's and young people liaison 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.
- There was no safeguarding flow chart available to staff and we could see no safeguarding check lists in the department. These would be helpful in ensuring staff had information available when a safeguarding issues is raised.
- At the time of our inspection we saw no safeguarding referrals being made.

**Mandatory training**

- Data provided by the trust showed nursing staff across all A&E sites completed mandatory training using e-learning. 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%

For medical staff the figures were much lower and there were aspects of mandatory training that needed to improve.

- Fire training 59%
- Moving and handling training 59%
- Health and Safety training 48%
- Infection control prevention 65%
- Equality and Diversity 61%
- Safeguarding 67%
- Information governance 41%

**Assessing and responding to patient risk**

- As part of our inspection, we looked at the triage process in place within the department. Walk-in patients were registered at the main reception and asked to wait in the waiting area before being triaged by a nurse. We were told by receptionist staff, if there were any immediate concerns about a walk-in patients' health the receptionist would contact the nursing staff to ask for immediate assistance.
- Systems and processes were in place to receive ambulance pre-alerts for major emergency cases.

# Urgent and emergency services

- There was no rapid assessment intervention team for patients arriving by ambulance. Rapid assessment and intervention provided early assessment of 'major' patients arriving in the department by senior medical staff.
- However, we saw patients who attended by ambulance were greeted by nursing staff in the middle of the majors area. There was a verbal handover from the ambulance staff to the nursing staff which meant that on the whole, patients arriving by ambulance could be placed in the correct area quickly.
- We saw Paediatric Early Warning Scores (PEWS) documentation was available in the department and we saw guidelines for the use of PEWS in the department.
- Adult nurses were not trained to assess children in the triage area which could mean paediatric issues may not be picked up in a timely manner.

**Nursing staffing**

- According to information provided by the trust, there was a 45% nursing deficit in 2015 and a total sickness of 4%, with a staff turnover of 15%. Current vacancies were being managed using agency staff. The department had an average of 7% use of agency nurses to cover the deficit.
- The department management team we spoke with told us that staffing levels were reviewed regularly and recruitment was on going to fill the vacancies. We were told approximately £200,000 had been spent on agency staff for the month of June 2015.
- Nursing staff told us they felt 'stuck' and had no real opportunities for career progression that was why staff left the department. 12 nurses had left the department in the last six months. Staff told us there was no funding for training and personal development and no cover in order to attend training. They felt there was a vicious circle of no staff; no opportunities for training making staff unhappy so staff leave.
- There were 7.7 band 7 nurses and we were told that these band 7 nurses would be taking a dual role across the emergency and major's area. A standard operational policy (SOP) was being developed to support this initiative.
- There were 12 WTE band 6 staff which was over establishment and the trust had recently appointed 12 band 3 technicians who were due to start work at the end of August 2015.
- The major's area had two registered nurses, one band three technician and one nurse in charge.
- There was appropriate staffing levels in the minors area. There were six emergency nurse practitioners to staff the minor's area. There were three band 6 and three band 7 nurse practitioners and provided a service from 7am to 12 midnight.
- There was not a full dedicated paediatric trained workforce in the department. There were three paediatric trained nurses in the department so staff found it difficult to provide children's cover in the evenings. This would not comply with the Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012)

**Medical staffing**

- According to information provided by the trust there was a vacancy rate for medical staff of 20.81%, with a 22% sickness rate and a turnover of medical staff of 13%.
- There was medical consultant cover Monday to Friday until 7 pm, Saturday and Sunday 11am-5 pm
- There were four consultants during the day: four until 1pm, three until 5 pm and two until 10 pm with no consultant cover overnight.
- There were three substantive consultant posts one consultant had been brought from the William Harvey hospital to help increase the consultant cover from 3.75WTE. The trust spent £2,000,000 in locum staff over the last year.

**Major incident awareness and training**

- All staff we spoke with either had taken part in major incident training or were booked on a session in the near future. There were action cards relating to the roles outlined in the plan and these were kept on the trusts electronic system.
- Staff could also access a training DVD with regard to major incidents.

# Urgent and emergency services

## Are urgent and emergency services effective?
(for example, treatment is effective)

Requires improvement

Staff were well supported with good access to training, supervision and development. Evidence based guidance was used across a range of conditions but these were often out of date and some staff did not know how to access them.

The department participated in national and local audits about their clinical practice. However, the 2015/16 Clinical Audit Programme for Urgent Care & Long Term Conditions Division highlighted there were a number of audits undertaken by the department where there were no action plans to improve the outcomes for patients.

Some of the college of emergency medicine CEM audits demonstrated outcomes for patients may not be as good as expected. This may mean, improvements identified via the audit process may not result in improvements being made and as such patients may not receive best care.

The pain management policy was in draft and was being developed in conjunction with the trust's medication policy. Patients in the department did not consistently receive timely pain relief.

Induction was given to new and agency nurses and to medical staff. All registered nurses were paediatric intensive life support (PILS) trained.

Patients were being 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). Some staff understood the basic principles of the Act and could explain how the principles worked in practice in the department. However, three members of staff we spoke with did not know about DoLS.

**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.
- Data from the Trauma Audit and Research Network (TARN) was used to promote improvements in care through national clinical audit and to show performance comparison information on survival rates of patients with major injury who were admitted to hospital. Results from the Trauma Audit Research Network (TARN) were taken to the monthly trauma board meetings which were also saved onto the intranet.
- The department had a forward plan for auditing its practice such as: care of the patients with a pneumothorax, head injuries and sedation in ED. However, the 2015/16 Clinical Audit Programme for urgent & long term conditions division highlighted there were a number of audits undertaken by the department where there were no action plans to improve the outcomes for patients. This may mean, improvements identified via the audit process may not result in improvements being made and as such patients may not receive best care.
- An audit for upper gastrointestinal bleeds showed documentation could be improved and was being actioned.
- Staff could access the trusts intranet where evidence based pathways were stored. Medical and nursing staff told us they would use this system. However, four members of staff told us it was difficult to use and finding it on the trust intranet was problematic as the location often changed. We asked staff to access some guidelines; two members of staff could not find them on the intranet.
- We also found information on the William Harvey electronic system did not match what was on the Queen Elizabeth The Queen Mother emergency department's website. We were told the trust was making improvements to the system for better access and usage.
- There was some confusion with junior medical staff undertaking clinical audit projects as part of their placement. One junior doctor told us they were

allocated audits to do on their placement; they could access the intranet and had good senior support whilst on duty. Whilst another junior doctor told us they did not do audit and had not been involved in audit activity for over four months.

- We were told emergency nurse practitioners (ENPs) in the minor's area would update their guidelines when necessary and a consultant would sign these off. ENPs used patient group directives (PGDs) in the minor's area but some of these were out of date.
- 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.
- There were clear admission criteria for patients being admitted to the emergency beds.
- We spoke with 10 patients who told us their care had been good, their pain had been assessed and they had been offered drinks. However, we spoke with one patient waiting in the corridor for a blood test who said they were not asked if they had any pain and the patient was in pain at that time. We informed the triage nurse that this patient was in pain.

**Pain relief**

- In the CQCs national A&E survey, 77% of patients staff told us staff did all they could to help control their pain. However, 44% of patients had to wait a long time for pain relief.
- ENPs had a forum where they share good practice such as an audit of eye care and pain management.

**Nutrition and hydration**

- In the CQCs national A&E survey, 65% of patients told us they could access suitable food and drink while in the department.

**Patient outcomes**

- Some of the CEM audits demonstrated outcomes for patients may not be as good as expected, for example: the audit of the severe sepsis and shock 2013-2014 showed a deterioration in the management of sepsis from previous years performance, such as 66% of blood cultures were obtained prior to a patient leaving the department, previous performance was 73%.
- 36% of blood cultures were obtained prior to antibiotic administration with previous performance being 82%.
- However, the management of sepsis was identified on the directorates risk register and plans were in place with actions and timescales to improve the management of this condition.
- The CEMs audit of Initial management of the fitting child clinical audit 2014-15 showed that over half of the children had a blood glucose recorded and were managed in accordance with advanced paediatric life support (APLS) guidelines.
- However, the audit showed that there should be improved compliance with documenting the treatment and a more consistent recording of hypoglycaemia. There was also no consistent provision of information for parents of patients presenting to the emergency department with fits. The department had put plans in place to rectify this
- According to data provided by the trust, in April 2015 the unplanned re-attendance rate to the unit within seven days of discharge was 9.2% which was above the England average of 5%. This may mean patients may not be getting the best possible care at their first attendance.
- We saw posters on the walls 'help break the cycle of re-attendance' the department were trying to reduce the number of re attendances and patients would be seen by the most senior person on return.
- We saw registered children's nurses looking after adult patients in the majors section while children were in the department and on one occasion one child was in the resuscitation area. The children's nurse had not been informed that a child was in the department. Nurses trained to specifically look after children are not trained to look after adult patients. Children's nurses felt out of their depth to look after adult patients.
- Over the last year approximately 150 patients (2.3%) left the department without being seen. This may be due to the long wait to be seen by a doctor in the department and could lead to the patient being more at risk of returning with the same illness.

**Competent staff**

- The department had a practice development nurse who was responsible for planning, coordinating and delivering in house training. There was a programme of competency based training and development for each grade of staff.
- Induction was given to the new and agency nurses and to medical staff.
- According to data provided by the trust, staff appraisals took place with 75% of nursing staff receiving their appraisal.
- There were no nurses who had attended the emergency paediatric immediate life support (PILS) course. However, 19 nurses who work across both sites had attended the advanced paediatric life support (APLS) with an additional six nurses booked onto a course in October 2015. All band six and seven nurses were APLS trained.
- We were told there were a lack of opportunities for career progression for junior grade doctors a lack of training and development due to the very high turnover of medical staff.
- There was no integrated teaching in the paediatrics department and junior staff we spoke with were unaware of a paediatric pathway they could use when looking after children.
- Across the four sites there were 19 nurses (band 6 and 7) who had advanced paediatric life support (APLS) training with an additional six nurses booked for training in October 2015; these nurses provided cover from 9am to 9pm 7 days a week.
- All nursing staff were DoLS and dementia trained and we saw the DoLS policy and documentation to support this. We were told junior doctors did not receive DoLS and dementia training.

**Multidisciplinary working**

- The trust had a pathway that states children can be directly referred to the paediatrics team in order to expedite children's care and treatment. However, we were told any staff grade would 'eyeball' the child and if all is well they were asked to make their way to the rainbow ward which was a 5 minute walk away which could be unsafe if the child's illness deteriorated.
- We saw the ambulance stroke pathway was working well and patients were fast tracked through the department ensuring the appropriate professionals were involved at the correct time in order to optimise the best patient outcome.
- We saw physiotherapists and occupational therapists working with patients getting them to mobilise and test whether the patient would be able to go home.

**Seven-day services**

- The department offered a seven day service with senior medical staff present in the department seven days a week.
- There was full 24 hour access to diagnostic and screening tests.
- Physiotherapists and occupational therapists were part of the integrated discharge team and provided a service Monday to Friday from 8am through to 8pm. We were told on occasion when the department needed specialist respiratory physiotherapy one of the acute physiotherapists would be called to treat the patient.

**Access to information**

- The department had an IT system which allowed tracking of the patients through the department.
- One consultant told us it was difficult getting timely results from blooded? tests. There was no separate service for the department and no separate slots that could be used to quicken up the waits for patients in the department. These, we were told, led to some four hour breeches. We saw an administrator in the department sat by the computer waiting for blood tests to come through so as to quicken this process up. More staff were needed to support taking blood samples to reduce the wait.
- We spoke with a consultant about children's services but he could not tell us how many children attended the department every year.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- We saw a 13 year old child admitted to the department, who was assessed and x-rayed without the consent of the parent or the teacher. The radiographer was not aware of the consent policy for treating children.

# Urgent and emergency services

- We observed patients being 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). Some staff understood the basic principles of the Act and could explain how the principles worked in practice in the department. However, three members of staff we spoke with did not know about DoLS.

## Are urgent and emergency services caring?

Good

We saw compassionate care given to children and patients in the department.

The CQCs national A&E survey showed that staff explained what was happening and had time to listen to patients.

On three occasions we saw patients' privacy and dignity being compromised.

Patients with a mental health problem experienced long delays to be seen by the mental health team and there were no dedicated facilities for them to stay in the department whilst waiting to be seen.

### Compassionate care

- The results of the CQCs national A&E survey disclosed the majority of patients (8 out of 10) said they had enough privacy and dignity when discussing their health problem with the receptionist. 9.1 patients out of 10 said they were acknowledged by staff and staff did not talk in front of them as if they weren't there. However, 6.7 patients out of 10 felt reassured by staff if they were distressed while in the department.
- Patients and relatives we spoke with were complimentary about the nursing and medical staff. We observed care given was considerate and kind.
- We saw a patient being mobilised by the physiotherapy team. The patient's gown was open and so was fully exposed to other patients in the cubicles nearby.
- We saw no comfort rounds taking place whilst we were in the department. This meant that patients who were waiting to be treated may not have been offered a drink nor have their pressure areas relieved.
- Junior doctors told us they felt patient care was compromised due to the lack of nursing.
- We saw a child being assessed by a doctor with the curtains fully open which meant there was no privacy and dignity for that child.

### Understanding and involvement of patients and those close to them

- Patients and those close to them were involved in their care. In the CQCs national A&E survey: 78% patients said they were involved as much as they wanted to be in decisions about their care and treatment.
- Also, 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% patients said they had enough opportunity to talk to a doctor if they wanted to.
- Patients and relatives told us they were looked after well by staff in the department and understood what was happening to them.

### Emotional support

- In the CQCs national A&E survey, 7.1 out of 10 patients said the doctor or nurse discussed their anxieties or fears they had about their condition or treatment.
- We saw a 13 year old child left on their own for long periods of time and with no age appropriate distraction provided.
- The CEMs audit of mental health in ED 2014/15 showed that 84% of patents with a mental health condition had a risk assessment taken and recorded in the patient's clinical record and 95% of cases the history of the patient's previous mental health issues taken and recorded. However, the mental state examination taken and recorded was only carried out in 3% of patients and no patients were assessed by a mental health practitioner within one hour. There was no dedicated assessment room for mental health patients.

## Are urgent and emergency services responsive to people's needs?

# Urgent and emergency services

(for example, to feedback?)

Requires improvement

Trusts in England were tasked by the Government to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The department had struggled to meet this target consistently; its lowest performance was in January 2015 at 80.15%.

The management of the department was aware of the increasing demands on the department and were working on introducing new services to manage the demand.

There was an ambulatory care unit where Triage and medical staff by-pass the emergency department. This was also the case for general practitioners (GPs). Since October 2014 the ambulatory care team had seen 1,400 patients who would have gone through the department and as such reduced the number of patients in the department.

Translation/interpreter services were available at the hospital for use when patients whose first language was not English.

**Service planning and delivery to meet the needs of local people**

- Trusts in England were tasked by the Government to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The department had struggled to meet this target consistently; its lowest performance was in January 2015 at 80.15%.
- According to data provided by the trust, 92% of patients were seen within 15 minutes of arriving in the department, 34.7% of patients were treated within one hour and 71.7% were treated in two hours.
- The management of the department was aware of the increasing demands on the department and were working on introducing new services to manage the demand.
- For example: triage and medical staff could refer patients directly to the ambulatory care team which helped to reduce the number of patients waiting in the department.
- Staff could ring the ambulatory care unit and by pass the emergency department. This was also the case for general practitioners (GPs). Since October 2014 the ambulatory care team had seen 1,400 patients who would have gone through the department and as such reduced the number of patients in the department.
- Patients gave positive feedback on ambulatory care stating they preferred the ambulatory care unit to having to be admitted to a specific ward.
- There was a shared waiting area for children attending with adults when they first arrived in the department. Once the children were triaged they were then moved to a separate children's waiting room and taken to a separate children's treatment area.
- There was no medical professional in view in the children's waiting area which meant children may deteriorate without staff being aware.

**Meeting people's individual needs**

- The friends and family test showed 80% negative feedback relating to delays in triage.
- Nurses were aware of caring for patients with dementia and overall they had a good knowledge about caring for people with dementia. However, staff were not aware as to whether there was a dementia pathway.
- There was a link nurse for looking after people living with a learning disability.
- There was access to translation services for people whose first language was not English.

**Access and flow**

- Staff told us the department was often very busy and the weekend prior to the inspection there were over 80 patients in the department at one time. We were told by medical staff covering that weekend that this did not feel safe. This was going to be reported at the next department meeting.
- At 10.30 am there were six patients waiting in the department for more than four hours; 17.5 hours,15 hours,7hours 42 minutes, 7 hours 10 minutes, 6 hours 5

minutes and four hours 20 minutes. The patient waiting over 17 hours was due to there being no mental health liaison service after 10.00pm and so had to stay overnight in order to be seen by a mental health nurse.

- Lack of consultant cover overnight means there was a delay in patients being seen and no guarantee that there would be a consultant up to 10 pm. You are promised a consultant but there very rarely is one.
- We were told by one member of staff there was a rule that when there were 65 patients in the department patients would be diverted to another hospital but the week before we inspected, there were 80 patients in the department and no increase in staff to cope with the demand.
- Ambulance crews told us handover was very quick and never took more than 15 minutes.
- No rapid assessment due to lack of space and consultant shortages.
- Minor's area and paediatric area were closed through December 2014 and January 2015 and used as bed space to avoid 12 hour breeches. This meant there were no dedicated facilities for children during this period.
- Delays had increased due to care home closures and more people attending the department.
- Referrals to other specialities can take a long time. For example; 1st April to 12th July 2015 data showed that the medical team responded to 1,865 requests to see patients in the department, they saw these patients on average within 48 minutes however, performance against the trusts internal standard of being seen within 30 minutes was breached;; 1,865 patients were seen in the department with 458 (25%) not meeting this target.
- The ambulatory care unit had a number of pathways including: the management of chest pains, anaemia, jaundice, pulmonary embolisms and deep vein thrombosis.
- Staff escalated concerns when the department was busy and we were told the consultant on call would be informed when patients were waiting over four hours. There was an escalation policy which was visible at the nurses' station although this was ineffective at times.
- We were told there was no policy to dictate which patients could go in to resuscitation. Patients do go into resuscitation to avoid breeching the four hour wait target.

**Learning from complaints and concerns**

- Between April 2014 to March 2015, 46 complaints were received in the department. The most common cause of complaint was concerns about their clinical treatment.
- Staff we spoke with were familiar with the complaints procedure and felt confident to deal with complaints.

## Are urgent and emergency services well-led?

**Requires improvement**

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 trusts '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.

Initiatives to improve the flow of patients through the emergency care pathway were underway.

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.

The directorate team were aware of the challenges the department faced and there was a senior managerial presence in the department. There was good visual clinical leadership on the major's floor which resulted in the department being calm.

# Urgent and emergency services

We observed good leadership in the minor's area although we were told this was sometimes hampered by senior manager's interaction and interruption.

We found staff morale was improving since the last CQC inspection. However, there was a culture of acceptance where staff came to believe there was no point in escalating overcrowding as this was a daily occurrence. We asked six members of staff at what point would they escalate unsafe occupancy levels, they told us there was no limit to the number of patients that were in attendance so they would not report the levels.

**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 trusts '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.
- There was no department strategy and no joined up leadership across the trust's different protocols. Staff told us there was no overall direction, only short term improvements.
- There was a recruitment strategy in place in order to fill the current vacancies.
- There is no standardised care across the two sites and procedures are different at each site.
- An external review had taken place to examine the issues affecting operational effectiveness and patient flow. The emergency care intensive support team (ECIST) had visited in May 2015. Its recommendations focused on demand and capacity pressures in the department, caring for children and young people in the department, staff awareness of the trusts Incident response plan in the department and staffing levels both medical and nursing. Recommendations had been incorporated into the trusts special measures action plan and progress against milestones was monitored on a weekly basis.
- There was a vision for children's services in the emergency department however; there were no plans for shared paediatric rotas and no plans for shared paediatric governance at this time.

**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.
- There were 12 risks on the divisions risk register. This 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.
- The way in which concerns/ incidents were reported led to an under reporting of incidents as staff used an informal process for raising issues (communication log) which should have been categorised as an incident. We crossed checked the daily communication log with the clinical incidents that had been reported via datix. There were a number of concerns raised via the communication log that should have been datixed.

**Leadership of service**

- The directorate team were aware of the challenges the department faced and there was a senior managerial presence in department.
- There was evidence of good visual leadership from the matron in the department.
- There was effective shift coordination relating to when the department was busy. There was visible leadership from the matron and at busy times we saw a matron in the department. We saw the matron going into the department and talking to patients and supporting junior staff that were providing care to patients
- Junior doctors were not aware of who the chief executive was or who was the medical director. Regular board rounds were carried out??

**Culture within the service**

- Staff told us morale was good and had improved since the last CQC inspection. We were told staff were more optimistic about the changes in the future.

**Public engagement**

# Urgent and emergency services

- 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. However, posters demonstrating their performance were not displayed in patient waiting areas.
- For the staff A&E survey the department scored 75% for the question 'How likely are you to recommend this organisation to friends and family if they needed care or treatment' and 52% for 'How likely are you to recommend this organisation to friends and family as a place to work'

**Staff engagement**

- Junior medical staff told us there were no team meetings since 2007 so no avenue to raise concerns.

# 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

At The Queen Elizabeth The Queen Mother Hospital (QEQM) medical care services were managed by the Division of Urgent Care and Long Term Conditions with the regional pPCI service based at William Harvey Hospital. The division also managed the discharge lounge and the Clinical Decisions Unit. There were seven medical inpatient wards, including acute medical units, general medical wards, care of older people, endoscopy services, stroke and cardiac services. The hospital provides primary percutaneous coronary angioplasty (urgent treatment for heart attacks) and thrombolysis (urgent treatment for strokes).

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 QEQM there were 2,010 admissions in the same period. Of these 48% were emergency admissions, 49% day case and 3% elective. General medicine was the speciality for the majority of admissions at 59%. Admissions to geriatric medicine accounted for 22%.

To help us understand and judge the quality of care in medical care services at The QEQM Hospital we used a variety of methods to gather evidence. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust and the hospital. We held staff focus groups and spoke with six doctors including two Consultants, about 29 registered nurses including ward matrons, ward managers, agency nurses, specialist nurses and healthcare assistants. We also spoke with allied health professionals and other support staff. We also spoke with about 29 patients, relatives and carers. We interviewed members of the Divisional Management Team. We observed care and the environment, and looked at records, including patient care records. We looked at a wide range of documents, including audit results, action plans, policies, and management information reports.

# Medical care (including older people's care)

## Summary of findings

Overall we found medical care services at The QEQM Hospital 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. Otherwise, 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; particularly important when there is a lack of staff or continuity of permanent staff. 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 in this regard. 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 well led was good. 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 disseminated to staff. Staff acknowledged the steps that had been taken within the organisation to improve structures, processes and systems of accountability and could discuss the trust philosophy. Individual wards developed their own strategies which staff understood. We observed a caring and positive ethos, and acknowledged developments to embed a more cohesive culture of openness between senior managers and staff. Staff reported that although the culture was improving they did not always feel actively empowered or engaged with improvement 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 The QEQM Hospital 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. A range of suitable forums for staff to receive feedback and learning had been established. Rates of harm free care as monitored by the national Safety Thermometer programme show a harm free care rate of 94.3% which is slightly above 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 facilities were not safely maintained to meet the needs of the patients. 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 in 2014 helped ensure staff had current knowledge and skills in key safety areas.

**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 Queen Elizabeth Queen Mother Hospital (QEQM) told us there was an evolving culture of encouraging the reporting of incidents. They knew how to use the system and were confident and could demonstrate its use to us.
- There were no "Never Events" reported 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.
- Medical care services reported 20 serious incidents between May 2014 and April 2015, out of 24 across 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).
- At QEQM Hospital between January and April 2015 there was one severe incident, 72 moderate and 497 low and no harm incidents reported. This indicates a good reporting culture.
- Staff we spoke with at all levels were aware that falls and pressure ulcers were the most common incidents reported and areas of greatest risk. We saw that appropriate mechanisms were in place for the screening, intervention and documentation regarding patients at high risk of falls.
- We found that a root cause analysis (RCA) was conducted for serious incidents requiring investigation (SIRI's). We saw good examples where the root cause was identified and that the resultant action plan reflected this.
- Training in root cause analysis techniques was provided for 54 members of staff which included matrons, or managers from medical care services.
- Matrons monitored incident information and we looked at a selection of minutes for ward and matrons' meetings held during May and June 2015, and subsequent divisional governance meetings. These demonstrated that safety incidents and the outcomes of their investigations were standing agenda items and that the data was used to monitor performance, track risk trends and cascade learning back to teams.

- Staff reported that the trust promoted and encouraged a culture of reporting incidents to promote improvement and told us that there was learning from incidents, which resulted in change of practice and gave us examples of how this had occurred at local level. We saw how initiatives to increase staff awareness of falls had been introduced together with the promoting of appropriate footwear for patients had decreased this rate.
- 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 organisation community as opposed to just their own areas of responsibility.
- Morbidity and Mortality meetings were held monthly within the division and on a trust wide basis to review the care of patients who had complications or an unexpected outcome. Learning points were shared with staff in a trust wide forum. We saw minutes that showed medical care services were involved in these meetings and that the care of medical patients. Individual trends were identified, managed and actions taken including disseminating lessons learned. Our monitoring showed that there were no mortality indicators which demonstrated a risk of increased mortality. The indicators showed that the trust was performing better than expected against comparable hospitals.

**Duty of Candour**

- The trust reported that 54 members of staff at the QEQM hospital had received Duty of Candour training as part of their RCA training. 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. When we reviewed the RCA process we saw that there were clear prompts included to ensure that the process was followed.

**Safety thermometer**

- 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. Safety thermometer data was incorporated into the divisional performance dashboard which was used to provide evidence of assurance to the Trust board. In May 2015 the QEQM Hospital achieved over 94.3% for harm free care.
- The trust reported that the rate of falls per 1000 patient bed days was currently 5.37 which placed the trust at slightly below the England average of 5.4.
- Hospital acquired harms (new harms) are now significantly lower than the national average. Current information reports that the trust was achieving 1.7% against a national average of 2.4%.
- A lower than average harm rate for new pressure ulcers and falls with harm has been achieved and rate of new VTEs in line with the national average.
- Urinary tract infections in patients with a urinary catheter has increased slightly above the national average but has reduced from the national average in 2013/14.
- All wards used safety crosses displayed on the wall for each month, and these were visible to patients, visitors and staff on the wards. These showed the number of falls, pressure ulcers and infections such as MRSA and C. difficile that had occurred during the month and on what date. The results were fed into the safety thermometer and ward to board assurance framework, which in turn contributed to the trust data. We saw the results of these were monitored by ward by managers and matrons.
- 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**

# Medical care (including older people's care)

- 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-resistanat staphylococcus aureas (MRSA) for the trust were within expected statistical limits and below trust targets.
- Throughout our visit we generally found the wards and specialist medical units were visibly 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 the 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 they were not consistently completed. 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.
- We saw that single patient use equipment, such as hoist slings were used, and that most clinical equipment was single use only.
- We looked at the results of Patient Led Assessments of Care Environment (PLACE) in the sections of cleanliness and facilities for Minster, Sandwich Bay and St. Margaret's and found they were above the national average with a range of 86.6% - 98.61% respectively.
- The trust operated an infection control score card giving performance against a range of infection control indicators, including hand hygiene compliance and 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 promoted display boards with key infection prevention and control messages and the performance score card for their ward. For example on Minster Ward there was a comprehensive display of safety thermometer results, including hand hygiene audit results and weekly commode audits showing the latest audit had achieved 100%. Staff on the ward told us this was value and provided evidence that the efforts of their ward team were recognised.
- A member of the cleaning team explained and showed us how any deficiencies identified as part of the audit were communicated to them, and 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. 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 audits of hand hygiene and that the results were publically displayed in ward areas. We saw results generally about 90% and saw frequent examples of 100% being achieved, for example on Minster ward. In areas where low compliance was reported weekly audits had been introduced and were seen to be actively monitored by the Infection control team. The results of these audits were displayed for staff to review and discussed at ward meetings.
- 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 compromised 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. However, on St. Augustine's Ward we observed staff entering and leaving an isolation room accommodating a patient with C. Dificile without using PPE and leaving the door open. On Sandwich ward we observed staff entering a room where a patient

with MRSA was being nursed, without following hand washing regimes or wearing PPE. The door to this patient's room was left open leaving the isolation information signs obscured. This demonstrated that not all staff were adopting the isolation protocols.

- 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.
- 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. With the Trust target of 85%, indications were that this programme of training would ensure most people had completed training by year-end.
- We saw that there were effective decontamination procedures for cleaning endoscopes after use, with supporting audits to maintain standards.
- The trust had a dedicated infection control lead and hospital based infection control teams with link nurse support across all departments. Staff reported that these teams were pro-active across the wards and provided unlimited support.
- On some wards we saw 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. There was no clear review or update information.
- 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 by nature of the age of the building and layout presented challenges regarding limited storage space. However, we found that some bathrooms and showers were used to store equipment.
- All the areas we visited during the inspection were clean and tidy, apart from St. Augustine's ward. This ward was commissioned during the winter months to respond to winter pressures and was due for closure in March 2015. The trust had decided to keep the ward open to assist with patients deemed medically fit for discharge, who were waiting for care packages, rapid discharge or who were approaching the end of life.
- The flooring in the corridor areas on St. Augustine's ward was uneven, dirty and badly worn with tears in the covering. This constituted a risk of falls, especially as the majority of patients appeared elderly and frail. The floor covering was also torn by the nurse's station making it difficult to clean and presenting a potential trip hazard to both patients and staff.
- At the time of our visit the cleaning cupboard door on St. Augustine's ward was open. This had the potential for patients to access the cupboard which contained chemicals. Patients could be at risk of harm if they swallowed these chemicals. Cupboards containing dangerous and caustic materials were found unlocked. This meant that substances were not being stored in accordance with Control of Substances Hazardous to Health Regulations 2002.
- Toilet facilities on St. Augustine's ward did not conform to requirements under the Disability Discrimination Act (DDA) and were unable to accommodate patients with walking aids. Shower and bathrooms were used as storage facilities and cluttered making them unfit for use.
- The Trust had recently established an equipment library. 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 a.m. to 5.00 p.m., with an out of hours 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.
- 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, which included the directive for daily checks to be recorded. We checked trolleys on all clinical areas that we visited and found that there were omissions on the majority of records. 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.

- Audits of resuscitation equipment were undertaken by the trust resuscitation officer but some 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. However, on St. Augustine's ward there were two pieces of equipment stored in a side room. One was a sit on weighing machine and one was a stand aid. Both these pieces of equipment had a service label on them indicating they were last serviced in April 2013. Potentially the weighing machine could give false readings as part of the service would include calibration. The stand aid potentially may be unsafe as it had not been serviced within the timescale required.
- 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 able 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.
- The trust scored below the England average for Patient Led Assessments of Care Environment (PLACE) in the sections of facilities. We looked at the results in the sections of condition, appearance and maintenance for various wards including Minster, Sandwich Bay and St. Margaret's and found they were in the range 75% - 91.67%. Minster ward was below the national average at 75%.
- We spoke with staff who explained the systems they followed when they encountered environmental problems or maintenance issues. They reported that generally it worked well for smaller issues but there were often delays when more serious breakdowns occurred. For example we heard how a faulty shower on Minster Ward, had remained outstanding after some months, despite continual reporting. By nature of the fault the continued use of this facility was presenting a water contamination risk to patients.
- We looked at fire-fighting equipment throughout the wards and medical speciality units and noted that equipment displayed labels confirming that it had been maintained and tested. There was a system of fire risk assessments in place.
- There were some ward areas that did not comply with current fire regulations. For example on St. Augustine's ward we found the fire exit doors wedged open and staff were using it as a thoroughfare to other areas of the hospital. Outside the fire door there was a concrete bollard preventing beds from being able to be wheeled away from a fire. If this escape route was chosen there would be a risk that patients would not be able to be taken to a place of safety. We were told by the trust fire officer that this was on the trust's risk register but also told the mitigating circumstances within the risk assessment had not been complied with. We were told the risk assessment identifies if this ward was going to open then some form of escape, other than on a bed, must be provided for staff, to put patients that can't walk on to enable a safe escape. We were also told that authority had been given to buy the devices to enable non-ambulatory patients to escape in the preceding few days. This was in contravention to Section 9 of The Regulatory Reform (Fire Safety) Order 2005 and although the risk assessment had been done, the mitigating actions had not been taken. This meant there were no means of evacuating patients who could not walk.
- We found storage cupboards on St. Augustine's ward were open and items were stored inappropriately. For example, the linen store used to be an office within the ward area, and since the ward has been open it has been used as the ward's linen store. The door to the linen store was not a fire door (HTM 05 – 03). Store 12C.LG.195 had cardboard boxes containing patient

slings which were stored on the floor. This potentially makes the floor difficult to clean and the contents of the boxes could be contaminated with the water used to mop the floor.
- Records were available to demonstrate that an average of 57% of staff in medical care services had completed training in Health and Safety and 68% in 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 Formularies and IV treatment guide that staff could reference when they needed to.
- We found that in the majority of areas, medicines were stored securely in locked cupboards, rooms and medicine trolleys and that keys to drug cupboards were held by appropriate staff.
- We saw that when applicable medicines were stored in dedicated medicines fridges. Records were available to us showing that daily checks were undertaken using the fridges built-in digital thermometer, although there was no minimum and maximum temperature recorded. This meant there was no robust assurance that medicines had been stored consistently at the correct temperature.
- Controlled drugs were stored correctly and patients had lockable cabinets for the storage of their own drugs.
- 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 Deal ward was left unlocked and unattended which meant the area was accessible for unauthorised persons.
- There were robust systems of control of controlled drugs in CDU with enhanced systems that had been introduced following a recent incident involving a theft of FP10 forms from the Emergency department. This demonstrated that medicines were being managed and stored correctly and learning from medicines incidents was shared.
- 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. Patients told us that pharmacy staff were happy to answer questions regarding their medication.
- Pharmacists visited ward areas daily to carry out medicines reconciliation and check for medicine to take away (TTA). Staff reported that this system worked well but frequently on the wards charts were taken to pharmacy with delays in obtaining TTA 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. The CDU department carried a stock of labelled TTA packs and there was a loan book for other departments to record items that had been borrowed.
- We visited the Ambulatory lounge and observed staff administering blood transfusions, and drug infusions. We noted that there were anaphylaxis kits by the patient together with spills kit. Staff told us that currently policies and procedures with supporting guidelines were being developed with the consultants.
- Staff explained a pilot that was being tested with the discharge lounge to facilitate a more rapid discharge from CDU, ambulatory care and the wards. CDU told us that this had reduced delays in TTA because patients were sent to the discharge lounge. The discharge lounge was located adjacent to St Augustine's Ward and received input from the pharmacist for the ward.
- We saw processes and checks in place before TTA's could be issued to patients ready for discharge. Staff told us that either a nurse and/or pharmacist were available to counsel patients on their discharge medicines. One patient at 11.15 a.m. was waiting for transport and told us that she already had her medicines, knew how and when to take them and was ready to go back to her home.
- In Viking unit we heard that an electronic prescribing system for chemotherapy was due to be introduced in October. National Guidance stipulates that all trusts providing chemotherapy should have electronic prescribing to ensure the safe prescribing, dispensing and administration. The pharmacy department had recently increased their input and there was a robust system of stock control of medicines, TTA packs available and the appropriate safety kits.
- There was a medicines safety group within the clinical governance structure. This group monitored the medicines risk register and when medicine safety issues

were identified, communication was sent to the relevant areas in the form of alerts and emails. 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 their full record. We looked at six sets of patient records and found that although 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, many of the records were disorganised and difficult to navigate. It was evident that there was no procedure for maintaining patient records to a uniform trust standard shown by wards and departments adopting 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. Within wards, records were generally stored in open notes trolleys, in pigeon holes or on shelves to which the public had access. Staff told us this was normal practice. On St. Augustine's Ward we saw records left unattended on the ward reception desk. This demonstrates that confidential patient records were not always kept securely.
- We found many examples of patient notes that were not consistently completed. We saw nursing assessments, repositioning charts, food charts and personal care round records were not completed on every occasion. For example on Deal ward, we were told by ward staff that care rounds had been completed but when we reviewed patient records we found no evidence that this had been recorded.
- Patients were risk assessed in key safety areas using national validated tools. For example we saw that patients at risk of falls were assessed, with good supporting documentation to record the interventions that had been taken. The risk of pressure damage was assessed using the Waterlow score. We noted that when risks were identified they were recorded but an individualised supporting care plan was not always in place to highlight the control measures and inform staff of the individual care required by the patient. This was particularly important when there is a lack of staff and lack of continuity of permanent staff to ensure that patient needs are clearly identified. For example on St. Augustine's ward we saw a patient who was admitted with a pressure ulcer but no initial details of grading had been recorded. There were no details recorded of any treatment or care to be administered in daily care notes. We were advised that this incident had been reported using the Datix system as a grade three wound but there was no evidence to support that a risk assessment had been put in place and no details to identify if the tissue viability nurse had been contacted for the 10 days following the patient admission.
- An average of 55% of staff across the medical division had received information governance training against the trust target of 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 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 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. This new group was a multi-agency trust-wide PART group.
- 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.
- 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.
- Generally patients we spoke with told us they felt safe in the hospital.

**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, manual handling, infection control, falls preventions, safeguarding and life support.
- 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, when it was due.
- All mandatory training for staff was provided through electronic learning but some staff reported they had experienced difficulty accessing the training due to incompatibility of the IT system. The introduction of a new training Application has been made available via an icon on each desktop computer and we asked a nurse to give us a practical demonstration of using the system. We saw how the system was accessed and were able to see how this person's status regarding mandatory training was recorded, showing all training requirements were up to date. Drop in e-learning clinics were available for staff who wished to complete their training with face to face support.
- Compliance with mandatory training over all for the medical division was 62.9 % for Doctors, 79.8% for nursing staff and 87% for allied health professionals against the trust target of 85%. There was no evidence to support that staff in medical services had received training in the safeguarding adults
- Staff described a comprehensive induction process for new staff at trust level and in their daily working environment. On the majority of wards there were orientation guides for agency staff.

**Assessing and responding to patient risk**

- We found that patients physiological parameters 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.
- There was an electronic system to record patients' physiological observations; this is known as a national early warning score (NEWS) system. We saw that where NEWS scores indicated patients may be deteriorating nurses had mostly requested medical reviews. Patient observations were recorded electronically using a system known as Vital Pac. This allows early warning scores to be automatically calculated. Nursing staff reported that generally the use of this system across the medical wards and medical specialities was used to prompt nursing staff to contact medical staff. The facility to bleep medical staff was reported as being intermittently effective, due to the availability of units and unreliable communication networks.
- We observed staff using the VitalPAC 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.
- 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 increased 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. 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 found incidents where pressure ulcers were not graded, referred to the

Tissue Viability Nurse or reviewed with the effectiveness of any treatment recorded. 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. For example on Minster ward clear information was displayed reflecting the patients' current needs including skin condition, risk of falls, nutritional information. This method of communicating patient needs was not consistent across the medical wards.

**Nursing staffing**

- Levels of nursing staffing were acknowledged as a major risk area. Common with many trusts, East Kent Hospitals University Foundation Trust 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.
- For the 2014/15 financial year the nursing WTE establishment for nursing and midwifery staff band 8 and below was 2366 but as of April 2015, 2148 were in post. This reflects a nursing vacancy rate in medical care services of about 9%.
- 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%. This was considerably higher than other areas of the trust.
- 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 appointment of ward manager assistants had been introduced to undertake general administrative tasks and ward managers reported that this was a good initiative that had eased the pressure on helping ward sisters to be more clinically focussed and have higher levels of visibility on the wards.
- On the day of our inspection there was one patient in the discharge lounge which was staffed by a nurse and HCA. Staff described that they were frequently required to work alone. For example if one staff member left the discharge lounge to obtain a patients discharge summary or medication, which was a regular occurrence. We saw that lone working had been appropriately risk assessed and escalation processes were in place if the number of patients significantly increased. Staff told us that they could have up to 60 patients waiting for discharge but this was exceptional.
- The numbers of staff vacancies across the medical services varied and some areas such as endoscopy services reported that they had successfully recruited into posts. Other areas like Deal ward reported that they had 6.81 WTE vacancies which increased their reliance on agency staff.
- An example of how staffing shortages affected the levels of patient care was identified when we spoke with a wheelchair bound patient on St. Margaret's Ward. They told us that they had been asking for a shower since they had been admitted the previous week but staff repeatedly told them they could not have one due to the lack of staff. We checked this with the ward staff who confirmed this was the case.
- 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'. On other wards for example Deal Ward only the actual number on duty was displayed.
- St Augustine's Ward is a 27 bedded ward, which by the nature of evolving from a temporary facility is constantly staffed using staff from other wards. Currently this ward operates without a ward manager. On the day of our visit we found all of the RN's and HCA's were agency staff including the nurse in charge. We were unable to communicate fluently in English with the nurse in charge and eventually asked if they could contact the matron as it was clear patient care was being compromised. We spoke with one agency nurse who told us the ward was a highly pressured and challenging area in which to work for both agency staff and permanent staff who were usually junior and struggling to lead. We saw from staffing rotas that in the previous two week period 30 agency HCA's and 14 agency RN's had been used to cover shifts to maintain staffing levels. Consistently we saw that staffing levels were at a ratio of 1:13. Although three RN's are planned for an early shift

we saw that there were regularly only two available. When we reviewed staffing rotas for the month of June we found that only one RN was a regular occurrence. For example on the 11th June, 13th June and 14th June only one RN was available on the early and late shift. Staff told us that they considered staffing levels on this ward were unsafe and as agency staff frequently did not turn up staff were then transferred from other wards that were already under pressure, which in turn compromised other patients and created resentment and bad feeling amongst the staff. Ward sisters from other wards confirmed that pressure to staff this ward had a negative effect on their own staffing issues.

- We looked at the staffing levels on Deal ward and saw that the planned cover for the night of 16th July the cover was 1 agency RN and 2 HCA's. Staff reported that this was insufficient due to the acuity of the patients and this matter had been highlighted at a meeting with the senior matron in June but to date no action had been taken.
- Staff reported that, following an appropriate risk assessment, additional staff were deployed on a shift by shift basis if individual patients required specialist one to one care, or if patient acuity had significantly increased. For example, a confused or challenging patient.
- The trust provided data regarding the levels of agency nursing staff used by 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, Deal ward reported an average of 11% reliance on agency staffing, Sandwich Bay 12.75% and CDU just over 10%.
- 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. Ward staff expressed concerns over the variability in skills and competencies of agency nurses.
- 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 comparable to an England average of 33%. Middle career doctors represented 6% in line with an average of 6%; Registrars 43%, more than the average of 39% and Junior doctors 19% against an average of 22%. This means there were fewer consultants and junior grade doctors than the England average.
- 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.
- Turnover rates for medical staff for the period April 2014 – April 2015 were higher than other areas of the trust with Speciality Medicine at 10.4% and Elderly Care (HCOOP) 7.3%.
- We found there was a high dependency on locum medical staff within the division. In particular we found that within stroke services for the period December 2014 – April 2015 the average locum usage was 8.74% with a range of 0 – 26.8%. In HCOOP the rate was 23.26% with a range of 10.5% – 37.4%.
- We found that medical staff reported that senior support was extremely good at consultant level but within CDU there had been no registrar available on two occasions during early July 2015. This resulted in two patients who required lumbar punctures waiting two days for the procedure. On Deal ward there had been no registrar since early June, and geriatric medicine was reporting shortage of middle grade medical staff impacting on patient care.
- Junior doctors reported that the impact of medical staff shortages resulted in difficulty getting study leave and we were told that on occasions they had taken annual leave to ensure they were able to attend exams. We also heard many examples from junior doctors who were unable to secure annual leave due to pressures caused by low staffing levels. We saw evidence to support that the corporate risk register identified that the vacancy rates of junior doctors was impacting on the organisation's junior doctors suffering increased levels of sickness and subsequently affecting patient care.
- We were told that there was a general lack of cardiology support available during out of hours universally across the trust. There was an out of hours cardiology service but specifically for advice and doctors told us that it was

operator dependent and no support for any interventions needed. This has resulted in instances where patients requiring coronary artery dissection have been transferred directly to St. Thomas's in London bypassing Ashford who refused to take the transfer. On these occasions we were informed that a Datix submission was made. As a result of this all Specialist Registrars now transferred directly to St. Thomas's which they acknowledged should not be happening. Further examples were given including when on two occasions patients with complete heart blocks were put at risk as there was nobody available to put temporary pacing wires in. The trust corporate risk register provided evidence that the organisation recognised how the lack of suitable staff being available presented a risk of severe adverse outcomes for patients requiring primary pacing wires.

- We were given many examples of when the lack of medical staff directly impeded timely discharge for patients. For example on St. Augustine's ward, which was predominantly used as a ward where patients deemed medically fit for discharge were accommodated, the withdrawal in April 2015 of the F1 medical cover had resulted in constant delays in discharge letters and TTA's. Staff reported that this was raised consistently but were unsure if there were plans to reallocate medical cover in the ward.

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

## Are medical care services effective?

Requires improvement

We rated the effectiveness of the Medical Services as requiring improvement.

We found the majority of policy documents were evidence based and readily accessible on the intranet and in hard copy. However, 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 learning disability needs.

We saw that patients' nutritional needs were assessed and scores were recorded, with risks identified. However, the use of generated care plans to manage these risks were 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. There were no designated or safe facilities for patients to be accommodated during this time.

Currently there is 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.

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

# Medical care (including older people's care)

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 QEQM Hospital was in the top quartile of trusts achieving good outcomes for patients with strokes.

Weekend medical cover was provided by a "Hot" and "Cold" team. The "Hot" team provided cover for new admissions and sick patients with the "Cold" system attending to ward patients and discharges. Medical staff told us that there were was poor communication regarding who was in the relevant team, constant gaps on the rota and high levels of sickness and absence due to pressure of work. They considered this often resulted in unsafe medical care over weekends.

Patients were being 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 has 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 we have seen. 11 audits carried over from the 14/14 programme and a total of 62 audits, 22 of which were national audits. This included the British Thoracic Society, Adult Community Acquired Pneumonia Audit. 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 and the Coronary Care Unit.
- 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.
- Staff could access evidence based pathways on Sharepoint which was an electronic intranet system.
- 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 clinical policies which had been printed out on wards and were out of date. For example on St. Augustine's Ward we found that the policy on The Care of Vulnerable patients was 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 The QEQM Hospital was broadly in line with national expectations. However in general medicine where the majority of activity occurred the relative risk was better than the national expectation at 96.
- 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 in recognition that the trust was not achieving a good standard of care for heart failure patients according to the audit data from the Enhanced Quality Programme. Now 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. They also visited the CDU and medical wards daily to pick up referrals to ensure that no patients are missed. A programme of information has been developed by this team to ensure that patients

understand the importance of self-monitoring, how to identify when the heart failure symptoms are worsening, coping strategies, medication and long term issue they may encounter.
- As part of the new NICE guidance on Acute Heart Failure the Cardiology team have developed an acute heart failure pathway that encompasses the new changes s (such as the introduction of BNP) and are working closely with various departments to ensure the safe implementation of the pathway.

**Pain relief**

- The trust pain management policy was in a draft and was being developed in conjunction with the trusts 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.
- 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.
- We observed a patient on St. Augustine's ward who was shouting and in a great deal of distress with pain whilst being moved. Staff had not assessed the levels of pain or considered that prn analgesia could have been given prior to attempting to move the patient. When we reviewed the patient record we saw that the patient had been prescribed oxycodeine but this had not been administered since 21.00 the previous day.
- 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 achieved 80% in the in the 2014 in-patient survey and 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**

- We observed that patients were served a choice of foods and that therapeutic diets were managed well.
- Patients were assessed by a dietician 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 dietician. 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.
- There were facilities that enabled families and visitors to purchase food and beverages.
- 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 and patients on the stroke ward told us that staff were very supportive.
- 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 the elderly care unit relatives and carers were invited to visit patients at meal times to assist with feeding. Staff told us this initiative had greatly assisted them during a busy time.

- We saw that 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.
- 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.
- The trust scored below the England average for Patient Led Assessments of Care in the sections of food.
- There were facilities within the hospital that enabled families and visitors to purchase food and beverages.

**Patient outcomes**

- 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 provides. 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. It is acknowledged by the audit that very stringent standards are set and at QEQM Hospital the stroke services achieved a C rating in September – December 2014 which increased to a B rating for the period January to April 2015. This meant that QEQM Hospital was in the top quartile of trusts and was achieving good outcomes for patients with strokes.
- The hospital participated in the 2012/2013 National Heart Failure Audit and achieved markedly below the England average in clinical care but slightly better in the clinical discharge category.
- In the 2013/2014 Myocardial Ischaemia National Audit Project **(**MINAP) audit, the hospital achieved worse than the national average for nSTEMI patients seen by a cardiologist or a member of the team and referred for angiography but above the national average for admission to a specialist cardiac unit.
- 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 QEQM Hospital 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. The QEQM Endoscopy Unit's accreditation level is due for renewal next year but currently scoring A and B in GRS for consent, training and development of staff. This meant that the endoscopy department was operating within current guidance and standards.

**Competent staff**

- We were told that all new staff attended a corporate induction programme, supplemented by a local induction. We saw examples of local induction packs and 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 appraisals process and we found documentation in ward areas and medical speciality units, together with overarching

reports on the central records system to identify current appraisal rates. The trust reported that 82% of nursing staff within the medical directorate had received an appraisal.

- Staff attended a wide range of training which was recorded on the central electronic training record. Many wards displayed their staff training status within the nursing office.
- 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 and we saw examples of these and spoke with staff who were undertaking the programme. We noted that there were a wide range of clinical and organisational skills included in this programme requiring formal sign off. This indicated that staff, their managers and patients could be confident staff had the skills to carry out their jobs.
- Staff told us that there were opportunities to undertake additional study, and that the organisation supported them in this. We saw from the specialist heart failure nurses how they have all attended development courses as part of their educational pathway.
- We saw there was a wide range of specialist nurses, for example the dementia care team, palliative care team, safeguarding leads, diabetic 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.
- Junior doctors we spoke with reported that although the trust was an excellent place for training, they were often unable to attend teaching due to low staffing levels.
- There was a robust system to ensure that nursing staff maintained current registration with the Nursing and Midwifery Council.
- Consultants we spoke with confirmed that they participated with appraisals and there were systems in operation regarding revalidation of GMC registration.

**Multidisciplinary working**

- Within medical care services we identified that there was a strong commitment to multi-disciplinary working. 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, dieticians, tissue viability, falls co-ordinators, dementia and diabetic consultant nurses and described good, collaborative working practices.
- 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.
- We saw that on the stroke unit all patients' notes were integrated with doctors, nurses and therapists using a single document. 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 but there were consistently pressures on the staff in the department to manage patients overnight without any mental health support. We heard that mental health services were provided by Kent and Medway NHS and Social Care Partnership under a service level agreement. Staff reported that access to designated mental health nurses 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 and there were no dedicated facilities for them during their stay in department.
- We discussed with ward nurses how the continuing care checklist was used to notify the continuing care nurses. Unfortunately a wait of six days was not unusual for an appointment to be arranged for the nurses to visit and assess patients to expedite discharge.

**Seven-day services**

# Medical care (including older people's care)

- The management team described their approach to seven day services as "A constant work in progress." The service was working towards a seven day service and the risk register recorded that there was a requirement for seven day consultant prescience across all divisions.
- New medical admissions were seen every day on one of the twice daily post take 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 critical care outreach, pathology and 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.
- Weekend medical cover was provided by a "Hot" and "Cold" team. The "Hot" team provided cover for new admissions and sick patients with the "Cold "system attending to ward patients and discharges. Medical staff told us that there were was poor communication regarding who was in the relevant team, constant gaps on the rota and high levels of sickness and absence due to pressure of work. They considered this often resulted in unsafe medical care over weekends.
- Endoscopy services operated a service with twenty four hour seven day access to consultant on call across the three hospital sites, with nursing staff supporting at each hospital.
- Currently there is 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. Some nurses picked up some therapy interventions e.g. mobilisation but this was not optimal.
- With pharmacy services only available until midday at weekends, timely discharge was impeded for patients who were unable to obtain their discharge medication.

**Access to information**

- We spoke to 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 good communication between medical and nursing staff.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- The Adult Safeguarding team had been renamed the "People at Risk Team" (PART). This team had responsibility for overseeing the implementation of MCA and DoLS within the hospital. Staff we spoke with knew how to contact the team and told us they valued their support and advice.
- There was no evidence to support that any staff had received training in the Mental Capacity Act and Deprivation of Liberty. When we spoke to staff they told us they had not received this training as it was not part of the mandatory training requirement. For example on CDU we found that only four of the 36 nursing staff had received training in MCA and DoLS.
- Staff we spoke with were 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 that standard authorisations were sought from the relevant supervising authority. We saw that consideration was given to using the least restrictive option. We reviewed documentation for this patient on Deal ward and found that it was completed correctly and had been reviewed appropriately.

# Medical care (including older people's care)

- 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.
- We observed a patient on St. Margaret's ward and saw that there was a DoLS order in place. A request had been made earlier in the day to the "Staff Assist" service, employed by the trust to provide personal support to the patient. Delays in the arrival of the staff assist meant that we observed that four other members of staff were interrupted from the care of other patients to manage the behaviour of the patient.
- Patients told us that staff gained their consent before care or treatment was given. We observed health care assistants gaining patients' agreement before carrying out care.

## 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 care that was compassionate from all grades of support and clinical staff. We also saw, and patients told us, that privacy and dignity was maintained at all times.

Patients were involved in their care and treatment and were given the right amount of information to support their decision making. We found there were arrangements to ensure patients could get the emotional support they needed.

**Compassionate care**

- The trust use the Friends and Family test (FFT) to get patients views on whether they would recommend the service to family and friends. FFT figures are used to calculate the net promoter score which enables trusts to be compared. We looked at the latest FFT scores that were available to us and during the period December 2013 to December 2014 the response rate for individual wards ranged from 10 - 60%. We used six medical wards for the period June – November 2014. The score for this period averaged at 79 out of 100 for med care services at The QEQM Hospital. The results can produce scores between -100 and +100; a score over 50 is considered to be excellent.
- The patients who contacted us prior to the inspection, and through our various listening events, told us that the care was usually very 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.
- Patients and relatives that we spoke with during our inspection commented on the kindness of staff in delivering their care.
- We observed that generally call bells were answered promptly, however on St. Augustine's ward we observed two call bells unanswered for ten minutes with staff at the nursing station not responding. We found the call bell to one patient on this ward out of reach with the patient calling for assistance.
- Mixed sex breaches are reported in the monthly Clinical Quality & Patient Safety Report, including those that occurred as being within the agreed scenarios. Medical care services reported there had been no breaches of guidance on mixed-sex accommodation since April 2014.
- In many ward corridors we saw that confidential patient information was displayed in the public 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.
- We observed that interactions between nursing staff and patients were professional, kind and friendly. We spoke to 19 patients and relatives who were generally very complimentary about the care they received from staff. One patient on Minster ward told us "Staff are always checking on me I never have to use my call bell".
- Patients told us that the nursing staff were respectful to them and every effort was taken to ensure their privacy was protected when personal care was being given.
- We saw examples of how staff were aware of the need for a quiet time for patients in the afternoon. An example of this was on Deal ward where the lights had been lowered and visitors to the ward were reminded that patients were resting after lunch.

- Toilet facilities on St. Augustine's ward were small and cramped with sliding doors which we saw were difficult for elderly patients to close. This meant that on two occasions we observed patients using the toilets without closing the doors. Courtesy curtains were located in front of the doors but only offered minimal levels of privacy for patients.
- We spoke with a wheelchair bound patient on St. Margaret's Ward. They told us that they had been asking for a shower since they had been admitted the previous week but staff repeatedly told them they could not have one due to the lack of staff. We checked this with the ward staff who confirmed this was the case.

**Understanding and involvement of patients and those close to them**

- 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.
- Initiatives had been introduced in the Stroke Unit to improve the engagements of patients and their families in planning their care and discharge with the introduction of a family meeting within two weeks of admission. A further meeting was then held two weeks prior to discharge. We reviewed six sets of patient notes and were able to see how this involvement had been recorded and used to support the needs of the patient.
- Data taken from 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, patients given enough care from health or social services, patients being given correct information and patients told who to contact post discharge. However they scored in the bottom 20% of trusts for: Being given enough privacy when examined or treated, staff gave explanation of what would be done, patients not feeling that they were treated as a set of symptoms and staff did everything to control side effects of chemotherapy. However, the audit was trust-wide, and did not indicate separate results for each of the hospitals.
- In-reach and out-reach services have been developed by the Stroke Therapists in conjunction with community colleagues to promote a seamless transfer of care.
- 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.
- We saw that where a patient required their personal carers to remain with them during treatment formal arrangements were made to clarify and define the parameters of care. For example on Minster ward there was a formal plan which had been discussed with relatives and carers to ensure that there were clear guidelines on what basic needs were to be provided by the carers and hospital staff. This meant that there was clarity for the patient and all parties during the episode of treatment.
- We found patients were given information to help them understand their disease and its treatment. For example we observed a physiotherapist describing the benefits of the programme developed for them. We noted that plain English was used and that the communication style was appropriate to the patients' needs.
- 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.
- Access to translation services was available for patients and staff were knowledgeable about how to access this support.

**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.

# Medical care (including older people's care)

- We found that patients could access a range of specialist nurses, for example in palliative care, stroke and diabetes care and that these staff offered appropriate support to patients, their families and carers in relation to their psychological needs.
- In some areas of the hospital there were facilities which enabled staff to speak with patients and their families confidentially. However, there were not always dedicated private areas in all 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 and gave an example of an occasion where a cupboard was used.
- 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 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 occasions when doctors were difficult to contact and consultant reviews less likely to occur. This had negative implications for the safe care and treatment patients.

We also found that support for people with mental health needs was variable and the discharge of patients was not managed in a timely manner especially at weekends.

We found that although there were arrangements to meet the individual needs of patients and that considerable developments were in progress to improve the care of people living with diabetes and dementia, the benefits of these were not yet fully embedded into practice.

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. With the closure of the chemotherapy service we found that the organisation was not meeting the needs of the local population by providing care at close to home. We saw that there were systems to promote planned discharge from hospital that was planned and met the on-going health and care needs of patients, but the lack of pharmacy staff impeded this and resulted in unnecessary delays.

**Service planning and delivery to meet the needs of local people**

- Patients were admitted to medical wards via the accident and emergency department or via their GP. GP requests were assessed in the CDU. This incorporated the Ambulatory Care unit where patients could be assessed in chair spaces rather than beds.
- This ambulatory care was provided so as to provide care closer to home and avoid unnecessary admissions. However, a doctor expressed concern that this area was not ring-fenced and had been used as extra capacity for medical inpatients when seasonal pressures necessitated this. This meant there was variability on the provision of a service designed to meet the needs of local people.
- 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.
- The Endoscopy Unit consisted of three endoscopy rooms which were refurbished four years ago and were all operational at the time of the inspection. When we spoke to the lead consultant we heard that there is currently a 7% increase year on year for services. There has also been a 17% increase in referrals across the trust with the department covering a routine elective list of seven days per week across the trust.
- 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 with feeding.

# Medical care (including older people's care)

**Access and flow**

- The trust was meeting the referral to treatment time targets for all medical specialities. With a range of 90.9% to 100% compliance with the 18 week target set nationally.
- From the data we reviewed for the period June 2013 – June 2014 the average length of stay for patients in medical services was below the England average for Geriatric medicine at 7.0 days (England average 9.8) and general medicine at 4.2 (England average 6.4) but above the England average of 12 days for stroke medicine at 13.6 days
- The trust held twice daily video operational meetings across each of the sites, mid-morning and late afternoon where the bed capacity of each site was discussed.
- We reviewed showed data that demonstrated there was currently a 30 day waiting time for patients on the cancer pathway against the 14 day target. We were told by senior staff that following a national awareness campaign there had been a significant increase in referrals and 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 trust board level.
- 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 246 and 428 per month. This showed that medical care services were unable to care for patients within their allocated bed base.
- During the period April 2014 to April 2015, 31% of patients experienced one ward move, 11% were moved twice, 5% three times and 3% were moved four or more times. This showed that nearly half of patients were not treated in the correct speciality bed for the entirety of their stay.
- We spoke with nursing and therapy staff who told us they felt that whilst there were arrangements to ensure that outlying patients were reviewed by speciality teams, there were occasions when doctors were difficult to contact and that consultant reviews were less likely to occur daily.

**Meeting people's individual needs**

- 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.
- 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.
- There were dementia champions available for support staff and dementia training available for staff to access, but the care of patients living with dementia was not embedded in clinical practice. Not all patients with dementia had dementia care plans in their patient's notes and the use of the "This is Me" document was not used to its full benefit. This document is produced by the Alzheimer's Society and used to notify staff about the social history of people living with dementia or as a method to alert staff to care preferences or any special considerations relevant to their care. We found the document included in many patient care notes on the elderly care ward but not completed, which means that it was a lost opportunity to engage patients' families in completing these documents in order to communicate their personal knowledge of the patient. Staff we spoke with were aware that these documents were available and often in use and told us they found them helpful when utilised.
- We found that some initiatives had been introduced in wards accommodating patients living with dementia, such as coloured doorways to lavatories and coloured toilet seats, but this was inconsistent.
- The hospital scored below the England average for Patient Led Assessments of Care in the sections for dementia with a range of 67.7% - 96.3%.
- We saw that patients had their needs assessed but 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. We found that nursing

assessments were not always completed. There appeared to be no consistency in the organisation of medical and nursing documentation which sometimes made navigation of the records difficult.

- We saw that a system of "intentional rounding" had been implemented to ensure that patients' fundamental needs were met. This system involves nurses checking patients every two hours for pain, nutrition, hydration, skin, falls and anxieties. We saw good examples of these records on Minster Ward and saw they were recorded as carried out at the specified frequencies. However, during a visit to St. Augustine's ward at 14.00 hours we found that a distressed patient had received no care rounding since 10.00 a.m., could not reach the call bell and whose catheter bag had not been emptied with no urinary balance or fluid chart completed for the day. There was no catheter care pathway in place for the on-going care for this patient. We saw further examples on Deal ward where no comfort rounding had taken place for over eight hours.
- 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.
- We noted that patient assessments identified when patients had sensory deficits and this was factored into care planning. We observed specialist equipment in use to aid communication with a deaf patient.
- We saw that with the exception of St. Augustine's ward bathrooms and lavatories were suitable for those with limited mobility. There were adequate supplies of mobility aids and lifting equipment such as hoists to enable staff to care for patients.
- Hospital mattresses were it 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 were able to access interpreting services for people for whom English was not their first language. Polish and British Sign Language were the languages most often requested. We did not see any patient literature displayed in languages other than English apart from information on spiritual guidance.
- 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.

**Learning from complaints and concerns**

- We saw that a new complaints policy had been introduced. This was available on the intranet for staff to access.
- We noted that information on how to raise a concern or complaint was prominently displayed in clinical areas throughout medical care services.
- We asked two members of staff about the Patient Advice and Liaison Service (PALS) and they were conversant in what support services would offer to patients and how it could be accessed. This demonstrated that patients could access the information and support they needed to progress a concern or complaint.
- 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 with four being upheld. Of these complaints only one was attributable to the QEQM for delay in allocation of an OPD appointment. 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. An example of positive action taken was in response to patients complaining about the levels of noise in the CDU ear plugs where made freely available to them.
- 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.

# Medical care (including older people's care)

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

## Are medical care services well-led?

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 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.

When talking with staff we noted a positive culture of respect for colleagues at all levels.

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 had undergone a level of change which was described by the Interim Chief Executive as "embarking on an improvement journey". Managers and Staff were articulate in understanding 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.
- All staff we spoke to at The QEQM Hospital 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.
- 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. We attended a staff handover session where managers described the process of assessing the acuity and needs of patients on the wards and ensuring staff

were made aware. Staff confirmed the process and we were shown how bay notice boards were used to display information as a constant reminder to staff of people's needs.

- 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.
- 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.
- 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.
- Staff in the stroke unit were complimentary about the strength of the unit's clinical governance and felt that they had a strong unit that was well led with quality improvements in place.

**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 wards regularly and were approachable and helpful. Staff told us that they felt supported by their line-manger to do their jobs well despite challenges, especially of capacity and recruitment. Staff of all grades were aware of the need for improvement; the challenges faced by the service and were aware of, and engaged with actions to mitigate the effects of quality and safety of care.
- Leadership at local service level was 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 trust were continually working with new initiatives to enhance the service but we heard that not all senior managerial staff were supportive of these and remained resistant to change which other staff found disappointing. An example of this was the development of an ambulatory care model across the trust and some staff told us they found this response unhelpful and a negative example for other staff.
- Consultant's described a successful forum held in May with another planned for July.
- The leadership academy was accessible for all staff who 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 strong leadership from matrons and the director of nursing was well-known to staff and seen in clinical areas.
- 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 is slow to resolve with examples of staff that had left because of stress and the inability to cope with the work pressures.

- We received correspondence from a research fellow working within the trust, taking part in a national NIHR – funded project evaluating a tool to improve the care of people with dementia, who commented on the commitment of staff to the project and the support received from the leadership. In particular to the CE finding time to attend initiatives such as attending the staff "singing for wellbeing" choir. One of the comments was; "Such support and interest means a lot to staff at the sharp end".

**Culture within 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 evident. This 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.
- 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.
- 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. The location of the hospital presented problems with the retention of staff due to its close proximity to London and the demographic makeup of the area. 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.
- The Trust had a number of staff in different areas who were recruited from overseas at a time when it had been difficult for the NHS to recruit sufficient qualified people in this country. We spoke with some of these staff. They told us they were treated well and respected by their fellow workers and managers.
- 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.

**Public and staff engagement**

- Patient satisfaction surveys were conducted by the trust and 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.
- 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.
- 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.
- There are initiatives in place to involve patients and their families to complement their care. Examples of these are the Stroke Unit which arranges weekly coffee mornings for stroke patients and dementia cafés held in the discharge lounge for all patients around the hospital on the second Thursday of each month.

**Staff engagement**

- Cluster meetings held on Fridays for Ward Managers 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 2050 staff responded. 72% of staff would recommend this hospital for treatment and 47% would recommend it as a place to work.
- 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 asked doctors about the support they received from the Director of Medical Education and found no evidence that they had visited the QEQM or engaged with medical staff on the site.
- 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 have been nominated by their peers for having "gone the extra mile".
- Generally staff described an environment with a transparent, diverse and supportive ethos although we did receive comments that there were still pockets of a bullying culture operating on some wards.

**Innovation, improvement and sustainability**

- Initially to support staff with the CQC inspection the organisation had introduced an improvement hub. This was in a dedicated room and manned at publicised times to provide an opportunity for staff to obtain information and contribute with suggestions, comments and experiences. Staff reported that this was a very useful resource and we were told that on occasions up to 200 people had attended an information forum.
- 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.
- The governance system used comprehensive system of metrics presented as dashboards to ensure that quality issues and trends could be readily identified. We found that through its clinical governance and performance review structures and processes, the divisional management team were well placed to ensure that improvements needed were identified and that performance across a wide range of metrics was sustained.
- In renal care we saw how an innovative alert system had been introduced by renal research doctors at the trust which had realised a 20% reduction in Acute Kidney Injury (AKI).
- 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.
- Nurses told us that there were opportunities for learning and development, particularly around enhanced clinical skills training in dementia and cardiac care.
- 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 main surgical activities at The Queen Elizabeth The Queen Mother (QEQM) Hospital during the period from July 2013 until June 2014 were day case procedures, at 46%. Elective surgery made up 23% of activity and emergency surgery contributed 31% of activity. The speciality with the highest activity was trauma and orthopaedics at 41%. During the last financial year there were 8799 admissions, representing an increase of 1053 on the previous year.

There were five surgical wards, with a combined total of 120 inpatient surgical beds. Unfunded beds accounted for 12 of the total bed compliment. There were six main operating theatres with associated areas for anaesthetics and recovery. The day-care unit had three theatres and two recovery bays, with 14 day-care bays.

We spoke with 11 patients and two relatives, held discussions with 28 staff and reviewed eight patient records. We also made observations in surgical areas and reviewed information provided to us prior to and during the inspection.

## Summary of findings

Whilst most areas in which surgical services were provided were suitable, the day-care theatre environment was not wholly safe. Fire safety arrangements within the main theatres was not sufficient, and there was a lack of risk assessment and consideration with this regard. Evacuation equipment was not available and staff had not been trained to the required standards. Some of the required safety checks were not being undertaken.

Although recruitment continued to be difficult, staffing arrangements did not always reflect the requirements, particularly when additional surgical beds were opened above the funded capacity.

Staff had not completed all the required mandatory training, which supported the delivery of safe treatment and care, and there was no formal evidence of ward staff having been trained in safeguarding vulnerable adults.

Arrangements for reporting adverse events and for learning from these had been improved.

Theatre utilisation was not always maximised and referral to treatment times were not always achieved.

Patient flow through the surgical services was adversely affected by availability of beds. This was linked to delayed discharges associated with provision of on-going support, rehabilitation and delays in take home medication.

# Surgery

Consent was sought from patients prior to treatment and care delivery. Consultants led on patient care and specialist staff and allied healthcare professionals participated in the delivery of treatment and care. Procedures were in place to continuously monitor patient safety and surgical practices and patient care reflected professional guidance.

Surgical outcomes were generally good and results were communicated through the governance structure to the Trust Board.

Patients commented positively on their experiences. They said they received kind and compassionate care, which maintained their dignity and respected them as individuals.

The surgical staff spoke positively about the leadership at departmental level and felt respected and valued. Staff understood the trust's values and recognised that there had been many changes, which had contributed positively to the change in culture they now experienced.

The governance arrangements supported effective communication to staff and the Trust Board. Identified risks were continuously reviewed and discussed and information was communicated with respect to service delivery and performance.

The views of the patients and staff were sought with a view to improving and developing the services.

## Are surgery services safe?

**Requires improvement**

The day-care theatre environment was not arranged in a suitably safe manner. Obsolete equipment was identified in an area used for clean preparation. Fire safety arrangements were not suitable within the theatre environment and equipment was not available to evacuate patients.

Overall, safety checks were being undertaken in surgical areas. However, we found resuscitation equipment had not always been checked or cleaned. The recording of fridge temperatures where medicines were stored was not always recorded. There were gaps in registers where signatures were required for the administration of controlled drugs.

Staff had not received all the mandatory safety training required to support the delivery of safe care and treatment to patients. There was no formal evidence of ward staff having been trained in the safeguarding of vulnerable adults.

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 regulations.

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. Where risks to patients were identified, these were acted upon. Staff monitored patients' well-being using an early warning alert system. There was action taken where deterioration in a patient's condition 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, there were arrangements to ensure staffing numbers and skills mix were appropriate to support the delivery of safe patient care.

# Surgery

## Incidents

- Incidents were reported using an electronic system. Ward staff and medical personnel we spoke with were able to describe examples of incidents they had reported and the process of investigation of these. Theatre staff discussed incidents at monthly clinical governance meetings and fortnightly band 7 meetings. However, there was no evidence of discussion at weekly staff meetings.
- Ward staff reported information related to incidents was disseminated in a variety of ways, including direct discussion, newsletters and ward meetings. A junior doctor told us they did not get feedback from reported incidents.
- 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 and found the contents reflected the sharing of information and learning.
- There had been one Never Event at the QEQM. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. Staff in theatres were able to describe the learning from incidents including the recent never event related to 'wrong side' nerve block. We saw actions that had been implemented as a result of this, including the use of 'stop before you block' stickers.
- 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 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.
- Mortality and Morbidity meetings were held regularly and minutes we reviewed confirmed this. We also reviewed a formal presentation of mortality related to the admissions in trauma and orthopaedics between February and April 2015. Lessons learned from discussion was identified and shared.
- 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'. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have, occurred. Staff understanding of 'Duty of candour was variable depending on their grade. For example band 5 theatre nurse had no awareness. There was however, a good understanding by more senior staff. We saw that the principles of being open and transparent were followed in the communications that were sent to individuals affected by recent incidents.

## Safety thermometer

- Queen Elizabeth the Queen Mother Hospital participated in the NHS Safety Thermometer scheme, used to collect local data on specific measures related to patient harm and 'harm free' care at a specific point of time. 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.
- Data was reviewed for ward areas and this indicated, for example, that on Quex Ward there had been one patient fall and one pressure ulcer in the month up to the date

of our visit. Seabathing Ward results showed one patient fall in the month and one MRSA. There were no reported falls or hospital acquired pressure ulcers on Cheerful Sparrows (female) Ward.

- 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 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.

### Cleanliness, infection control and hygiene

- According to the data presented in the draft governance report for the surgical services division, there had not been any blood-stream infections related to Meticillin Staphylococcus Aureus (MRSA) or Meticillin Susceptible Staphylococcus Aureus (MSSA). There had been no Clostridium Difficile Toxin (CDT) cases in the surgical wards between April and June 2015. Further, there had been no reported incidents of MRSA or CDT on Cheerful Sparrows (female) in the previous six months.
- There were infection prevention and control (IPC) link nurses on each ward and in theatres. They were responsible for cascading training and information and for ensuring staff were compliant with infection control best practices.
- Infection control audits had been carried out to check compliance with environmental and clinical practices. Cheerful Sparrows (female) and Seabathing had been audited in 2015. Non-compliance had been identified in all areas and action plans had been submitted or were in preparation. We saw examples of action plans and these had dates for resolution or when completed.
- The theatre audit for September 2014 indicated six environmental areas of non-compliance and two for clinical practice. An action plan had been drawn up which included target dates for completion.
- We saw information which measured cleaning tasks and actions. Results for Cheerful Sparrows (male) Ward were in the 90% plus range.
- There were dedicated staff for cleaning ward areas and they had been provided with nationally recognised colour coded cleaning equipment for use in defined areas or in specific circumstances. This helped to reduce the possibility of cross contamination. Information to guide staff in cleaning standards and processes was displayed.
- Theatres were cleaned at night by contractors in accordance with specific local guidelines. Weekly audit took place with a member of theatre staff to check standards. There were three monthly IPC link audits.
- In main theatres there were separate "clean" preparation and "dirty" areas for removing used instruments from the operating room ready for collection for re-processing by the external decontamination service.
- Surgical wards and the day-care unit were found to be visibly clean and most patients commented positively about the level of cleanliness and frequency of cleaning, including attention to detail. Theatre areas were appeared clean and generally well maintained.
- There was access to personal protective equipment, (PPE) including gloves and aprons in all areas we visited. We observed staff used these whilst going about their activities.
- Staff had access to IPC policies and procedures via the trust intranet. We looked at some examples and found they were in date and current.
- We observed staff in theatres and on wards complying with local infection control policies, such as management of sharps, hand hygiene, the management of bed linen and the management of clinical waste. There was good access to hand washing and drying facilities, as well as hand sanitising gel. We saw gel was available on patient beds, and at entrances to wards and bay areas. Patients reported they observed staff washing their hands and using hand gel and PPE.
- There was a specimen handling and management protocol in place, with most samples handled in-house by the pathology department. This meant the service could be delivered safely and effectively.
- We observed that the National Institute for Health and Care Excellence (NICE) guideline CG74, site infections (2008) was followed by staff in the theatre environment. This included skin preparation and management of the post-operative wound.
- We saw that when it was necessary to isolate patients, appropriate signage was in place. This provided safety guidance to staff and visitors in order that any risks could be minimised.

- Equipment used by patients on ward areas, including shower stools and commodes were checked and found to be clean. Staff in theatres followed a cleaning schedule for equipment cleaning and signed a book to confirm completion. However, the book was not always completed. The senior nursing staff monitored equipment cleanliness. Equipment we checked was notably clean in all areas, except a resuscitation trolley based between the Cheerful Sparrows wards. This was unclean, with a heavy build-up of dust.
- The decontamination of surgical instrumentation was outsourced in accordance with standard operating procedures (SOP). Procedures were in place for storage of dirty and clean instrumentation, with equipment items scanned and tracked accordingly.
- Infection prevention and control training was part of mandatory training for nursing and theatre staff. Theatre training figures indicated 88% compliance and ward areas had achieved compliance in excess of 80%, with the exception of Bishopstone, which was 75.76%.

### Environment and equipment

- There were six main operating theatres, only one of which had air flow exchange, (Laminar flow). This meant that some orthopaedic surgery was taking place in a standard theatre.
- There were three day case theatres, plus one theatre used for obstetrics. The recovery area had 12 bays, including two used for the post-operative recovery of children. Standard theatre environment was provided, with anaesthetic rooms, scrub facilities, clean preparation rooms and dirty utility.
- The day-care unit had three theatres and two recovery bays and 14 day-care bays. The day-care unit was not ideal as this was located in an older building and the scrub areas doubled as a clean set up area. Clean preparation areas should be totally enclosed and separate to an area where scrubbing up is taking place in order to avoid the possibility of airborne contamination.
- We identified the presence of an obsolete 'autoclave' (a machine for sterilising instruments) within the ophthalmic day theatre, which had been out of use for many years and had been raised as a concern at the previous inspection. The room where it was located was a designated 'clean room' and should not have had such equipment present.
- Theatres were located on the second floor of the building with a stair case as the only route of escape. A fire risk assessment had identified two mitigations that would need to be put in place to enable either evacuation or horizontal evacuation to a place of safety. The Director of Nursing had been made aware of the fire safety concerns and a fire risk assessment had been undertaken to comply with the regulatory reform (fire safety) order 2005; however the actions identified had not been completed.
- On the day of our inspection there were no devises in theatres to enable staff to evacuate patients down a stair case. We were told the manager had been given authority to buy the devises to enable non ambulatory patients to be evacuated down stairs a few days before our inspection.
- The compartment fire doors, which should have one hour fire doors were not and did not have any intumescent strips fitted. These strips effectively seal the door against the frame or against the other door in the case of double doors. This then makes a seal so as fire and smoke cannot pass through for a period of time that the door is designed for. We saw four store cupboards with signs on stating "fire door keep shut" and all were open. The store with door number 016.F.015 had no intumescent strip so could not be classed as a fire door. There was a kitchen within theatres and the door stated 'fire door keep shut.' This was not a fire door and to comply with Health Technical Memorandum (HTM) 05-01- Managing Healthcare Fire Safety requirements the door on a kitchen area should be a 30 minute fire door to be compliant.
- Plant air handling, water safety and generator servicing in theatres was managed by estates in accordance with Health Technical Memorandums.
- There was adequate storage for different types of equipment in theatres and on wards. Staff reported that they had enough equipment to enable the safe and effective delivery of care. Single use equipment such as syringes; needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner.
- Emergency equipment in theatres was available and included resuscitation items, emergency intubation and for malignant hypothermia. Routine checks on this equipment had been made and items were clean.

Resuscitation equipment on wards was available but there were several dates where the trolley shared between the two Cheerful Sparrows Wards had not been checked. We saw a check-list that recorded scissors were not available on the 26 and 29 March 2015. There was no evidence of any action taken to address this.

- Wards and theatres were accessible to individuals with disabilities. Technical equipment was available to support individuals when required. This included operating tables appropriate for bariatric patients.
- The equipment library was well managed and ensured that staff had access to portable equipment, and that items had been checked and serviced. We saw safety check labels attached to equipment.
- We found the Association of Anaesthetists of Great Britain and Ireland safety guidelines Safe Management of Anaesthetic Related Equipment (2009) was being met. It was recorded in the patient's anaesthetic record that the anaesthetic machine check had been performed, that appropriate monitoring was in place and functional, and that the integrity, patency and safety of the whole breathing system has been assured.

## Medicines

- Medicines optimisation was supported through pharmacists and technicians. Staff told us pharmacists visited wards to check prescriptions. Technicians reviewed discharges in order to facilitate timely provision of take home medicines.
- We observed the processes for ordering, storage and disposal of medicines on surgical wards and the day case unit and found procedures were carried out safely and in accordance with best practice in most areas. This included temperature checks of fridges used for storing certain medicines. Patients own medicines were stored in a lockable section of the patient bedside unit. Controlled drugs (CD's) were stored in locked cupboards, which were secured to the wall. However, we found gaps in the CD registers of second signature for at least six administrations on Cheerful Sparrows (female) Ward. Daily CD checks had not been done on eight days preceding our inspection visit on this ward.
- CD were checked twice daily in theatres and the registers we viewed were complete.
- Medicines fridges were checked in theatres. However, the temperatures at which items were stored were not recorded. Temperature checks had been undertaken on warming cabinets, used for the storage of certain fluids.
- Pharmacy had undertaken an audit in May 2014 with respect to the processes for ordering, receipt, administration, record keeping and storage of controlled drugs. Also included was the storage of epidural injections, strong potassium solutions, and high dose morphine/diamorphine and midazolam preparations. Results were presented along with an action plan and an indication of further audit to take place in November 2014; however, we did not see any results to indicate if such an audit had taken place.
- We observed medicines being given to patients by nursing staff on wards and in day surgery. Appropriate checks were done prior to administration.
- Staff had access to up to date guidance on medicines.
- We saw antimicrobial protocols were clearly visible. There were reminders about antimicrobials in all theatre areas, particularly in anaesthetic rooms.
- Medication errors were reported as part of the safety system and were subsequently investigated. We were told about an error which was under investigation. We were told an action plan would be developed from the findings, which had involved a number of staff over a number of days.

## 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 saw evidence of involvement of the multidisciplinary team, such as occupational therapists and physiotherapists. We saw information recorded about 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. 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.
- 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. We saw two days of audit and saw there was one failure to complete the sign out section on the 14 July 2015.
- We saw there were audits to check staff compliance with 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.
- Staff explained the system in place for transferring patient records between hospital locations. They reported that there were seldom any problems in having notes present for pre-assessment.

## Safeguarding

- Staff reported having access to a safeguarding protocol and named staff that were able to support staff in this area.
- Safeguarding children's training was undertaken by staff in clinical areas. Staff told us it was also covered as part of the induction training, along with Deprivation of Liberty Safeguards, (DoLS). A sister on Seabathing advised us that staff had also been updated on these subjects at a recent meeting. Theatre attendance figures were shown to us. For adult safeguarding, attendance was at 81% and for child protection training, the figure was 92%. Discussion with theatre staff about safeguarding indicated that they were aware of the relevant safeguarding lead staff and how to report concerns. Ward training figures for child protection were in excess of 90% for the majority of wards.
- Medical staff were required to complete mandatory level 3 safeguarding children training every three years. We saw a programme of training dates for the months ahead and noted training included child sexual exploitation, trafficking and female genital mutilation.
- Apart from theatres, there was no formal evidence from staff or in figures provided that safeguarding of vulnerable adults training was taking place for ward staff.

## Mandatory training

- Mandatory training included equality and diversity, moving and handling, fire, information governance, health and safety and infection control. Child safeguarding was a mandatory subject but not adult safeguarding.
- Wards retained their own e-learning training completion figures. For example, information for Seabathing indicated all the required training had not been completed by 11 members of staff. The ward sister on Cheerful Sparrows (female) Ward advised us the mandatory training rate was showing red on the report but this had not been updated since staff had completed more recent training.
- The surgical division recognised that mandatory training compliance was poor and had provided a trajectory of achievement going forward. In addition, they had identified actions to be implemented as a means of increasing compliance, with particular focus on meeting specified targets of 90%.
- Training rates for staff working in the day-care unit were good, with 88% having attended manual handling and 95% hand hygiene.

- Areas where training attendance fell into a red category in May 2015 related to information governance and health and safety, with Cheerful Sparrows (female) and theatres not achieving the target, (the latter subject figures being 70% and 70.5% respectively).
- We were told that the trust fire safety training was delivered via e-learning only. The HTM 05-01 states: that e-learning is not acceptable as the sole means of training for the following reasons: it does not take account of significant findings from fire risk assessments; it does not take account of changes in working practice; it cannot adequately train staff in evacuation techniques, particularly those involving patient evacuation; it is unlikely to provide for job-specific training; there is little opportunity for direct feedback to trainees' questions.

### 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. We saw and heard from staff that the hand held devices sometimes did not work, which was frustrating and meant having to find another device from other staff members to enable results to be recorded.
- There was a response team available attend to patients when their condition deteriorated and required escalation to medical staff. We observed a response to a cardiac arrest and the manner in which staff acted was professional, organised and considered.
- 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.
- Two hourly rounds was 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.

### Nursing staffing

- Staff confirmed with us that there was a senior nurse out of hour's who covered the surgical areas providing support and advice. Wards generally had a designated person in charge each part of the day and night.
- Staffing levels based on planned and actual needs were displayed on wards and in theatre areas. For example Seabathing Ward had four nurses and three health care assistants (HCA) on the morning and afternoon shift and three nurses and two HCA on the night shift.
- A member of medical staff gave an example to us where staff shortages had impacted on the care of an individual patient. The RCA had resulted in highlighting issues around irregular observation recording because of the lack of staff. This had subsequently been rectified by having more agency staff.
- We reviewed duty rotas, which indicated the staffing arrangements, gaps filled by agency or to be filled and skills mix per shift.
- The senior nurse on Cheerful Sparrows (female) Ward reported that staffing levels were not based on an official acuity tool. They told us staffing on the ward was based on 20 beds, but that there were numerous occasions when an additional six beds in an overflow section of the ward were opened and staff had not been increased to cope with the additional demand. The ward had funding for 12.53 WTE band 5 nurses but the actual levels was 9.6. However, an intake of new staff was expected in September, which would bring up to the funded levels. The vacancy was being managed by the use of regular agency staff. Two HCA vacancies were anticipated to be filled following interviews the previous week.
- We found from information provided to us that both Cheerful Sparrows Wards had bed occupancy levels above the funded capacity. Staffing levels had associated cost implications and ward budgets did not allow for the additional demands when extra beds were opened. Information reviewed by us for September 2013-December 2014 indicated that when additional beds had been opened the numbers of nursing hours required to support the delivery of patient care was never met.
- Recruitment had been recognised by the trust as an on-going concern and overseas recruitment had taken place, although for surgical areas we were told the uptake had not been very good. There were plans to go to other countries, such as Greece, Croatia and Hungary.

There were six whole time equivalent (WTE) vacancies of nursing staff on Seabathing Ward and one WTE healthcare assistant. Gaps in duty rotas were filled by agency staff, who were generally familiar to the ward. The agency induction included routine expectations, using the electronic data base for recording patient observations and medicines.

- There were no vacancies in nursing personnel within the day-care unit and there had not been any requirement to use agency staff.
- The pre-assessment service was covered by a small team of staff with different speciality skills and experience. There were seven WTE nurses and one part time and three HCA. A surgical nurse practitioner supported the colo-rectal service one day per week.
- Turnover rate of nursing staff was reported in the draft surgical services divisional governance report. Figures for May 2015 stated highest turnover of staff on Cheerful Sparrows (female) Ward, at 27.72% and 17.71% on Cheerful Sparrows (male) Ward. Both of these were rated as red on the balanced scorecard system. Turnover was rated green on Bishopstone at 1.31%, and their vacancy rate was also achieving a green rating, at 8.49%. Seabathing Ward had a red rating for staff turnover, and their vacancy rate.
- Sickness rates for May 2015 were highest on Quex and Bishopstone, 11.77% and 5.54% respectively. Cheerful Sparrows (male) Ward and theatres also had a red rating for sickness.
- There were 134 (WTE) staff in theatres, with one band 5 vacancy. We reviewed evidence that indicated there had been one agency staff member used for the previous two months. This person had completed an induction and we were provided with a copy of the documentation in confirmation. A review of the staff rota confirmed that skill mix was in line with standards and national recommendation.
- A patient on Cheerful sparrows female told us they thought there was insufficient staff, telling us, “they are always in a rush.” They said buzzers were not responded to very promptly at night. We made an unannounced visit to this ward during the morning before night staff had gone off duty. We did not identify any concerns about staffing levels or response rate to patient call-bells.
- Detailed handover of patient information took place between changes in shifts and was a combination of board and around the bed communication of information. On-coming staff were provided with a formal record of information to follow, in addition to having access to care records.
- Handover of patients also took place between recovery and ward staff when a patient was to be returned to the ward. There were delays at times in nurses being free to collect patient from recovery but information was shared so that the on-going treatment and care could continue safely

### Medical staffing

- The surgical directorate had undertaken workforce activity since the last inspection. This had led to the recruitment of an additional colorectal consultant at this location and three senior middle grade doctors, appointed as locums to the emergency surgeon role. The QEQM had five colorectal consultants, two upper gastrointestinal and three emergency surgeons (two of which were to apply for post once completed their specialist training). Induction packs were provided to locum medical staff, which were very informative and instructional in content.
- We saw from medical rotas for general surgery that there was a designated consultant of the day and a named consultant for the hours of 6pm to 8am. Registrars were on day both day and night and there were senior house officers (SHO) for days and night shifts for the same time period. First and second on call junior doctors were also identified.
- Trauma and orthopaedic medical cover indicated consultant cover for each day, with SHO cover at weekends between the hours of 8:15am and 10pm
- Nursing staff told us the out of hours cover for weekends included a consultant and registrar on site, both day and night. A consultant round in the mornings included a review of any patient admitted in the night and a review of their own patients.
- Discussion with a junior doctor indicated there had not been any locum medical staff in the four months up to our visit on Cheerful Sparrows (female) Ward. The consultant was said to be easily accessible and ward rounds were led by the consultant one to three times per week. The registrar led the ward rounds on other days. Junior doctors in their first year of training did not undertake any nights in surgery and there was registrar available at night.

# Surgery

- Theatre staff reported no concerns with medical cover. Emergency theatres and trauma lists were covered by appropriately skilled surgeons.
- Handovers between outgoing and on-coming medical staff took place at 8am and 8pm, with consultant presence at the morning handover but not evening. Verbal information was conveyed about each patient, supplemented with a typed document.

### Major incident awareness and training

- There was formal guidance available to staff regarding actions to be taken in the event of a major incident. Information was displayed on every noticeboard and action cards appropriate to areas were within this.
- Staff confirmed there was a training DVD with respect to major incidents.

## Are surgery services effective?

Good

Patients were assessed, treated and cared for in line with professional guidance. The majority of patients reported having effective pain management and that staff monitored this aspect of their care.

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

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

Staff caring for patients had undertaken training relevant to their roles and completed competency assessments to ensure safe and effective patient outcomes. There was no formal evidence to demonstrate that staff were trained with respect to mental capacity and deprivation of liberty safeguards and there was variable knowledge in these areas. Staff received an annual performance review, which included discussion of their learning and development needs.

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

### Evidence-based care and treatment

- The emergency theatre protocol reflected Royal College of Surgeon principles and practice guidelines.
- We saw information, which indicated that patient's treatment and care complied with National Institute for Health and Care Excellence (NICE) guideline CG124: Hip fractures – The management of hip fractures in adults. This included a fast track flow process for staff to follow in order to ensure the patient was operated on the day of or day after admission and having relevant assessment and interventions.
- Although there was some lack of awareness in theatres of the NICE guidance being followed, we observed that staff were following NICE guidance on falls prevention, the management of patients with a fractured neck of femur, 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.
- Surgical site infections were monitored and reported to Public Health England. We saw from information provided that infections occurring after knee replacement had been above the national average. An action plan to address this had been developed and was to be presented to the divisional governance board.

- Staff in recovery followed NICE clinical guidelines CG65, which concerned Peri-operative Hypothermia (inadvertent). They assessed and recording patient temperature at regular intervals.

### Pain relief

- There was access to a pain team if required and we saw evidence of referral in patient notes we reviewed.
- We observed that consideration was given to the different methods of managing patient's pain, including patient controlled analgesia pump. 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.
- Patients who attended the physiotherapy 'joint school' received information regarding pain management directly from nursing staff.
- The fractured neck of femur analgesia pathway included suggested pain relief, such as, Facia Iliac (local injected medication) block for pain relief, where patients were suitable, oral or intravenous Paracetamol and opiates.
- A patient on Cheerful Sparrows (female) Ward said they had experienced pain and that staff gave her pain relief at medicines rounds and when they requested in between. They told us staff did not check if the medicine had worked. However, other patients told us they had regular pain relief and nurses checked if this was effective.
- A patient on Cheerful Sparrows (male) Ward told us that nurses came to their aid when they needed extra pain relief, and that this was given quickly and the effect checked by nurses.
- Patients on Bishopstone and Seabathing Ward also commented to us on the levels of pain relief medicines provided and how nurses monitored their pain and checked if pain relief worked.
- We observed nursing staff asking patients about their level of comfort and if they had pain.

### Nutrition and hydration

- Pre-admission assessments included nutritional assessment of patients using a nationally recognised screening tool.
- Patients coming round from their operation were given sips of water through a straw if they were thirsty and able to drink.
- Fluid balance charts were provided and used to monitor the patient fluid input and output. We observed nurses checking information with patients regarding their intake and recording this.
- Risks assessments were in place for patient's nutritional needs and these had been reviewed as part of the patient's progress reports. Nutritional supplements were available on wards; however, we noted that the fridge used to store such items on Cheerful sparrows (female) Ward had not had the temperature checked on four occasions in July, prior to our visit.
- A patient who was on a restrictive diet told us they were "well-hydrated" with fluids. Other patients told us they were encouraged by staff to drink and had their jugs and glasses regularly topped up.
- A dietitian told us there were delays in request for special diets, which could impact on patient care. A plan had been put in place to overcome this but had been delayed.

### Patient outcomes

- The surgical service divisional clinical governance board were responsible for monitoring, reviewing and agreeing the divisional clinical audit programme, for ensuring that changes were embedded in practice and for monitoring these.
- Figures for the period July 2013 to June 2014 indicated that the relative risk of re-admission performance for elective surgery patients was highest in general surgery and colorectal surgery. With the exception of colorectal surgery, the remaining top two specialties for non-elective surgery risk of readmission were better than the national average.
- Hip fracture audit results for 2014 indicated that the location scored better on seven of the indicators in comparison to the England average. For example, 94.3% of patients seen by a senior geriatrician within 72 hours of admission, against England average of 86.8%. An abbreviated mental test was performed in 99.8% of patients, which was above the England average of 96.9%.
- 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, were monitored. Patient self-reported health outcomes for

groin hernia, hip replacement and knee replacement were worse than England average. The Oxford knee score indicated better than 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 multidisciplinary 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. The low rates for these two areas was noted; however, it was not known if this was a reporting error or if the trust had challenged the accuracy and validity of the information.
- Lung Cancer Audit results for the trust in 2014 indicated that out of the 456 cases, 95.4% were discussed at a multidisciplinary meeting, which was almost comparable to the England average of 95.6%. The percentage of patients receiving CT prior to bronchoscopy and surgery was worse than the England average at 85.6% and 13.6% respectively.
- Queen Elizabeth the Queen Mother Hospital was compliant with 16 of the 28 National Emergency Laparotomy Audit outcomes for 2014. Good results were achieved with respect to having a fully staffed operating theatre available 24/7, an emergency surgical unit and a formal rota for on-site diagnostic endoscopy. Areas identified as poor included for example, not having a formal rota for on-site interventional radiology 24/7. There was also a lack of policies, such as a policy for surgical and anaesthetic seniority according to risk.
- The surgical division followed the Royal College of Surgeons standards for unscheduled care, which included having consultant led care, prioritising the acutely ill patient and ensuring that preoperative, perioperative and postoperative emergencies led to appropriate outcomes.
- 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.

### Competent staff

- Staff confirmed they had opportunities for a review of their performance and discussion of training and development needs during their appraisal. Appraisal rates for theatre staff were 78% at the time of our visit and 90% on Seabathing Ward. On Cheerful Sparrows (female) only one appraisal was outstanding due to sick leave.
- Ward staff were assigned link roles for different areas, such as falls, pressure area management, infection control and dementia. Their roles and responsibilities in these areas were evaluated as part of their appraisal.
- The senior nursing staff in pre-assessment were training staff in competencies to enable them to work in the pre-assessment clinics. Skills such ECG recording and blood taking were part of the competencies required.
- All nurses and health care assistants on Quex Ward had been trained by physiotherapists in mobilising patients following hip or knee replacement.
- Induction training was different for staff groups in theatre. For example, qualified staff and healthcare support workers they had a Power Point presentation and completed an induction record. They also had a six month probationary period. Newly qualified staff were also allocated a learning plan and a learning contract had to be completed.
- Clinical updates were part of the audit days, where learning and sharing information took place.
- Revalidation rates for medical staff were indicated to be 31, with two deferments.
- Appraisal rates for the surgical medical staff were stated to be as follows: anaesthetics; 87%, general surgery: 81%, head and neck: 87%, trauma and orthopaedics, 87%, and Vascular & Urology 76 %.

### Multidisciplinary working

- Multidisciplinary team (MDT) meetings took place on wards. For example, Seabathing Ward held an MDT on Tuesdays, which was attended by the orthogeriatrician, therapists, the registrar and other relevant staff. Patients with complex needs, those who had fallen or had medical issues were discussed, along with discharge arrangements.
- There was MDT working in pre-assessment, with anaesthetic involvement and links to speciality nurses and the learning disability team when required.

- Daily trauma MDT meetings took place, during which all patients seen by the on-call orthopaedic team were discussed.

### Seven-day services

- Emergency theatres were available at all hours. Scheduled surgery lists were undertaken on Saturdays, mainly for orthopaedics. Radiology was booked in advance for these cases as required. Consultants had access to a small 'c arm' for radiological use. Radiologists, CT and X-ray were available at all times for emergency work.
- The day-care unit was occasionally open for procedures on a Saturday.
- In Physiotherapy an on call service was provided from 4.30pm to 8.30am Monday to Friday and from 8.30am to 8.30am Saturday and Sunday. This was primarily for emergency respiratory patients. A limited seven day service was provided to T&O patients at QEQM, which was primarily for elective patients and fractured neck of femurs. The service was funded for four hours on a Saturday and Sunday.
- Out of hour's pharmacy service availability was arranged as follows: Saturday and Sundays 9am until 12midday, with an on-call pharmacist outside of these times.
- Microbiology operated an on-call 24-hour service Out of hours, Cellular Pathology operated a six day week, as there was no demand reported for any additional service. Blood Sciences were available at all times through the continual pathology service.

### Access to information

- Staff had access to guidelines and protocols via the trust 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.
- Specific information was available to patients who had a total hip replacement. A detailed 'rapid recovery' information book was provided, which included all relevant information designed to enhance effectiveness of treatment and improve outcomes.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We could not identify any specific training figures with respect to Mental Capacity Act 2005 (MCA) or deprivation of liberty safeguards (DoLS).
- Senior nurses were able to give examples of issues to be considered around patient capacity and consent. We heard an example of learning from a situation where consent had been signed by an individual who had a cognitive impairment, which did not meet with the guidance. The staff had met with the next of kin and agreed actions to avoid a similar situation.
- Patients told us they had been made aware of the risks involved in having surgery before they signed the consent form. Other patients confirmed that staff discussed with them what they were going to do before treatment or care, ensuring they obtained their consent.
- We discussed mental capacity and DoLS with theatre staff. They reported that the main issue was they had little contact with patients who had not already been pre assessed. Training was said to available on these subjects but it was not always taken up and other training took priority.
- Staff working in theatres had a varied understanding of the mental capacity act, depending on their grade, but limited understanding of DoLS. Senior ward staff had a good understanding of the MCA and DoLS, and the sister on Seabathing provided example of how best interest decisions had been used for a particular patient.

## Are surgery services caring?

Good

All the patients we spoke with were positive about their treatment and care. We heard comments which demonstrated that staff were understanding, caring and compassionate. We observed staff being mindful of the privacy and dignity of every patient. Staff were friendly towards patients, and treated them with understanding and patience.

Patients told us that they were involved in decisions about their care, and were kept up to date with their progress. Emotional support was provided by staff caring for them and by clinical nurse specialists, who visited the wards regularly. However, communication to patients and families was not always clear where multiple medical staff were overseeing patient treatment and care.

### Compassionate care

- For the period December 2013 to November 2014 Friends and Family Test (FFT) average response rates for the location were 34.1%, which was better than the national average. The highest response rate was 76% on

Quex Ward and the lowest on Cheerful Sparrows (male) Ward, at 29%. Results of FFT were displayed on wards and we saw, for example, 95% of patients who had been cared for on Cheerful Sparrows (female) Ward in June 2015 would recommend the ward. Comments which accompanied the results included, "excellent care all round", "happy staff, always there to help" and "nurses work hard." Results on Seabathing Ward indicated 94% of the 18 respondents would recommend the ward.

- We observed numerous thank-you cards displayed on wards, indicating that care had been delivered with kindness and reassurance. We found excellent patient survey results had been achieved on the day-care unit (at 96% for May 2015), despite the environment not being ideal.
- We spoke with 10 patients on surgical wards and one in the day-care unit about their experiences. A patient told us staff were caring, sensitive to their needs and always introduced themselves during the shift changeover. Another patient told us the staff were understanding, caring and compassionate, and were mindful of their privacy. They stated with respect to the staff, “They can’t do enough for you.” Other comments made to us included staff asking their preferred name to be addressed by, and nurses having “smiley faces” and showing concern. A patient on Seabathing Ward told us the nurses took their time to talk to them and, “they go more than the extra mile, they are very human.” This patient added that there was great camaraderie within the team and patients.
- We observed a ward nurse taking time to ask a patient how they were feeling and suggesting how they could improve their level of comfort. This was done in a caring and compassionate way. We also heard very encouraging, and kind words spoken by a nurse when helping a patient behind closed curtains. Patients also commented positively on their observations of staff towards other patients. One example described was staff using different communication approaches when dealing with a patient who had a hearing impairment.
- We observed good interactions between recovery staff and patients who had been to theatre. Patients were spoken to in calm, reassuring manner. They were also asked about their level of comfort and given additional blankets when needed.
- Patients told us their dignity was protected by staff, such as closing the curtains when undertaking care and that staff respected their confidentiality. We observed staff ensuring curtains were drawn when delivering care or personal discussions. Patient’s modesty was protected when moving about ward areas, or being taken to other departments.
- One patient told us how they were managing to be as independent as possible, having been encouraged to do exercises given by therapists.
- Patients on Seabathing Ward also commented positively on the caring nature of staff. An example was given to us of how nurses had identified a problem and found a solution to this to improve the patients comfort and to minimise the risks of pressure areas.
- We observed that patient call bells were responded to quickly.

### Understanding and involvement of patients and those close to them

- A patient who had been in the Emergency Department (ED) prior to being admitted on to Cheerful Sparrows (female) Ward told us they felt less anxious since arriving on the ward, where nurses had explained about their procedure in a “simpler way”. She had since felt in control of her condition, which had reduced her stress levels. They commented that in ED, it was difficult as staff were busy and she did not understand what was happening but felt staff were too busy to ask.
- Another patient who had been admitted via their GP and the ED commented to us that their condition had been spotted immediately and that they had been fully informed about the treatment required and received.
- A patient explained how the nurses introduced themselves at shift handover and that their care was discussed. They told us they were encouraged and felt able to add to the discussion.
- Patients on Cheerful Sparrows (male) Ward told us they had been kept informed at every level. One patient explained how they had been awake during their procedure and had been able to ask questions and that the consultant and team conversed with him.
- Patients on Bishopstone Ward told us how they had been fully informed of each stage of their treatment and procedures. One patient told us they had been encouraged to ask questions and had straight response, with no fancy terms, “very plain and straight forward.” Another patient confirmed they had been seen by a variety of staff from the multi-disciplinary team and said they had been fully informed and involved, as well as understood the processes.

- We spoke with visiting relatives and they were concerned that they did not know what was happening to the patient because there was more than one consultant involved and communications were differing. They hadn't been given the opportunity to meet with all the multidisciplinary team and the patient to clarify matters. With their permission, we brought this to the attention of the matron, who subsequently discussed this with the ward manager. However, we observed a missed opportunity for the matron to engage with the relatives who they walked past when leaving the ward.

### Emotional support

- There was access to a range of clinical nurse specialists, such as pain nurses and those with additional skills in colorectal, oncology and tissue viability.
- There was access to Chaplaincy and patients confirmed they were visited by the Chaplain during their stay.
- Patients reported receiving emotional support from staff. For example, a patient on Seabathing Ward told us how they were feeling down and the occupational therapist had helped by giving encouragement and information related to increasing independence.
- Patients requiring specialist mental health input were referred to the psychiatry liaison team. A 'Smart+' tool was used to risk assess patients who exhibited behavioural and mental health problem. This tool assessed the patient's mental health risk and signposted ward staff to an appropriate plan of care based on the risk score identified. 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 arrange to see and assess the patient.
- All cancer patients had access to a CNS for counselling; this followed the patient to the community following discharge.
- 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.
- The patient pre-admission assessments included information about their psychological wellness and any previous issues which would need to be considered within their treatment and care.

## Are surgery services responsive?

Requires improvement

Referral to treatment times were not being met over consecutive months for surgical specialties. Theatres were not always effectively utilised and this affected performance.

Arrangements for pre-admission and specific treatment pathways were in place. Procedures had been put in place to enable staff to respond to emergency admissions.

Patient flow through the surgical services was limited by availability of beds at times, caused by delayed discharges.

Improvements were needed for the day-care environment, as this did not provide sufficient privacy.

The individual care needs of patients had been fully considered and acted on by staff. Arrangements were in place to support people with disabilities and cognitive impairments, such as dementia. Translation services were available and information in alternative languages could be provided on request.

The complaints process was understood by staff and patients had access to information to support them in raising concerns. Where complaints were raised, these were investigated and responded to. Where improvements were identified, these were communicated to staff through a range of methods.

### Service planning and delivery to meet the needs of local people

- The majority of surgical activity at QEQM for during the period of July 2013 and June 2014 was day case procedures (46%). Elective surgery made up 23% and emergency surgery contributed 31% of activity. The speciality with the highest activity was trauma and orthopaedics(41%).
- Generally, services had been planned around, and met the needs, of the local population.

- The environment in the day care unit did not provide sufficient privacy as it consisted of one room where patients waited for admission and were cared for post-operatively. Relatives also waited in this area.

### Access and flow

- Patients confirmed the access to surgical services was via GP referral or via the Emergency Department (ED). One patient on the day-care unit was very satisfied with the accessibility of the service, stating that the service had been "excellent", particularly as they had only seen the consultant that week.
- Pre-admission assessment was provided for patients who required surgery, including orthopaedic procedures and colorectal surgery. Staff told us the service had evolved over time and there was a schedule in place to ensure that patients didn't arrive all at once, enabling staff to have time to go through the processes safely and effectively. Pre-assessment included consideration of anaesthetic risk and there was an anaesthetist present on Monday, Tuesday and Thursday. High risk patients were identified and if necessary, were booked for William Harvey Hospital.
- Elective orthopaedic surgery patients were booked into a "joint school" whilst awaiting surgery. This provided individuals with the opportunity to understand the operation, recovery process and a range of exercises required to optimise their recovery. Most hip and knee replacement procedures were done under spinal anaesthetic as this improved early mobilisation, with the aim of discharging patients on day three. Length of stay targets had been reduced from 5.7 days stay in April, down to 4.3 days in June 2015. Delays were attributed to patient comorbidities rather than surgical reasons.
- One-stop clinics were held for all day case surgical admissions. This meant patient who were seen by the specialist in the outpatients could then be directed straight to the pre-assessment clinic.
- The day-care unit was closed after 6pm and had no overnight stays.
- Emergency services were provided in a responsive way, with a protocol in place to pre-optimise the patients who required urgent surgery for commencement at 8am. We saw there were expectations of designated personnel within the protocol and methods for communicating arrangements.
- The trauma coordinator attended trauma meetings and was responsible for calling patients at home and organising admission if needed. They could also arrange pre-operative assessment and also made consultant aware of patients, so that any cancelled sessions could be filled.
- The percentage of patients whose operation was cancelled and were not treated within 28 days at the trust was better than the England average in seven of the eight quarters for 2012/13 to quarter three 2014/15.
- Referral to treatment time (RTT) was monitored through the balanced scorecard for the surgical division and was not split by location. We saw that up to June 2015 RTT targets for admitted patients were rated as red, with a score of 81.34%. The incomplete RTT was below target at 89.61%, but the non-admitted RTT was above target of 90%, at 95.51%. The figures did not identify specific data for the QEQM. However information provided pre-inspection indicated that RTT for Ophthalmology, Thoracic Medicine and Urology met the 90% standard, whilst ENT, general surgery and trauma and orthopaedics did not. At the time of our inspection the Admitted Adjusted RTT figure was 82.1% overall for patients seen within 18 weeks and well below the standard.
- The figures provided in the theatre efficiency dashboard indicated that cancelled operations at this location for 2014/15 was 87 for non-clinical reasons, 255 for clinical reasons and 110 were cancelled by the patient. In March 2015, 44 patients were cancelled, 19 of which were ophthalmic patients, as there was no surgeon available.
- For the period June 2013 to July 2014 the average length of stay (ALOS) for elective surgical patients was better than the national average for the top three specialities. This was a similar position for non-elective surgery too.
- Theatre utilisation for the period April 2014 to the end of April 2015 was reported in the surgical division theatre efficiency dashboard as 83.5% across all three locations. Main theatres were utilised between 83.4% and 88.9%. Day theatres were less well used, with a range between 78.1% and 82%. Utilisation targets for main theatres at Queen Elizabeth the Queen Mother Hospital were set at 85% and in April 2015 they achieved 82.8%. Day theatres utilisation was set at 85% and achieved 74.4% for the

same period. Extra patients were added as required and each consultant list was monitored, with an overview displayed on the theatre notice board. This meant staff could try to fill gaps in lists.

- Theatre start times were set a target of 90%. Delayed theatre start times contributed to an amber rating of 83.1% for the period April 2014 to end of April 2015 across all three locations. On time starts for main theatres at the queen Elizabeth the Queen Mother Hospital achieved better than target at 92.7% for April 2015. On start times were 85%, worse than the target of 90% for day theatres in April 2015.
- Recovery staff reported there were delays in returning patients to wards because of staffing availability on wards. At times the delay was in excess of an hour. They also reported that patients who required a HDU or ICU bed were nursed occasionally overnight in the department due to lack of critical care beds.
- Bed meetings, which took place twice a day Monday to Friday, were used to review patient flow and capacity.
- Staff reported that unfunded beds were used on most days on Quex ward, as this helped in the admission and discharge processes.
- Discharge arrangements were described by the sister on Seabathing Ward as often complex and there was no standardised pathway to simplify matters. They told us the date of discharge was identified as far as possible in advance and therapists made equipment arrangements early. However, they added the lack of availability of rehabilitation beds could cause a delay. The senior sister on Cheerful Sparrows (female) Ward reported delays in patient discharges as a result of doctors not writing up the discharge letter, pharmacy delays and lack of social care provision in the community. In particular that referrals took a long time to respond to and there was a long waiting list. An example was given of a patient going home after 100 days only the previous day, even though they were medically fit for discharge a month earlier.
- A patient who spoke with us on Seabathing Ward described being frustrated by their discharge home as they were waiting for in excess of 24 hours for pharmacy supplies. They also reported not knowing about their follow up following the initial procedure they had been admitted for.
- We reviewed an audit undertaken by pharmacy, which indicated low achievement rates for dispensing take home medicines where they were required urgently and by the time required between April 2015 and March 2015. However, they did achieve non-urgent dispensing within the four-hour target for 10 of the 12 months.

### Meeting people's individual needs

- Comments made to us by patients on their experiences included, "the experience has been good so far" and treatment has been, "very good". Another patient said, "If you can transfer hospital ratings to the hotel league, this is five star." This patient explained how they had come through the ED and arrived without any belongings, such as pyjamas and toiletries, which were subsequently provided by the ward.
- Patient's religious and cultural needs were assessed and met by staff. For example, a patient told us when they provided their religious details to nursing staff, they had asked if they would like to see the Chaplain and this was arranged.
- There was access to interpretation service. There was also access to information leaflets and these could be produced in an alternative language, large print, Braille or audio on request.
- Patients reported feeling safe with the staff and that they were suitably knowledgeable. A patient told us they felt extremely safe in the knowledge the staff were correctly trained and knowledgeable about their health. An example was given of the doctor having reviewed and changed their medicines, which they told us had taken into account their overall health needs.
- There were specific goals within the pathway used for patients who had a fractured neck of femur. The goals were aimed at remobilisation and preparation for discharge and were flexible around their individual needs.
- Where people were able to eat and choose from the menu, they commented in the majority of cases favourably on the food. Comments such as, "It's all very nice", food is "good, nice and much better than it used to be." Positive comments were made with respect to choices, temperature and portions size. Negative comments were very few and related to large portion size.
- Patient who had a learning disability were cared for in accordance with their needs. Family or carers were encouraged to complete a personal passport for the individual to enable staff to follow this as closely as possible. Where a patient had learning disability and

they were having surgery the list was planned to facilitate them early on and they could be accompanied to the anaesthetic room by a carer/relative and attend the recovery area too.

- There was no formal agreed process in place to identify patients who had additional needs associated with living with dementia. Although there had been some work around this, action had not been concluded as staff were keen to seek feedback from relatives about identifying individuals using a flower motif or similar. However, staff acknowledged and respected the individual needs of this particular care group and where closer support was needed, this was provided.
- We did hear comments from patients about the lack of staff ability to be as responsive as would be expected. For example, on Bishopstone Ward we were told that staff were rushed in the bay where patients living with dementia needs were cared. At night, we were told staff were not able to respond to call bells as promptly as during the day. On Seabathing Ward a patient reported that staff were not always able to respond as quickly as was needed. They gave an example where a patients' immediate needs had not been met.
- We visited this ward as part of our unannounced inspection and did not identify any staffing concerns or delayed responses from the night staff at the time.

### Learning from complaints and concerns

- There was information about the complaints procedure available in surgical areas and information about the Patient Advice and Liaison Service (PALS) was available to patients.
- Patients told us they knew how to complain if they needed to. We reviewed 11 complaints, which had arisen from surgical areas at the location between April and June 2015 and found most related to communication matters.
- A senior nurse on Cheerful Sparrows (female) Ward explained how they managed complaints, including making home visits or meeting on-site with people who had raised a complaint. At the time of our visit there were four active complaints for the ward and two in the process of closure, the records of which we reviewed. Poor communication was indicated as being the most common theme of these complaints.
- Complaints were reviewed within the surgical divisions governance report. We saw that the speciality was identified, the date the complaints was received, the stage of the investigative process and description of incident was shared with attendees. Where the matter was closed the action taken had been summarised.
- Staff explained how they were involved in root cause analysis of complaints if necessary and how information was shared as part of the learning process.

## 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 and improving 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 a number of actual and potential risks and had in place mechanisms to manage these risks and to monitor progress. However, they had not identified risks associated with fire safety within the operating theatres.

Staff reported positively on a change in the culture, having proactive leaders, their approachability, visibility and support. Staff felt valued, respected and 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 initiatives were in progress or being developed.

### Vision and strategy for this service

- The surgical division directors oversaw the surgical services across the three locations and recognised the

challenges this presented, particularly with respect to medical staff rotas. They 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 anaesthetist was taking the lead for identifying the most optimum pathway for electives and non-elective surgical 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.
- Senior staff at this location told us there was a shared vision and focus, and staff at "ground level" knew about the improvement journey. Theatre staff explained the focus of the values was on providing care. They were aware of an anti-bullying initiative.
- Senior nursing staff were very aware of the vision and direction of travel. They were confident that the staff knew the values too. One senior sister told us it was up to them (sisters) to ensure staff were fully aware.

### 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. They were supported by band 6 managers to deliver the required agenda, 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.
- 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.
- 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. We reviewed minutes of the Surgical Services Clinical Governance Board for the months December 2014 through to April 2015 . We found 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.
- Senior nursing staff reported much improved governance arrangements around patient safety and quality. One senior sister said they had attended clinical governance meetings and that other nurses had also had the opportunity to attend. They felt this had improved understanding and awareness.
- We were provided with a draft surgical services division governance report for the location, covering data for June 2015. This information included figures and information related to the focus on 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 on the surgical divisions. We noted the risk register had very few surgical specific risks listed and there was a concern that some risks may not have been identified. For example, there was no reference to the limitations of the lack of Laminar flow operating theatres or the risks related to having obsolete equipment in the theatre area.
- We were made aware that the trust had carried out a fire risk assessment to comply with the regulatory reform (fire safety) order 2005. The required actions had not been completed. In particular the order stated that 'the responsible person must make a suitable and sufficient assessment of the risks to which relevant persons are

exposed for the purpose of identifying the general fire precautions he needs to take to comply with the requirements and prohibitions imposed on him by or under this order.' Risks related to the inadequacy of the current fire safety training had not been addressed. Further, neither the risk register for the surgical directorate or the corporate risk register identified fire safety issues.

### Leadership of service

- The surgical services division was overseen by a management 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 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 base to affect change. Examples of action being addressed included, divisional communication, team based work, staff attitudes and behaviours, workforce planning and innovations.
- Staff in theatres were aware of their roles and responsibilities. Senior leaders within theatres held weekly, fortnightly and bi-monthly audit meetings. A newsletter was also circulated every two weeks, which contained updates from all the relevant link staff such as updates on tissue viability, health and safety and infection control.
- Staff in theatres told us they were satisfied with their immediate line management and the divisional strategy.
- A member of the junior medical staff told us the best thing about working at the location was the consultant. However, they reported that “management was very distant” and gave an example related to the changes on the rota and there being a requirement of junior doctors to cross cover each other during annual leave.
- The ward manager of Bishopstone was very proud of the care delivered by the staff and was passionate about devolving high quality care. Feedback was given at each staff meeting and there was encouragement for staff to develop and take succession planning opportunities.
- Senior nursing staff in pre-assessment reported knowing staff on other trust sites and of having a joined up approach, where previously there wasn’t a standardised approach.
- Nurses commented on the efforts put in by the nursing and medical director to develop a joined up approach across the locations. Where issues of unacceptable practice had been raised, these had been dealt with proactively by senior personnel.

### Culture within the service

- The staff charter outlined the rights of staff to be treated with respect, fairly and valued for individuality and diversity. A support line had been set up for anyone concerned about bullying and workplace buddies were available to listen, advise and support.
- We were told there had been a change in culture, with senior colleagues being more willing to listen to concerns and that there was a motivation to change. The majority of staff told us they had lots of feedback, through team-brief, the CEO, news updates and general meetings. We reviewed various copies of such communications to confirm this. Senior staff reported being invited to meetings and making contributions to these. Matrons were described by staff as being open and approachable. A physiotherapist told us that overall staff were friendly and approachable, and they would recommend it as a place to work, with particular praise for the physiotherapy team.
- Our observation and feedback on the culture in theatres was that there was lots of communication, through a range of methods. There were opportunities for staff to raise concerns and staff confirmed they were generally happy. Minor concerns expressed related to lack of training and suspension of this until September 2016.
- Staff were comfortable to report incidents and near misses as well as to raise concerns. Senior nurses reported having a voice and feeling valued and respected. They told us they could be autonomous, could get help and were listened to. The director of nursing was described as a “people person, easy to talk to and having a different air about them” to previous post holders.

- Theatre staff reported that there had been some changes in the culture since the last inspection. Variable behaviour and standards had been identified, discussed and action plans developed to bring about change. For example they had a 'celebration tree', which staff could post positive feedback on with respect to the department. We saw too that theatre staff had created a visual aid memoire of their journey, which included starting point, the previous inspection visit by the commission and progress after this. Theatre staff had also agreed their statement of purpose in a "values, beliefs and clarification" exercise. Recovery staff reported that they could ask for support and supported one another.
- A dietitian told us they felt much more involved than they had been prior to the previous inspection. They gave an example of how this had translated in work activity, which included participation in MDT ward rounds. However, they did add that they felt there needed to be more acknowledgment of the dietetic team.
- Staff well-being was monitored with regard to sickness absence. We noted from a formal report provided that sickness rates were elevated and peaked at times when additional beds were opened on Cheerful Sparrows (male) Ward, particularly in July and September 2014. April and November 2014 had the highest level of sickness absence at the same time when the additional beds had been opened.

## 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.
- We saw from information provided that there were various public engagement events in the region. For example, in relation to abdominal aortic aneurysm (AAA), vascular and prostate nurses focus groups.
- Staff engagement on wards and in surgical areas was encouraged through the various meetings. Staff were encouraged to represent various areas of clinical practice, for example, we spoke with a sister who had become a member of the end of life board. Staff were also involved in 'TIPS', teams involved in patient safety, and had projects to improve aspects of safety. This included for example, do not attempt resuscitation activities.
- The recently established Quality Innovation and Improvement Hub provided staff the opportunity to express their views and for actions to be documented recording what was done in response.
- The QEQM held an EPIC (Empowering, Passionate, Inspirational, Caring) surgical celebration day in April 2015. During this event there was a focus on celebrating what they did well as a division. Future dates were posted for a similar event.

## Innovation, improvement and sustainability

- There were pockets of innovation and projects at operational levels. Staff told us there was a DVD being developed on the WHO checklist and trials were taking place related to the recording of information in respect to patients having a urinary catheter.
- Staff on Seabathing Ward had developed a care pathway to ensure patients discharged home with ridged cervical collars in place could come back for skin care and checks of the pressure areas. We saw information to support this in a patient care plan and also saw a patient who had come back to the ward that day for care.
- Pre-assessment were carrying out a trial where patients underwent a Cardio-pulmonary exercise tolerance test. This was overseen by an anaesthetist and was enabling staff to provide clearer information on the risks of having an anaesthetic to patients, so they could make informed decisions to proceed or not. Staff in the pre-assessment service were also in the process of developing an electronic pre-assessment, to reduce the number of patients who were coming back to the hospital for an assessment.
- A stoma pathway to be used with patients following discharge had been developed in January 2015, which involved telephone calls to the patient at various intervals and home visit on days two and 14, with annual appliance review.
- During a Trauma & Orthopaedic audit day held in May 2015, an improvement action was discussed for patients attending pre-assessment. This had resulted in agreed action changing the way pre-assessments were

delivered. For example, all patients at point of listing would receive a one-stop pre-assessment, pre-assessments were to be valid for three months for inpatients instead of six weeks for some procedures giving more flexibility to provide capacity. Patients waiting longer than six weeks before their surgery date were to receive a short nurse led pre-assessment to re-do bloods and swabs, consultants could also see the patient to do the consent or review any special requirements. All appointments with the consultants were to be agreed between the consultants and pre-assessment staff. This new process was planning to go live in mid-August.

- 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.

# Critical care

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

## Information about the service

The Critical Care Unit (CCU) at the Queen Elizabeth the Queen Mother Hospital provides care for up to nine adults. The unit has the funding and capacity for six patients who need one-to-one nursing care (level 3 care) and two high dependency care beds (level 2 care). There was an additional bed that can be used for either level 3 or level 2 care depending on staffing and needs of the patient. A Critical Care Outreach (CCO) team of six nurses was available twenty four hours a day, seven days a week who assist with the management of critically ill patients across the hospital. The CCU a had daytime consultant intensivist, which is a physician who specialises in the care and treatment of patients in intensive care cover Monday – Friday, with on-call anaesthetist cover out of hours. Between January 2014 and March 2015 the service treated 785 patients. 90% of the patients admitted from January 2015 to March 2015 were unplanned medical or surgical cases. We spoke with six staff including nurses, doctors and support staff. During the inspection we looked at care and treatment and we reviewed care records. We held listening events with the public and focus groups with staff to obtain their opinions of the service being delivered. Before and during our inspection we reviewed performance information from, and about, the trust.

## Summary of findings

We found appropriate and effective reporting and learning from incidents and Morbidity and Mortality (M&M) meetings. Patients were cared for in a clean, well maintained and safe environment. Staff demonstrated good awareness of infection control and there were systems in place to minimise the risk of health acquired infections.

Staffing levels were sufficient to meet people's needs and consultants provided cover in line with the national recommendations. There was also adequate access to diagnostic and screening services out of hours. 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 risks associated with inconsistent compliance with nasogastric (NG) tube placement and checks. This was a trust-wide problem that involved a lack of understanding and consistency with standard operating procedures.

The CCU had procedures in place to ensure the safe storage, handling and management of medicines. Documentary evidence demonstrated that patients received their medicines in a timely manner and reasons for omission were clearly documented. Pharmacy support was provided as well as regular reviews and internal audits. Safety thermometer data was collected and collated and used to improve and

# Critical care

drive service change. Data was displayed in a public area which meant it could be accessed by those who wished to view it. We found an adequate supply of serviced equipment to enable staff to care for their patients. Staff demonstrated an established approach to multidisciplinary working with other specialists in the Trust and showed us how they could obtain treatment and care for patients with complex needs, including psychology assessments. The needs of people with delirium or dementia were met by well-educated staff but the Confusion Assessment Method for ICU (CAM-ICU) was not routinely used as an assessment tool. Training was provided on a rolling basis for nursing staff and a dedicated team ensured that trainees and new students were well supported and had the opportunity to develop. Leadership on the unit was found to be strong and effective.

## Are critical care services safe?

**Requires improvement**

We have judged the safety of theservice delivered at the Queen Elizabeth, the Queen Mother (QEQM) Hospital 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 inconfirming 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.

Nursing staffing levels were found to be adequate and safe and consistent care was provided. However, only 35% of nursing staff had completed a post-registration CCU course. This was lower than recommended by the national guidance issued by The Faculty of Intensive Care Medicine.The CCU had appropriate systems in place to report, monitor, and learn from incidents. We saw documentary evidence that incidents were investigated and had their learning disseminated to the clinical team to prevent recurrence. It was standard practice to conduct a Root Cause Analysis (RCA) investigation of serious incidents in the unit. M&M meetings were embedded in the CCU culture. We also found evidence of learning and changes to practice from these meetings.

The CCU environment was clean, well maintained and monitored regularly for infection control risks. The unit had very good safety thermometer outcomes and there was evidence that learning and quick action took place when failures were identified. Infection rates of MRSA (Methicillin-Resistant Staphylococcus Aureus) and C.Diff (Clostridium Difficile) were very low for the year leading to our inspection. Morbidity and Mortality meetings took place monthly and learning had been identified from these.

Safeguarding and mental health needs were understood by staff and a clinical nurse educator ensured that up to date information was cascaded to nurses. There was an active safeguarding lead within the CCU. Training was provided on a regular basis in mandatory subjects such as safeguarding and infection control and additional training was often made available to staff as part of their development. This was facilitated by protected learning time and improved

support for accessing e-Learning. Adequate consultant cover was provided Monday – Friday during the day, with out of hours cover provided by on-call anaesthetists. Junior doctors felt supported and reported a good standard of education and personal development opportunities on the unit.

There were systems in place to ensure that medical records were kept securely and confidential. The condition of the records was adequate and the quality of the recording was sufficient to demonstrate continuity and safe approach to the care delivered. Although a major incident policy was in place, training had been delivered inconsistently and it was not clear that staff would know what to do in the event of a major emergency.

**Incidents**

- Monthly Morbidity and Mortality (M & M) meetings took place with consultants, the matron, a nurse consultant and sometimes a CCU outreach nurse and junior doctors. The minutes of meetings demonstrated that learning regularly took place, such as the demonstration of new equipment at anaesthetist monthly audit meetings. Where actions had been identified following a person's death, these had been referred to monthly medical M&M meetings.
- The root causes of medical errors were investigated and their outcomes through meetings and there was evidence that agreed actions from these investigations were implemented.
- Matrons manage risks and incident reporting, and the process was overseen by the consultant nurse. Feedback from incident reports was fed into a multidisciplinary critical care steering group and the surgical division governance board.
- The unit operated an effective risk register where the risks in the service was documented and appropriately monitored once identified. The register was reviewed regularly and there was evidence that concerns were escalated to senior trust management via the governance, safety and risk pathways available.
- The CCU reported no never events (A never event can be defined as a serious incident that is considered preventable) in the last 12 months.
- We spent time speaking with a clinical nurse educator, a charge nurse and two staff nurses about the Duty of Candour. In all cases we found that staff had a good understanding of their responsibilities in this area. As part of the electronic incident reporting system, staff were automatically prompted to disclose necessary information to patients and relatives. A nurse educator said, "Our Duty of Candour processes work well in practice. The nurse in charge and matron take the lead on communicating issues and errors with relatives and patients."
- The trust had a nutrition policy in place, however, we found that it did not reflect best practice of X-Ray checking of all tubes to ensure the correct position of the NG tube before feeding. We were aware that a standard cross-site approach to checking did not exist. For example, one hospital had a serious incident where the position of the NG was checked according to the trust policy, however the tube was not in the patient's stomach. Feeding was commenced and caused avoidable harm to that patient. The trust's adult nutrition policy was updated in March 2015 and NG practitioners have been updated on its use and compliance.
- The hospital site where this happened took the decision to ensure that all patients had the position of their NG tube x-rayed before use to guarantee its position. We are concerned about the lack of consistency across the sites especially as the CQC were aware of an incident involving the incorrect position of an NG tube which resulted in serious harm to a patient which occurred on 15 July 2015. Senior managers were investigating the incident at the time of our inspection. Information has been submitted to us subsequently that indicates the standard operating procedures for the trust NG policy was not always adhered to. We have been assured by the executive team that Cortrak-trained practitioners have received additional support in ensuring NG policy is followed and is compliant with NICE guidance.

**Safety thermometer**

- 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 (UTI).
- A Safety Thermometer display was in place in the unit. It displayed data for the calendar month prior to our inspection and showed that the CCU had no recorded falls, new pressure ulcers, new blood clots or new urinary infections. The display indicated that for the

month prior to our inspection, the unit had been 100% harm free for patients. From looking at unit records, we saw that this level of care had been maintained every month since June 2014.

**Cleanliness, infection control and hygiene**

- Monthly infection control audits had taken place and where there had been areas of non-compliance, an action place had been implemented. For instance, Estates had been contacted with regard to the repair of damaged walls and staff had been reminded of PPE compliance requirements, with accountability for this clearly allocated and documented.
- Between April 2014 and March 2015, the CCU had three instances of MRSA and no instances of Clostridium Difficile within 72 hours of admission.
- The CCU undertook monthly audits of hand hygiene practices of staff. Between April 2014 and March 2015, there was a 94% compliance rate across all staff grades.
- Staff were observed wearing PPE (Personal Protective Equipment) and adhering to trust infection control policy.
- There was appropriate systems in place to manage and monitor the risk of hospital acquired infections.

**Equipment**

- An emergency intubation trolley was available on the unit and had been checked regularly.
- A difficult airway trolley was available which was 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.
- 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 hour's staff and each equipment shelf had photographs of the equipment and what they were called.
- Staff told us they had access to the necessary equipment to ensure they could provide save care to patients.

**Medicines**

- The CCU had systems in place to demonstrate that medicines were handled securely, and were securely stored and accounted for. Patients received their medications at the time they needed them and in a safe way.
- We reviewed a sample of medication charts (five in total) during the inspection. We found the charts reflected national prescribing guidelines. Patients had their allergies and sensitivities noted and there was a record of regular pharmacist review and audit.
- When a medication was omitted, the reason was clearly documented. If a medication was omitted due to a clinical error, it was reported via the electronic reporting system and documented actions were taken to prevent recurrence.
- Medications were stored in locked cupboards in line with trust policy.
- Controlled Drugs (CD's) were stored, received and returned to pharmacy in line with trust policy. The CD register we saw demonstrated that daily stock checks were being completed and that drugs were being signed in and out by two staff members.
- Pharmacist support was regularly available and utilised on the unit.
- Staff had undertaken a competency based assessment before they were expected to administer medication on the unit.
- Medication charts were routinely audited to identify errors. These were reported and investigated as per trust policy and learning outcomes and action plans put in place to reduce recurrence.
- A 'Drug buddies' system was introduced to reduce the rate of medication errors on the unit.

**Records**

- The medical records we reviewed were found to be accurate, fit for purpose and stored in a way that ensured confidentiality.
- We reviewed a sample of five records during the inspection. We obtained consent from the patients and or their relatives where possible.
- We found the records to be in good condition and kept in chronological order.
- The records we viewed contained relevant risk assessments which were continuously reviewed as the patients conditions changed. For example we saw pressure area assessments and body mapping tools, nutrition and hydration risk assessments and

Multidisciplinary Team (MDT) referrals and input. We also noted Urinary Tract Infection (UTI) risk assessments as well as elimination charts etc. The trust had an expectation that all pressure ulcer scores graded 2 and above be reported via the electronic reporting tool. However, the CCU had taken the progressive step to ensure that all pressure lesions were recorded regardless of grade in an attempt to improve practice. This was occurring at all CCU across all sites.

- Medical records demonstrate that there was regular communications with patients and their relatives about their condition, progress and treatment plans.
- There was documentary evidence that decisions regarding the active resuscitation and treatment plans were discussed in detail with families.
- 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 recording system 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 to ensure continuity of the care was delivered.

**Safeguarding**

- The CCU had a designated safeguarding training lead that had been supported by their manager to attend an advanced course, which had enabled them to teach critical care safeguarding to other nurses.
- There was also a dementia lead nurse in place and a learning difficulties link worker on-call in case of a related safeguarding concern.
- All members of staff working on the CCU had attended a classroom session on safeguarding in critical care. A clinical nurse educator told us that this included an introduction to the Mental Capacity Act (2005) and Deprivation of liberty Safeguards (DoLS) and that the Trust offered more in-depth training on demand.
- Training in the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) was included in the safeguarding training undertaken by staff, of which 75% of the team had completed for adults and 73% had completed for children and young people.

**Mandatory training**

- Staff had been trained in resuscitation, hand hygiene, moving and handling, safeguarding, falls prevention and obtaining consent for care and treatment. A training matrix was maintained by a dedicated member of staff who booked staff onto upcoming courses to ensure a high degree of conformity was maintained for mandatory training compliance.
- 35% of nursing staff had attended a post-registration intensive care course. We spoke with a clinical nurse educator about this. They told us that this rate was lower than the national standard recommended by The Faculty of Intensive Care Medicine due to staff who had been trained then left to go into other nursing roles or transferring to other areas of the Trust. We saw that all band 6 and band 7 nurses had undertaken the CCU course and a programme of training was underway to increase the number of staff nurses trained. We found that staffing levels were flexible to accommodate staff training, such as the use of some nurses as supernumerary to cover the loss of staff in training.
- A core mandatory training day was held every two months to ensure staff nurses remained up to date. Training days had included areas of need indicated by staff feedback and performance and had included basic life support and medication errors. Training for senior nurses was included in protected time after staff meetings.
- As part of mandatory training, senior nurses had to attend four team meetings per year that included the opportunity to raise concerns or issues about staffing or training.
- A senior member of staff told us that although there had been problems with access to e-Learning in the past, there was a real drive from the learning and development department to improve this. They said, “The education centre has an advisor on hand to help and our own administrator is excellent, he monitors the training matrix to help staff to keep up to date”.

**Assessing and responding to patient risk**

- Deteriorating patients were managed in line with national recommendations. The unit used the ‘Deteriorating Patient Programme’ which was overseen by the critical care steering group and performance was audited by a consultant nurse.

# Critical care

- Staff used the Modified Early Warning Trigger Parameters, the Paediatric Early Warning Score and the AKI renal alert assessment system as tools to provide urgent care and treatment for deteriorating patients.
- We saw documentary evidence that patients were reviewed in a timely manner when they were identified as being at risk of deterioration.

**Nursing staffing**

- The unit was not continuously meeting the national standard for ensuring that a supernumerary charge nurse was available on all shifts. Data received showed the CCU met this standard 80% of the time.
- The unit employed 3.12 band 2 and 3 WTE (Whole Time Equivalents) clinical support staff. It had 36.27 band 5 nurses, 8.74 band 6 nurses, 2 band 7 nurse and one band 8 nurse. The unit was also supported by a practice educator for 10 hours a week and 2 administration staff.
- The unit had two band 5 and one band 6 position vacant at the time of inspection and were in the process of recruiting into the positions. This accounted for a vacancy of 450 hours a month.
- Team meetings were held regularly for each staffing group. From looking at the minutes of a previous meeting we saw that staff were encouraged to use them as a forum for discussing their involvement in team projects and that they set their own ground rules. Staff told us that any issues raised were assigned to a named person who followed it up and then reported back to everyone.
- Staff we spoke with said that although more staff would be appreciated, they never felt that they were short staffed enough to compromise safety. A senior member of staff said, “We are adequately staffed, never dangerously staffed. We’re almost up to full staffing and our established minimum of seven [staff per shift] is always maintained.”
- Senior staff told us that the skill mix of the nursing team was very good. One person said, “We have a core group of people who have been here a number of years. We also have some really good junior nurses doing the CCU course. We have the infrastructure to build a quality, stable workforce.”
- The unit used NHS Professionals to ensure staffing levels were maintained appropriately, which staff said worked well.
- A business case had been submitted by the consultant nurse to secure a higher staffing establishment that could see a 9th, presently unfunded bed, be used to offset delayed admissions and discharges.

**Medical staffing**

- Consultant cover was provided Monday – Friday during the day and was dedicated to the CCU, with no duties outside of the unit. Out of hours, consultant cover was provided by anaesthetists, which staff said often slowed down decision making.
- The Consultant patient ratio did not exceed the national range identified as being between 1:8 – 1:15 and the CCU resident/patient ratio should not exceed 1:8. We saw records that demonstrated that in the three months prior to our inspection, the unit had not used any locum doctors
- Nursing staff said that there was a good relationship between themselves, doctors and consultants. One person said, “We’re all on first name terms, that’s a rare but very nice way to work.”
- Daily multidisciplinary handovers, led by a consultant took place daily.
- There was an education programme planned to run from September 2015 that was to include a daily morning teaching round followed by a tutorial for junior doctors.
- The unit supported anaesthetic CT (Computed Tomography) trainees, who followed a Royal College of Anaesthetists curriculum.

**Major incident awareness and training**

- An updated major incident policy was available for staff to access.
- However, staff told us that training was unreliable and often cancelled.
- Senior nurses said that they had watched a briefing video regarding major incidents and were aware of their roles should an incident occur.

## Are critical care services effective?

Good

We have judged the service delivered in the critical care unit at QEQM to be effective.

# Critical care

National and best practice guidance was followed in the unit and treatment was provided as determined by NICE, the Intensive Care Society and The Faculty of Intensive Care Medicine. An on-going audit programme was in place to improve and standardise evidence-based practice.

Patient outcomes demonstrated the effectiveness of the unit, such as low unplanned readmission rates and low mortality rates. National guidance was used to assess deteriorating patients, to highlight early warning signs of deterioration.

A critical care outreach team provided services across the hospital twenty four hours a day and worked closely with unit-based staff to provide effective care and treatment. Patients had their pain and nutritional requirements risk assessed and addressed in a timely manner.

Pain and nutritional scores were regularly documented and acted upon. The patients we talked with told us their pain and nutritional needs managed appropriately during their admission.

Care was delivered by competent staff that were supported to develop their competence with a programme of specialist education and learning by a dedicated clinical nurse educator. The National Competency Framework for Critical Care Medicine was used to progress staff and complemented a wider programme of staff development. There were good links with academic providers in the area and an established mentorship programme ensured that new staff were able to deliver appropriate levels of care.

We found a MDT approach to the care delivered on the unit. This was evidence from our conversations with patients and staff, and the medical records we reviewed. Suitable arrangements were in place to ensure access to diagnostic, screening and therapy services out of hours.

**Evidence-based care and treatment**

- We found appropriate systems in place that demonstrated the service took account of published research and national guidance. The CCU also used the findings from local and national audits to ensure that action was taken to protect patients from the risk associated with unsafe care and treatment.
- We found the CCU was implementing recommendations from NICE clinical guideline 83 on critical care follow-up and rehabilitation by developing a dynamic robust rehabilitation service for patients.
- Policies and care pathways demonstrated that the unit used NICE, Intensive Care Society and The Faculty of Intensive Care Medicine guidelines to determine the treatment given.
- A rolling programme of audits was planned and tracked by a medical team. This included an audit that was already underway to standardise the use of inotropes (an **inotrope** is an agent that alters the force or energy of muscular contractions) across all hospital CCUs in the Trust and the implementation of the Sepsis Screening tool and Sepsis 7 pathway.
- The outreach team used Wardwatcher (an electronic tool to collect data for surveillance purposes) to provide three monthly audits of activity by type and location to maximise efficacy.
- We noted the unit had a consultant audit lead who supervised regular audit activity in the unit.
- The unit participated in a VTE audit monthly. Data submitted to CQC demonstrated a 100% compliance rates for six out of a twelve month period. The other six months were reported as achieving between 91% and 93%. There was note in the data that suggested the dataset for the VTE audit was corrupt and systems were in place to avoid this with future data collection.

**Pain relief**

- The CCU had systems and processes in place that meant patients and their pain needs were assessed and acted upon in a timely manner.
- We observed staff using an appropriate pain scoring tool to measure and identify patients pain levels. We also observed staff adapting their communication style to meet the needs of the patient to achieve the pain score.
- There was a wide range of methods used to ensure patients individual pain needs were met. This ranged from oral, intravenous, PCA (Patient Controlled Analgesia), epidural and spinal blocks.
- Patients had routine pain relief prescribed on admission to the unit which meant that if a patient required pain relief it could be administered without delay. The charts we viewed showed us that pain medication was administered routinely and as and when the patient required it.
- The patients we talked with told us that they received adequate pain relief. The relatives we spoke to also confirmed that their loved ones pain needs were met.

**Nutrition and hydration**

- There were effective systems in place to ensure that the risk of poor nutrition or dehydration was identified and acted upon admission to the unit.
- We observed all the patients on the unit receiving suitable nutrition for their individual conditions. This ranged from normal diet for HDU (High Dependency Unit) patients, to NG (Naso Gastric - a tube that accesses the stomach via the nose) and TPN (Total Parenteral Nutrition- which is a method of feeding that bypasses the gastrointestinal tract).
- Nutritional support was provided within the timeframe set out in best practice guidance outlined by the Intensive Care Society and NICE CG32.
- All patients had a MUST (Malnutrition Universal Screening Tool) risk assessment in place and had been weighed on admission to the unit. Patients had their weight continuously monitored and documented.
- Patients had their fluid intake and output monitored continuously and the actions taken if an intervention was necessary. This was clearly documented in the medical records we reviewed.
- Dietitian and speech and language therapists conducted a review of all the patients where a review was clinically indicated.

**Patient outcomes**

- The CCU contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. Results from ICNARC showed that patient outcomes were within the expected range when compared to similar hospitals nationally.
- Unplanned readmission rates to the unit were low and equated to less than one patient per month.
- The average mortality rate for the unit was 11.7% from January 2015 to March 2015, which was below the national average for all but two weeks in this period.
- There were no unit-acquired blood infections in the reporting period January 2015 to March 2015.
- The average length of stay on the unit was reported as one day.

**Competent staff**

- Appraisals were promoted as a collaborative development exercise. Before having an appraisal, staff completed an exercise titled 'Things to think about before your appraisal.' This gave staff the opportunity to reflect on what they would like to change in the unit and whether they were meeting their professional objectives.
- 91% of staff had undergone an appraisal in the year prior to our inspection.
- Staff were given four probationary reviews in their first six months of joining the CCU. We saw that these were motivational and encouraging. For instance, one person's review stated that they were "very observant" and another stated "Her patients are always very well cared for and she delivers her care to a very high standard." We saw that staff were also challenged to progress and to build their professional practice. For example, staff had been given support on how to interpret constructive feedback and how they could challenge themselves.
- Staff were given opportunities for learning above and beyond that required by mandatory standards. For example, some staff had been trained, after their request, how to use a specialist LiDCO cardiac monitor despite the CCU not using this very often. The member of staff was able to request to be contacted when the monitor was next used, to consolidate their knowledge and understanding from the study.
- The National Competency Framework for Adult Critical Care Nurses was used by clinical educators and band 5 nurses were supported to complete the first level of this.
- There was a system of mentors in place to help support new staff. Mentors had to be qualified nurses and to have undergone a formal mentorship training programme before taking the role. Staff we spoke with told us that the system worked well. One nurse said, "We've seen a clear improvement in the quality of people after they come through the period of mentoring."
- Staff were encouraged to take higher education courses through the local university but the number of staff taking degrees had reduced because of funding cuts.
- Students were offered specialised training modules that had been developed by the nurses responsible for their supervision.
- 97% of staff had recent (basic and intermediate) resuscitation training.
- 60% of nurses held a relevant degree and five more nurses were on a degree pathway.

- 72% of staff had been trained in safe transfusion practice and 81% of staff had venous thromboembolism training.

**Multidisciplinary working**

- We found the care delivered had a multidisciplinary team (MDT) focus and input. This meant that patients had specific expert input form a range of professionals during their admissions.
- Medical records and the conversations we had with staff and relatives, demonstrated that there was a multidisciplinary approach to the care. During the inspection we spoke to a range of staff that had a professional input into the care delivered. For example physio, dietician, microbiologist, speech and language therapists, pharmacists, surgical and medical team input.
- All patients discharged from the CCU were followed up by the outreach team and the physiotherapists involved in the rehabilitation service.
- The CCU nurse outreach team, which cared for patients with acute pain and those with a tracheotomy, supported the nursing skill mix. There was an active recruitment drive for an additional outreach team nurse and a risk assessment in place relating to the potential for uncovered outreach shifts.

**Seven-day services**

- The CCU provided consultant-led care seven days a week. Consultants worked on the CCU between eight a.m. and two p.m. at weekends and out of hours cover was provided by consultant anaesthetists.
- A physiotherapy service was also provided at the weekends which meant that patients continued to receive the same standard of care at weekends.
- There was also an on call pharmacist available to provide support to the CCU out of hours.
- There was adequate access to imaging, and pathology services, but we noted that there was no Occupational Therapy (OT) service provision.

**Access to information**

- Patients and their relative had access to a wide range of information on the CCU . The information supported patients and their relatives to make decisions about their care and treatment and the services available to them. It also made them aware of trust services for example facilities, chaplaincy etc.
- All the relatives we spoke to told us they felt they could approach staff to ask for additional information if required.
- We also found appropriate access to the latest information for staff on the CCU..

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

- There were systems in place to gain and review consent from those who used the service. Patients could be confident that their human rights were respected and taken into consideration.
- We found evidence that patients had their mental capacity assessed and the assessments acted upon if necessary.
- The clinical nurse educator was active with a delirium working group and was active in exploring the introduction of appropriate screening tools.
- Staff were aware of their role to escalate their concerns about capacity should they arise.
- We reviewed DNACPR (Do Not Attempt Cardio-pulmonary Resuscitation) documentation and found that it reflected national guidance and was appropriately discussed with the next of kin, and the patients if applicable.
- It was apparent from the conversations we had with staff that they were less confident in their knowledge of DoLs (Deprivation of Liberty Safeguards). However, they were able to provide evidence that risk assessments were carried out when patients were forced to wear mittens (a medical restraint) and bed rails assessments.
- Some elements of consent and the Mental Capacity Act (2005) had been included in mandatory safeguarding training but this was not specialised. More detailed training was available through the Trust and this was being arranged for staff.
- Records demonstrated that 85% of staff had received training in informed consent.
- 72% of staff had been trained in safe transfusion practice and 81% of staff had venous thromboembolism training.

# Critical care

## Are critical care services caring?

Good

We have judged the service at the critical care unit at the QEQM to be caring. Staff delivered compassionate, holistic and individualised care to their patients. They spoke about their patients and relatives needs in a way that demonstrated a very good understanding of each individual. Staff were observed demonstrating empathetic, considerate care to their patients. They spoke entheusiaststically about likening their jobs and their attachment and determination to make 'patients better'.

Feedback from patients and their relatives was very complimentary about the CCU staff and the quality of care they received. They told us "they all do a good job" and "they keep us well informed" and "We are so impressed with the care and attentiveness of the staff". Emotional support was provided by CCU staff, specialist nurses and the chaplaincy team. Support was also available form a member of the rehabilitation team who had a counselling qualification. There were plans being put in place to obtain funding for permanent psychological support for patients. Patients and their relatives told us they felt their emotional needs were met. One relative told us" I cannot tell you just how well they look after us, they are first class".

The CCU also provided a bereavement service that provided emotional and practical advice to relatives. The feedback about this service was entirely positive. Relatives referred to the staff member responsible for delivering the service as being 'magnificent'.

### Compassionate care

- Staff spoke passionately about their work. A nurse said, "The opportunity to give the patient the best care possible is the best part of working here. It's so great to see the good results. And we have such a great working system here, everyone is so thorough and careful with everything."
- Patients and relative we talked with told us staff treated them with compassion and kindness.
- Survey data demonstrated very high rates of patient and relative satisfaction rates when asked about the quality of care.

### Understanding and involvement of patients and those close to them

- Staff demonstrated a good knowledge of how to involved patients and their relatives in the planning of their care.
- We observed staff interacting with patients and their relatives in a positive and proactive way to ensure they were as involved as possible in making decisions about the care they received.
- The patients and relatives we talked with told us they felt very involved in their care planning and were kept regularly in formed by staff. Patients and relatives told us they were happy with staff communication. A relative said, "We get all the information we need and they are happy to answer any questions". Another relative told us "they always talk to the patients and treat them with respect".
- A patient told us, " they are so kind and helpful and always tell me what's happening"
- We observed staff care for a patients who was deemed a vulnerable adult. Staff were aware of this patients individual needs and had built a close relationship with community carers to ensure they could meet this individual's needs.
- The medical records we viewed demonstrated that patients and their relatives were consulted and regularly communicated with.

### Emotional support

- Emotional support was provided by the CCU's nursing and outreach teams. Support was also provided by trust wide specialist nurses who provided expert knowledge and support to families for example, cancer, bowel and learning difficulties specialist nurses.
- A chaplaincy service was also available to provide emotional and spiritual support.
- The relatives we talked with and survey results we viewed demonstrated that their emotional needs were being met.
- Patients had their individual risk of anxiety and depression assessed and acted upon. Support included reassurance from nursing and medical staff, and referrals to the appropriate professional. We were told that there was no formal psychological or counselling services provided. However, if necessary, a referral could be made to external providers. The trust was in the process of exploring the possibility of providing this

service. The CCU operated a high quality bereavement service. This included providing a unit specific bereavement pack to relatives which included 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 was also a notification of death form which only needed to be completed once but could be used to inform a range of organisations. This meant that relatives were spared the emotional upset of repeated form filling.

- One month after a death a member of staff contacted the next of kin to carry out a welfare check and provide additional support and information, if required. This approach to bereavement support has been rolled out across the three CCU's. Each unit has a bereavement lead and meets with the leads for the other CCU's regularly to ensure continuity and a standardised approach. Bereaved relatives were encouraged to give feedback about the quality of the support they received from the CCU. The data we reviewed demonstrated very high levels of satisfaction and immense gratitude to the staff that provide the service.

**Service planning and delivery to meet the needs of local people**

- Staff told us that deprivation in the local area was high and that they often saw patients with alcohol or substance misuse problems. As a result they had established a single point of contact in the hospital for specialist referrals. This consisted of a team of three nurses who could be contacted twenty four hours a day. Staff were also aware of the needs of elderly people in the local community and told us that they were able to give person-centred care based on the needs of the individual.
- A psychiatric liaison nurse was on-call twenty four hours for any patients who were admitted with drug misuse symptoms.

**Meeting people's individual needs**

- The clinical nurse educator was active with a delirium working group and was active in exploring appropriate screening tools to introduce
- Access to an on-call learning disabilities nurse was available and there was a 'dementia champion' on the CCU. This meant that patients with complex mental health needs could receive care and treatment appropriate to their needs with additional support from specialists.
- Staff sometimes used patient diaries to help those who spent longer than four days in the unit. These were used inconsistently and staff told us that they had experienced varying degrees of success with their use in the past. A nurse told us that some relatives and patients had found diaries very useful while others had not.

## Are critical care services responsive?

Good

We have judged the service delivered to be responsive.

Staff we spoke with had a good understanding of the needs of the local population. Provision was available to address specific needs such as alcohol and drug misuse, dementia and learning disabilities. There was also an active link to a delirium working group and a 'dementia champion' on the CCU. Although the unit was funded for eight beds, a ninth bed was regularly used as the CCU frequently operated at 100% capacity. We found staffing levels to be flexible in response to this. Poor flow elsewhere in the hospital meant that there were frequent discharges during the night and significant discharge delays for patients. However, the risk posed to patient care was being mitigated by the use of an extra bed. Delays were caused by access and flow problems in other departments in the hospital. There was a process to review patients who were discharged from the CCU to monitor their process. An established complaint policy was in place and the rates of formal complaints were very low. Patients and their relatives could be confident that concerns and complaints raised would be investigated, responded to and learned from. There was document evidence which demonstrate complaints were used to improve the service and patients experience.

**Service planning and delivery to meet the needs of local people**

- Staff told us that deprivation in the local area was high and that they often saw patients with alcohol or substance misuse problems. As a result they had established a single point of contact in the hospital for

specialist referrals. This consisted of a team of three nurses who could be contacted twenty four hours a day. Staff were also aware of the needs of elderly people in the local community and told us that they were able to give person-centred care based on the needs of the individual.
- A psychology liaison nurse was on-call twenty four hours for any patients who were admitted with drug misuse symptoms.

**Meeting people's individual needs**

- Access to an on-call learning disabilities nurse was available and there was a 'dementia champion' on the CCU. This meant that patients with complex mental health needs could receive care and treatment appropriate to their needs with additional support from specialists.

**Access and flow**

- Staff said that the main problem they faced was to do with capacity and discharging patients at the appropriate time.
- An escalation plan was in place that meant staff could use a ninth, currently unfunded, bed on the CCU and then the recovery unit for additional bed space if needed. Senior staff monitored staffing levels 48 hours in advance to ensure bed occupancy could be maintained safely.
- A robust admissions process was in place that had been approved by the Critical Care steering group. This included information on decision-making, accountability and how to ensure patient safety by escalating problems with transfers or capacity.
- Some patients who were ready to be discharged had this delayed by over four hours and some were discharged during the night. Between January 2015 and March 2015, there were four out of hours discharges and 54% of patients had their discharge delayed between four hours and five days.
- Between April 2015 and June 2015, 32.8% of all discharges (14 patients) occurred during the night and 38.6% of discharges were delayed by more than 24 hours. Out of hours discharges had increased in this period compared to data from April 2012 to April 2015, when these were consistently lower than the national average. The matron was aware of the implications of out of hours discharges and the inappropriate environment for a wardable patient. Such occurrences were due to broader flow and capacity problems at the hospital and were being mitigated where possible with the support of a dedicated bed coordinator at the hospital.
- The unit's risk register indicated that where discharges were delayed by more than 24 hours, an incident was raised and the matron along with their senior team investigated causing factors. We did not find evidence that patient safety had been compromised as a result of delayed discharges.

**Learning from complaints and concerns**

- There were appropriate systems to deal with comments and complaints and this was well established amongst the senior team. It had been used to investigate two complaints since November 2014. We saw that where a complaint had been upheld, learning had taken place from this. This meant that there was a robust complaints procedure in place which aided learning and service improvement in the department.
- The trust complaints policy was being followed by the CCU staff.
- We found that complaints data was routinely examined and staff meeting minutes demonstrated that complaints were routinely discussed. This meant that the service monitored complaints to improve service quality and to aid learning in the department.
- The Patient Advice and Liaison Service (PALS) provided assistance to patients and their families wishing to raise a concern or complaint.
- The complaints data we reviewed showed very low levels of complaints. When a concern or complaint was raised, there was evidence that the affected relatives were invited to a face-to-face meeting with hospital staff to discuss their concerns. This demonstrated effective, responsive and complainant-centred approach to complaint handling.
- The five relatives we talked to during the inspection told us they were very happy with the service provided. They were aware of how to make a complaint and were confident if they raised a concern it would be listed to and acted upon.

# Critical care

## Are critical care services well-led?

Good

We have judged the service at QEQM to be well led.

There was evidence of a realistic vision and strategy that staff had contributed to in the department. However, there was some concern about how this would be incorporated into the future trust vision. The CCU evidenced quality drives and measurement tools to monitor and ensure that it was providing a good service in line with national guidance and other CCU's nationally. We found operational governance and risk management arrangement were in place to support the CCU to deliver high quality care.

We also found evidence that the unit had systems in place to promote a healthy, open and candid culture in the department.

The CCU was led by a management team who were well respected by staff and had fostered a transparent, collaborative working environment that encouraged good practice and innovation. There was a strong drive to engage staff in learning and development opportunities and leadership training was cited by staff as particularly beneficial. Innovative approaches to improving staff communication had worked well, such as providing assertiveness training and coaching staff in effective emotional intelligence techniques.

There was evidence of good engagement with staff and families. The results of regular surveys indicated a broad, high level of satisfaction with the service and working environment. A staff newsletter was also in place and was used to engage staff at all levels with updates in practice as well as to welcome new members to the team. A 'colleague of the month' scheme had been introduced, which used peer nominations to identify outstanding practice by colleagues.

### 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 CCU's future to overcome known staffing problems and to ensure that the CCU was compliant with the standards of the Intensive Care Society and the Department of Health.
- Staff told us they were aware of the vision and the wider strategy of the trust and they felt involved in this and able to make suggestions or comments if they wanted to.

### Governance, risk management and quality measurement

- Documentary evidence and conversations we had with staff demonstrated that the unit operated effective Governance, Risk and Quality measurement processes. The service had developed a genuine culture of learning from and avoiding harm. Concerns and incidents were escalated via the relevant channels when necessary.
- Meeting minutes we reviewed demonstrated that risks identified and reported were related to the multidisciplinary critical care steering group and the surgical division governance board.
- Staff expressed confidence in the structure and output from governance and risk boards.
- The CCU had an appropriate risk register in place (reflecting risks in the service) and clear lines of responsibility. The top risks to the service were identified as delayed discharges, staffing recruitment and retention and the environment. The main mitigating strategy for delayed discharges was the effective use of a bed coordinator role. Evidence from the risk register indicated that the matron and senior nurses were proactive in planning and implementing discharges and transfers with the coordinator. Where such movements were delayed due to capacity and flow issues, an incident was raised and this was investigated using a root cause analysis process. Although no patient harm was known to have occurred as a result, occurrences were treated as unacceptable by senior staff, who ensured that the unit's escalation policy was used to try and better coordinate flow.
- There were appropriate processes in place to mitigate and act upon risks identified in the service for example infection control, staffing control, staffing, patient outcomes and capacity/ flow.
- The service demonstrated it had effective processes in place for carrying out clinical audits and action was taken to act on their results.
- The senior executive team informed us that they were aware of the incidents with NG tubes and the inconsistent use of x-rays in-line with trust compliance policy and standard operating procedures. We have been assured using examples from the trust's critical

care risk register that NG tube practitioners have been reminded of NG tube standard operating procedures, the adult nutrition policy and the central alert system to avoid future non-compliance in this area. The procedures were made to be compliant with NICE guidelines.

**Leadership of service**

- Nurses told us that they felt that leadership developmental opportunities and support they received were very good. For instance, one individual told us how they were supported to progress from band five to band six by completing the critical care course at university and then consolidating their knowledge by spending a year on the CCU . After they were promoted, they were given one month of management experience then two months as a supernumerary band 6 nurse. They told us, "All of this – the development, study days, leadership days – made sure I was ready before I led a shift myself." Leadership training was detailed and helped people to understand others, such as assertiveness training. Staff told us that this was part of a wider programme of operational leadership training that included topics such as 'having difficult conversations.'
- Staff told us the senior team was visible on the CCU. A nurse said, "The matron is lovely, she is approachable and always contactable by phone."

**Culture within the service**

- A culture of collaboration and learning was embedded in the service and it was used to help improve patient safety, care and experience as well as staff performance. For example, we saw that a nurse had been supported to develop their emotional intelligence as an effective communication tool. By developing this, they had been able to improve their relationships with consultants, particularly during decision-making processes.
- Staff spoke openly about the positive working culture. One nurse said, "Everyone is really hard working and I've never had any concerns or experiences of bullying."
- A group of past nursing students had sent unsolicited feedback to the senior team on the CCU from a recent placement, stating "the team were extremely welcoming and supportive – they always tried to provide learning opportunities that were relevant.

**Public and staff engagement**

- A monthly family satisfaction survey was used to gauge the experience of people. For the year prior to our inspection, people had rated the competence of doctors as excellent, the competence and communication skills of nurses as excellent or very good and the overall concern and caring of CCU staff as excellent.
- A newsletter was produced by staff on the CCU and included feedback from patients and their relatives, updates to staffing and details of audits. The newsletter was collaborative and we saw from looking at staff appraisals that everyone working in the unit was able to contribute. The newsletter had a positive tone and praised staff for good work as well as having a 'welcome' section for new staff. Details of training opportunities were also publicised in this way.
- Staff were encouraged to engage with the senior team on a day-to-day basis. A senior nurse said, "Staff are confident to approach us with concerns or queries, it's something we really push with new staff"
- The CCU continuously monitored the opinions and welfare of its staff through staff meetings and surveys.
- Staff told us that a recent CCU survey had improved their working relationships. A senior member of the team said, "I've noticed the difference since the survey got some niggles out of the way – we have a great place to work, staff look forward to coming to work every day. The ward manager is strategic – they put people in the place they need to flourish".

# Maternity and gynaecology

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

## Information about the service

The East Kent University Hospitals NHS Foundation Trust provides all services relating to pregnancy and women's health. As part of this inspection we reviewed the obstetrics and gynaecology services at the Queen Elizabeth the Queen Mother Hospital. The Trust also provides maternity and gynaecology services from the William Harvey Hospital, Kent and Canterbury Hospital, the Buckland Hospital and provides obstetric care to women in the community. These are subject to a separate report.

Queen Elizabeth the Queen Mother Hospital (QEQM) provides antenatal and gynaecology clinics; a fetal medicine unit; a maternity day care unit; Kingsgate, the ante and post natal inpatient ward; a consultant led labour ward with three induction beds, eight labour rooms, a twin room and a birthing pool; There is one obstetric theatre; St. Peter's Unit, a midwife-led unit with four rooms and two birthing pools. Birchington Ward (Gynaecology) has 15 funded inpatient beds with four contingency beds for general gynaecology, a gynaecology assessment unit, a nurse led pre-assessment clinic for all elective admissions and a nurse led early pregnancy assessment unit. There is a special care baby unit at the QEQM which takes babies born after 28 weeks. Those babies born earlier or who are very sick are transferred to the William Harvey Hospital.

Last year the trust delivered 7,032 babies including home births. Of these over 2,800 were delivered at the QEQM. Gynaecological surgery is carried out both in the dedicated obstetric theatre and the hospital's main theatres.

We visited all inpatient areas of the maternity and gynaecology services as well as outpatient areas. We spoke with six women and their relatives, took into consideration comments from patients who contacted us before and during the inspection and reviewed patient feedback on NHS Choices website. We reviewed seven sets of patient records as well as other documentation. We observed care and treatment and spoke with over 20 staff who were working in a variety of roles including the division director, board members, acting head of midwifery, consultants and other grade doctors; matrons, ward managers, midwives and their assistants, specialist midwives and allied healthcare professionals. We held focus groups for staff and received information from members of the public who contacted us to tell us about their experiences both prior and during the inspection. We also reviewed the trust's performance data.

At our last inspection of the maternity and gynaecology services offered at the QEQM, we found there was not enough staff to always provide a safe service to women and their babies. Some areas of the environment did not facilitate safe care and essential equipment was not always available. Although staff were focused on providing a caring experience for women and their babies, due to staff shortages and interim management arrangements clinical guidelines were not up to date and the effectiveness of specialist services had not been measured or evaluated. Decisions taken at a senior level did not appear to relate to the experience of staff at a ward level. We found there was a disconnect between the strategy and the organisation in general and the maternity services at an operational level.

# Maternity and gynaecology

## Summary of findings

We found the maternity and gynaecology services at Queen Elizabeth the Queen Mother Hospital (QEQM) required improvement, because the majority of issues identified in the previous report had not been addressed.

Since the last inspection the midwifery service had been through a period of instability of leadership which led to a great deal of staff dissatisfaction and unrest. The Trust had identified there had been a culture of bullying and harassment within the trust. The lack of leadership, the culture of bullying and lack of strategic direction was felt throughout the midwifery service and had resulted in a lack of focus and direction for the obstetric service at the QEQM Hospital for several months. However since April 2015 a number of interim, acting and substantive posts had been filled and although a number of staff remained unhappy, progress was being made to stabilise the midwifery service. These issues had not affected the gynaecology services which had benefited from stable leadership for some time.

There remained a problem with understaffing. Although there had been some improvements; with the Trust now actively recruiting to the vacancies, agency and bank staff now being used and an improvement of the midwife to patient birth ratio to 1:28. However it was still routine practice for staff to go without meal breaks or work over the end of their shift in order to ensure the ward was covered, to catch up on documentation and to keep women safe. Staffing on the gynaecology ward remained an issue because services were stretched with medical outliers and the use of a four bedded bay that was not funded for extra staff. Women at times experienced delay in obtaining pain medication while waiting for a second nurse to check medications and qualified staff spent time when they could be attending and supporting patients undertaking routine administrative work especially at weekends.

At the previous inspection we found there was a lack of capacity, with the maternity units across the Trust closing on many occasions. There had been no change in this situation with over 88 closures or diverts happening in the past year. This reduced the choice available and meant that women in labour had to travel more than 30 miles to the next available hospital.

We found that there remained issues with the general environment and lack of equipment across the obstetric department. The general environment was tired and cramped with a lack of storage facilities. There was a shortage of basic medical equipment from medical devices such as fetal monitoring equipment to broken printers and photocopiers. At the QEQM Hospital we found there was a lack of en-suite facilities for women in labour and only one obstetric operating theatre for both emergency and elective procedures.

We found there was under reporting across the maternity service although this was not an issue for the gynaecology services. Although staff were good at recording any clinical incident, non-clinical events were not being recorded. The Trust was aware of the issue of under reporting and had strengthened the governance system and improved training and development in reporting and managing incidents and complaints.

The majority of the nursing, midwifery and medical notes we reviewed were well completed. However there was a risk that babies were could miss the new-born screening test as NHS numbers were allocated manually with insufficient printers in place. The hospital had systems in place to identify when patients who were becoming increasingly unwell, and provide increased support. Recognised tools were used for assessing and responding to patients' risk.

However throughout the problems with leadership and staff unrest during the year we noted that staff had continued to provide women with positive pregnancy and birth experiences. Women told us that staff involved them in their care and kept them informed. Emotional support was provided by staff in their interactions with patients, together with support from specialist lead midwives. The majority of feedback received was positive and the kind and caring attitude of the staff praised.

Both the midwife led unit and the consultant led unit had rooms with pool facilities and a variety of couches for women in labour. These were well situated and well

maintained to offer women a real choice in how they wished to give birth. There was effective multidisciplinary working both within the hospital and with outside agencies.

Since the last inspection clinical governance had been reviewed and there was now a system for reporting patient safety and clinical governance issues from the wards to the Board. Quality and performance data were starting to be used to inform service provision. Action logs were now in place that were regularly monitored, reviewed and updated. A thorough review of all relevant policies and procedures had taken place to ensure they met with current best practice. Some audits had taken place last year and with a more stable leadership in place the audit programme was planned to improve over the coming year.

There were mechanisms in place to enable staff to learn from any accident, incident or complaint. We saw that clinical governance arrangements were improving with the change in culture. Staff were now more confident at raising concerns with their managers and whistleblowing when things were not right. Staff demonstrated a good understanding of infection control procedures, with robust monitoring of their effectiveness. We found that staff attendance at mandatory training was good and staff were knowledgeable in how to safeguard and protect vulnerable women and their babies.

## Are maternity and gynaecology services safe?

**Requires improvement**

We found that the safety aspects of the maternity and gynaecology services at the Queen Elizabeth the Queen Mother Hospital (QEQM) required improvement.

We found that patients were not always protected from avoidable harm because there was under reporting of incidents. Although the Trust was proactively working to address the issues staff were still not always non-clinical incidents. This was not the same for the gynaecology wards who demonstrated a good reporting culture. At this inspection we found that although the midwife birth ratio had improved, there continued to be a number of vacancies across the maternity and gynaecology departments. The Trust's inability to safely staff the acute sites at times of high activity or unanticipated staffing issues meant that there were occasions when understaffing impacted on the care patients received. Understaffing was an area not often reported through the Trust's reporting systems.

There remained issues with the general environment and lack of equipment across the obstetric department. There was a shortage of basic medical equipment from medical devices such as fetal monitoring equipment, infant resuscitaires and CTG devices to broken printers, photocopiers and electric fans. The environment was not always a safe place to care for women and their babies as there was only one obstetric operating theatre for both emergency and elective procedures.

Although we noted an improvement in medicine management there were still some practices which did not meet current best practice or comply with national guidelines such as out of date guidelines, unlocked drug fridge and cupboards.

The majority of the nursing, midwifery and medical notes we reviewed were well completed. However there was a risk that babiescould miss the new born screening test as NHS numbers were allocated manually.

We found that staff attendance at mandatory training was good and staff were knowledgeable in how to safeguard and protect vulnerable women and their babies.

# Maternity and gynaecology

The hospital had systems in place to identify when patients were becoming increasingly unwell, and provide increased support. Recognised tools were used for assessing and responding to patient's risk.

There were robust systems and processes in place to ensure that a high standard of infection prevention and control was maintained.

**Incidents**

- It is mandatory for NHS trusts to monitor and report all patient safety incidents. At the QEQM Hospital all incidents were reported through the trusts electronic reporting system. There was an incident reporting policy and procedure in place that was readily available to all staff on the Trust's intranet.
- The trust had reported no maternity or gynaecological 'Never Events' over the past year. Never Events are serious, largely preventable safety incidents such as retention of a foreign object following surgery or wrong route administration of medication.
- There had been 31 reported incidents relating to the Birchington Ward (Gynaecology. The majority were classified as 'No Harm' or 'Low harm' incidents. Two incidents were classified a 'Moderate harm'. There were no patterns or trends identified in these incidents. We saw that appropriate action had been taken to investigate and resolve each of these issues. We noted that staff on the gynaecology wards reported all incidents appropriately including non – clinical issues such as near miss incidents, inappropriate patient transfer, faulty equipment, catering and security issues. This demonstrated a good reporting culture on the gynaecology wards.
- Maternity services reported 28 serious incidents over the past year that met the criteria for reporting through StEIS, the national reporting database.
- These mainly concerned unexpected admission to the Neonatal Intensive Care Unit and unexpected Neonatal death. Other incidents included intra-partum death and sub optimal care of a deteriorating patient and baby.
- We noted that during the past year the incidents reported by the Trust to the National Reporting and Learning System (NRLS) were low compared with other similar Trusts nationally. Staff told us that the process for completing the incident notification was 'slow and long-winded'. They told us that taking 45 minutes to complete an on line form discouraged them from reporting all but the most essential incidents.
- We found that although staff on the obstetric wards reported any incident that involved patients, non-clinical incidents were poorly reported. For example staff did not always report when they were understaffed, when consultants were late in attending or when the hospital's policies or procedures were not followed for any reason. Staff told us "We do raise concerns and report, but nothing happens - it happens so frequently". Staff shortages were not frequently identified in the reports we reviewed. Other staff told us that they only reported high risk patient issues as the system took too long to complete and, there wasn't enough time to complete them without staying after work.
- The ultrasound sonographers told us that they did not report when specialist fetal medicine midwifes were not available to support patients when a fetal anomaly was discovered during an ultrasound procedure. They gave two examples where fetal problems had been identified and there was no one available to speak with the patient. They told us that this had not been reported through the incident reporting system, but the issue had been escalated.
- The staff we spoke with could not give us examples where they had reported an incident and changes were made as a result. We also spoke with doctors who told us that they knew how to complete the electronic reporting tool but had never needed to.
- An independent review conducted by the clinical commissioning groups (CCG) in February 2015 found that there was a failure of staff in seeking support and escalating issues about lack of staffing. We found that although the trust was providing education and training about appropriate reporting practices there was still an element of fear of reprisals and anxiety when reporting non clinical issues.
- The majority of staff told us they felt that incident reporting and obtaining feedback was improving although a few staff told us that due to personality conflicts with certain managers they did not always feel able to speak out about concerns. They told us how they received ''Lots more feedback now from the root cause analysis (RCA) and investigations. They confirmed that

investigations took place across the Trust's sites, which improved objectivity. One midwife from QEQM gave an example where they had completed a RCA at the William Harvey Hospital with the support of the matron.

- We were told how feedback from any reported incident was disseminated through team meetings, ward meetings, email communications and the clinical governance newsletter 'Risky Business'. We saw copies of the 'Risky Business' newsletter on staff notice boards giving details of learning from recent incidents.
- Learning from incidents was also discussed at the midwifery development days that occurred twice a year. We saw evidence of these sessions on the development day agendas.
- We looked at the Trust's investigation into the six most recent maternity incidents. We saw that a RCA had taken place and there was a system in place to undertake an investigation of each of the incidents including assessing if there had been any shortfall in care, treatment or service delivery. The process included establishing if recurrence could be eliminated and identify the lessons learnt. Investigations were usually performed by a senior member of staff from one of the other hospitals in the group where possible. We saw that staff, patients and relatives were supported and informed of the outcome. Action plans were put in place which included sharing learning and any changes in practice.
- We spoke with consultants and senior managers, who told us about the clinical governance and risk meetings, which were held monthly by directorate.
- We saw minutes from the perinatal and maternal mortality meetings which showed that each incident was discussed amongst the relevant staff peer groups
- There was no formal mortality and morbidity meeting in gynaecology. Any issues were reviewed as part of risk management meetings.
- We did not see any information for staff relating to their responsibilities under the Duty of Candour and it was not mentioned in any of the team minutes we reviewed. However in each of the perinatal review meeting minutes we reviewed 'Being open' was discussed and how information was shared with the patient and her partner. Staff on the midwife led unit also gave a recent example of how a patient was informed about wrong blood test results demonstrating a good understanding of the legislation.
- We saw from the gynaecology investigations that the Duty of candour was discussed and appropriate contact made with patients where there were concerns of harm.

**Safety thermometer**

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism.
- We found that the NHS Safety Thermometer information was available on the gynaecology ward but not on the obstetric units. On Birchington Ward (Gynaecology) the Safety Thermometer displayed the number of 'Harm free days' and provided information for patients on the safety of the ward.
- The Trust was not using a maternity dashboard but was taking part in the Clinical Maternity Network pilot. A draft copy of the data used was available for the period April 2014 to March 2015. A maternity dashboard is used to record adverse maternal events such as eclampsia (Eclampsia is a life-threatening complication of pregnancy), haemorrhage, failed instrumental delivery, 3rd and 4th degree tears and admission to Intensive care units. Infant events such as unexpected admission to a special care baby units and birth injuries would also be recorded.
- The performance data available indicated that the number of all caesarean sections performed at the QEQM hospital was similar to the national average.

**Cleanliness, infection control and hygiene**

- There were infection prevention and control policies and procedures in place that were readily available to all staff on the Trust's intranet.
- In 2014 the Trust maintained its level 3 accreditation with the NHS Litigation Authority (NHSLA) Risk Management Level Three Standards. This included hand hygiene training and inoculation injury standards.
- We noted that the hospital's infection rates were consistent with the national average for bacterial infections such as MRSA and C. difficile during 2013/2014. There were no particular issues noted with infection in the maternity or gynaecology departments. The performance data available indicated that maternity related infections, such as puerperal sepsis (A serious infection related to giving birth) were within the expected levels.

- There was a designated midwife with infection control responsibilities. We were told that they regularly undertook hand hygiene audits in order to make sure all staff were compliant with the trust's policies such as hand hygiene and the use of personal protective equipment (PPE).
- All of the hospitals sites we inspected where patients were seen and treated were visibly clean and tidy. In particular the midwife led unit was clean, bright and uncluttered.
- Hand washing sinks were readily available with sanitising hand gel throughout all the locations we inspected. We saw infection control information available for mothers when making up bottled feeds for their babies.
- Disinfection wipes were available for cleaning hard surfaces in between patients. Once equipment was cleaned the contract cleaner labelled it to indicate it was clean and ready to use.
- Clinical and domestic waste bins were available and clearly marked for appropriate disposal.
- The cleaning of the hospitals was undertaken by an outside contractor. We saw that the linen cupboards were fully stocked and kept tidy, the cleaning equipment was colour-coded and used appropriately. We saw cleaning rotas and cleaning checklists completed appropriately by the contracted cleaners and checked by a manager.
- We found that equipment and clinical stock was in date and stored appropriately. Equipment was marked with a sticker when it had been cleaned and was ready for use.
- We noted in the outpatient clinics, furnishings; such as chairs, were damaged, tired and required replacing. This presented an infection control hazard as damaged furniture is difficult to clean effectively.
- There were systems in place to test the quality of the water in the birthing pools to make sure it was safe. We noted that one pool had been out of action for 10 days as bacteria had been identified and following deep cleaning, repeat tests were being undertaken to ensure the water was safe before being used again.
- We found that staff generally were aware of the principles of the prevention and control of infection (IPC) and observed staff regularly use hand gel on entering clinical areas and between patients. The 'bare below the elbows' policy was adhered to and personal protective equipment (PPE) such as disposable gloves and aprons were readily available in all areas.

**Environment and equipment**

- At the previous inspection undertaken in 2014 we found the environment and fabric of the buildings forming the consultant-led Kingsgate ward and delivery suite was in a poor state of repair, dirty, poorly lit and difficult to maintain. For example there was water leaking from the ceiling in Kingsgate Ward and furniture and flooring was stained and visibly dirty. There were insufficient fetal monitoring machines available on the labour ward, with staff using older 'condemned' equipment that had not been replaced. Staff were not concerned about this lack of equipment as it was 'custom and practice' for staff not to have the full range of equipment for each delivery room. Staff managed this within their day-to-day practice and did not question or challenge the need to change. Lack of equipment was not on the Trust's risk register.
- At this inspection we found little progress had been made in addressing the issues. Although the midwife led unit provided a suitable environment the facilities on the labour ward were tired and cramped. The labour rooms were too small to include the resuscitaire (infant resuscitation equipment) which was stored in a treatment room.
- There were concerns that in the midwife led unit the infant resuscitaire was attached to a wall of the treatment room and not moveable. NICE guidelines recommend that there is minimal separation of the baby and mother. Taking the baby to another room for resuscitation does not meet with this guideline and is not recognised as best practice. Using the treatment room for resuscitation purposes meant that if another patient required a dressing or medication the room would be inaccessible when a baby was being resuscitated. At the previous inspection undertaken in 2014 we found there was a lack of medical equipment, particularly a lack of baby resuscitation equipment and CTG machines. CTG is used antenatally to monitor the baby heart rate over a period of time.
- During this inspection we found there remained a lack of equipment across the obstetrics department. This ranged from medical devices such as resuscitation equipment, fetal monitoring equipment and CTG devices to broken printers, photocopiers and electric fans.

- Ultrasonagraphers told us that two of the machines they used were over five years old and difficult to use for certain patients. Because the lists weren't amended to take this into account, this led to appointments needing to be rebooked.
- We were told there was a rolling programme to replace equipment. However although some equipment had been replaced, staff told us there was still not always enough working equipment available. Although more equipment had been provided following our last inspection there remained a lack of medical equipment, particularly a lack of baby resuscitation equipment and cardiotocograph (CTG) machines. CTG is used antenatally to monitor the baby heart rate over a period of time.
- We were told that there was a particular issue with theft of equipment and bedding across the Trust and staff gave several examples where medical equipment had been stolen. For example new sonic aids were ordered every quarter to replace those that were stolen from the hospital at over £300 each. In order to address this issue locked equipment boxes were due to be installed in clinical areas. The hospital had also implemented an equipment library, which staff told us had helped with the availability and reliability of some of the equipment.
- The CCG report in February 2015 documented that lack of appropriate available equipment had featured as a contributory cause in a number of serious incidents over the past year.
- We reviewed the testing and maintenance of equipment such as resuscitation trolleys and resucitaires (resuscitation equipment for babies), CTG machines, sonicaids (a handheld device midwives used to detect a fetal heart beat), medicine trolleys and fridges. We found that majority of equipment had been labelled to verify it had been electrically tested within the past year to indicate that it was fit for use. Staff documented equipment checks in the ward diary. We noted there with few exceptions that equipment was usually checked appropriately on both the obstetrics and gynaecology wards.
- Managers told us that following an issue identified with the security swipe cards, an electronic key fob security system had been put in place and the unit was now secure.

**Medicines**

- At the last inspection we found that medicines were not always stored and managed safely. We found several medicine cupboards and clinical fridges unlocked and drug records not always signed appropriately.
- Since the last inspection there was an improvement noted in the security of medications with digital locks now on the drug cabinets and the controlled drug cupboard key held by the nurse in charge. However the medicine fridge on the midwife led unit was not locked.
- The Trust told us they now conducted two medicine audits each year. The results of the audits indicated that there had not been any significant improvement in compliance. It was noted that in 2014 Kingsgate ward was among the highest reporting wards for medicine management incidents.
- At this inspection we noted an improvement in medicine management however there were still some practice which did not meet current best practice or comply with national guidelines.
- The staff we spoke with were aware of the Trust's medicine management policies, which were readily available on the intranet however many were out of date. For example although the Trust had guidelines on the use of patient group directives (PGD), they were not often used and were either not available or were out of date. For example we noted that all 13 of the PGDs had expired over a year ago and many had expired over four years ago.
- Controlled drugs were checked twice daily and this was documented. We noted that on the labour ward the controlled drugs key was not held separately to the main bunch of medicine keys. The controlled drugs policy had been rewritten and now required two signatures to sign for all controlled drugs.
- On Birchington Ward (Gynaecology) staff told us that because of staffing shortages there was sometimes a problem in having two registered nurses to check controlled drugs. This was especially an issue at night.
- The medicine fridges were usually checked daily. Although the temperatures had been checked on the day of inspection, looking back through the records the temperatures were not consistently recorded. We did not see that the ambient room temperatures recorded in any area where drugs were stored. Many medicines become unstable or deteriorate when stored over 25°c.
- We reviewed a sample of medicine administration records which were completed appropriately.

# Maternity and gynaecology

**Records**

- The Trust was using a mainly paper-based record system, supplemented with electronic records. Standardised obstetric records were in place that tracked the patient's journey through initial booking to post delivery. We did not see any audits of record keeping.
- Patient observations were undertaken using an electronic system that automatically uploaded patient observations. This gave doctors access to test results so appropriate treatment could be arranged quickly. Staff told us that the trust's electronic-based system was very efficient with information, regarding viewing tests and investigations which were available online.
- The system for electronically issuing new born babies with NHS numbers wasn't working. All babies require an NHS number within 4 days of birth as they usually undergo a screening test on the 5th day for which the number is required. This meant that midwifery and administration staff were spending a lot of time manually allocating numbers. There was a risk that babies were could miss the new-born screening test if the number had not been allocated appropriately as the NHS number is the key identifier for each baby.
- We noted that a number of serious incident reports over the past year gave incorrect or incomplete records as a contributory cause. For example midwives not accurately recording woman's history or the telephone enquiry sheet not being fully completed.
- We noted that the maternity records were kept in a loose leaf format where there was a risk that individual pages could get lost or miss-filed.
- The labour ward used a triage form when women in labour contacted the ward for advice or to be admitted.
- We were told that the paper scanning cards often got lost meaning that appointments sometimes were missed.
- Staff told us that there was much duplication of paperwork adding to their time management frustrations. They gave examples where three different computer programmes were needed to discharge women from the hospital.
- On each ward, unit or clinic we reviewed a small sample of obstetric, gynaecology and medical records. We found the majority of the nursing, midwifery and medical notes were clear, concise and recorded appropriate information in a logical and legible format. Entries had been dated, signed and timed appropriately.
- The hospital used the adult surgical pathway for any woman who required surgical intervention to safely deliver their baby or for gynaecological interventions. All of the surgical records we reviewed were fully completed and included completed World Health Organization (WHO) surgical safety checklists.

**Safeguarding**

- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on its intranet.
- The women's' health division had a safeguarding lead, which acted as a resource for staff and linked in with the trust's safeguarding team.
- Midwives assessed social vulnerability when women were initially booked into clinic. Extra information was requested from a woman's GP or social services if necessary. Midwives gave women information about relevant support services, (for example about substance abuse, sexual abuse of under 16s or a violent partner).
- Staff told us about the Young Person's Team which liaised with local authority safeguarding teams to protect young people.
- Safeguarding training was included in the trust's mandatory training programme. We were told that all staff undertook basic safeguarding training. Those staff with additional responsibilities undertook level two and three training. The results of mandatory training indicated that 91% of staff at the QEQM Hospital had undertaken child protection training.
- Staff told us that training on FGM (female genital mutilation) formed part of the unit's mandatory safeguarding training. All the staff we spoke with knew how to escalate concerns if a female baby was flagged as high risk. On the gynaecology incident report we noted that an incident of FGM had been identified and appropriate action had been taken to alert the safeguarding authorities and protect the vulnerable young person.
- Staff we spoke with told us that they had received safeguarding training as part of mandatory training.
- We saw that staff on Birchington Ward (Gynaecology) raised concerns about a vulnerable person who had been admitted to the ward and took appropriate action

to report their concerns through the Trust's safeguarding referral process. We noted that staff raised concerns about the lack of feedback following the reporting of the concerns.

**Mandatory training**

- We looked at the staff mandatory training records and identified there was a good uptake of training for the maternity and gynaecology departments. Between 88 – 91% had attended Midwife development days which included child protection
- We spoke with consultants and doctors of all grades. They told us that mandatory training, such as safeguarding and infection control, was available, although it was not always easy to find the time to attend. We noted that only 34% of doctors at the QEQM Hospital had attended the 'Skills Drills' training.
- Although we were told that the hospitals tried to use the same agency staff that were familiar with the Trust there were concerns raised that there wasn't an orientation pack for agency staff new to the wards.
- At the QEQM Hospital 89% of staff had completed their Skills Drills training which included: moving and handling, maternal and neonatal resuscitation skills, obstetric emergencies and mental health issues. We spoke with staff who confirmed that training was readily available however there was not always time to access it. Midwives and doctors were taught together at the monthly 'skills drills' sessions
- We spoke with an anaesthetists who told us they ran live 'Skills Drill's' training on a regular basis. They told us the next one due was in September and was about obstetric emergencies such as haemorrhage.

**Assessing and responding to patient risk**

- During our inspection fire safety concerns were identified within the maternity department and maternity theatre. We found that fire doors had been recently repainted and the intumescent strip designed to seal the doors in the event of fire had been painted over rendering them obsolete in the event of fire. We noted that a fire safety risk assessment had been carried out in January 2015 and 30 action points agreed; of these 13 had been addressed and closed. This meant that in addition to the concerns found at inspection there were additional actions that the hospital had not fully addressed to reduce the risk of fire to patients, visitors and staff.
- During our inspection we noted the hospital's security officers walk through the department checking with staff that everything was alright. Staff told us that this happened randomly through the day and was reassuring to both patients and staff.
- Recognised tools were used for assessing and responding to patients' clinical risk such as the Malnutrition Universal Screening Tool (MUST) and the venous thromboembolism (VTE) assessment tool to identify those at risk from developing blood clots.
- The trust used a modified early warning score (MEWS). This scoring system enabled staff to give early identification of patients who were becoming increasingly unwell, and provide increased support.
- We saw examples of staff in the labour ward and midwife led unit using the MEWS system to identify deteriorating patients and ensure that they were seen quickly by a doctor.
- The divisional risk register for gynaecology patients identified that opening additional beds at periods of high demand on Birchington Ward (Gynaecology) was a risk without sufficient funding for additional staff. This had been on the risk register since September 2013.

**Midwifery staffing**

- At the last inspection we found there were gaps in staffing due to vacancies, secondments, and maternity leave. Staff had been "acting up" to cover vacant posts for a significant period without having been formally recruited to. The midwife to birth ratio was over 1:33 when the National expected ratio was 1:28.
- At this inspection we found that although the midwife birth ratio had improved, there continued to be a number of vacancies across the maternity and gynaecology departments. The Trust's inability to safely staff the acute sites at times of high activity or unanticipated staffing issues was raised on the divisional risk register.
- In February a CCG report indicated that the Trusts publication of nurse staffing data showed significant gaps in staffing levels over the past year. The fill rate for the maternity care assistants was under target from May 2014 to January 2015. This had potentially impacted on patient care as the wards with the highest reported staffing difficulties were amongst the highest reporting ward of medicine management incidents.
- The wards did not use a 'Safe Staffing' board. We were told by senior managers that the Trust was currently

undertaking a review of acuity to assess the current level of staffing provision. The results would be independently verified by the Local Supervising Authority (LSA) and appropriate action taken to address the findings.

- Managers told us that NHS Professionals and bank nurses were now used to cover vacant shifts; however there were still occasions where there were insufficient staff on duty. Managers tried to book the same agency staff who were familiar with the ward. They told us that the bank staff were usually staff already employed within the midwifery department. Staff told us that they now used agency staff, which was an improvement on the previous year when agency staff were not allowed. Staff were moved between wards and units and on occasions community midwives were brought in to support the hospital service.
- On Birchington Ward (Gynaecology) staffing was not identified as a risk unless additional beds were allocated to outliers at periods of high demand.
- At the previous inspection the birth ration was 1:33. This had now improved to 1:28 which was the national standard ratio of midwives to births.
- Staff told us there was a problem recruiting due to the rural location of the hospital. Managers told us that a number of appointments had recently been made such as two band seven nurses. They described the recruitment process as lengthy exacerbated by a 'bottle neck' when the applications got to the administrative section of the recruitment process.
- We were told that over 50% of staff had been granted flexible working patterns which had led to considerable problems when organising safe cover for the obstetrics department. There had recently been a change in the policy for granting flexible working as this was unsustainable. However change to working patterns was causing additional staff unrest made worse by the 'impersonal' e-rostering which did not take into account personal circumstances when allocating shifts.
- Across the Trust we were told that clerical and administrative staff had left and not been replaced. This was putting additional burden on the existing staff and meaning that midwives and midwifery healthcare assistants were undertaking more administrative work. Staff told us it was very frustrating being called away from the patients' bedside to undertaken administrative tasks.
- On Kingsgate Ward (Ante and post natal) staff told us that staffing levels were low. They told us that for 22 patients there were often only two midwives and sometimes only one. One midwife told us "We are at breaking point – it can't go on like this". They told us of weekends in particular where there were insufficient qualified staff. They told us the ward had to close twice in the past week because of lack of staff. Obstetric consultants told us that staffing on the post natal ward remained a challenge as they were always busy and constantly stretched. They gave examples of high risk patients not always having one to one care because of the lack of staff.
- On St. Peter's Unit (the midwife led unit) staff told us how they worked long shifts of 13 hours and didn't always get time to take breaks.
- Patients told us that they thought the staff were overly busy, very rushed and stressed. However they did respond quickly to call bells however much pressure they were under.
- The trust employed two consultant midwives however we found that this resource was not being used effectively. We met with one consultant midwife but were unclear about her role as a consultant in supporting staff. Midwives and doctors on the wards told us they did not see any impact from their appointment. They told us the consultant midwives were not a visible presence although they were contactable by phone or email if needed. Consultant midwives would usually be used to help modernise the service working directly with patients and developing practice through research, education, staff and service development. We didn't observe that happening at this trust.
- Specialist midwives were available to support patients and act as a resource for staff. These included specialists in screening, fetal medicine, teenage pregnancy, bereavement and the care of vulnerable women. There were lead midwives for health and safety, infection control and catheter care. However there were no guides for staff as to the role, remit and responsibility of the lead midwives. We were told that only the lead for student midwives had guidance available. Managers told us that the lead midwife role was currently under review. The job descriptions for Matrons and the consultant midwives were available for inspection.

**Medical staffing**

# Maternity and gynaecology

- The trust had a slightly larger proportion of Consultants and middle career doctors than the England average, however it had been identified that additional consultant cover was required to address antenatal and labour ward cover. A business case for two further consultants had been approved. The clinical director told us this would facilitate the antenatal clinics and provide cover for a second obstetric operating department in the future.
- The clinical director for women's health told us that the medical cover for the labour ward was good with 70 hours of consultant hours which included seven day cover. This was confirmed by the consultants we spoke with. However we found that the consultant presence in the department was not solely for the labour ward as recommended by guidance issued by the Royal College of Gynaecologists, but included the elective caesarean sections operating list, cover for the gynaecology ward and the emergency department.
- Obstetric consultants told us that there were now no problems with the junior doctor staffing levels and there were no vacancies. They told us of close working and friendly interactions with the midwifery team. They spoke highly of the senior midwifery team particularly the matron who 'Gets things done' and gave examples of working together with the junior doctors and midwives to produce a 'survival guide for new doctors as part of their induction.
- Staff told us that although three doctors' rounds took place during the day with the consultants, registrar, senior house officer and lead midwives, the consultants were not always present and may attend by telephone as after six pm they were not usually on site.
- We spoke with consultant anaesthetists who told us there was cover for the obstetric unit Monday to Friday with weekends covered by an emergency on call rota.
- The available data confirmed that although the Trust employed slightly lower percentage of registrars there was a higher number of junior doctors than the England average. The midwives we spoke with told us that there was generally no problem in obtaining medical opinions and they always received a prompt response from the medical team when they had concerns.

**Major incident awareness and training**

- East Kent University Hospitals NHS FT was located in an area with several high profile locations where major incidents may occur such as the ports, international rail links, Channel Tunnel and airports.
- The trust had a major incident policy with robust measures in place to deal with major incidents and maintain public safety. We were told how regular training took place on responding to major incidents alongside of other emergency services, health and social care providers. Two live exercises were planned for 2015.
- Staff were made aware of the Trust's Major Incident Plan through videos, posters, flow charts, action cards and the trust's policy which was available on the intranet.
- On Birchington Ward (Gynaecology) staff demonstrated familiarity with the major incident policy and showed us the folder which contained all the information needed to deal with a major incident or loss of business continuity.
- The trust had business continuity plans in place for all hospitals, including the QEQM Hospital. These included communication details and useful telephone numbers.
- There was an escalation policy in place to ensure a standardised approach when diverting women to the other acute site or when both maternity units were closed. The maternity units were closed or diverted 88 times in the past year. The reasons for this were where the staffing levels or bed capacity did not allow for further admissions or the neonatal facilities were full. During the inspection a 'divert' was in place for a short period due to the special care baby unit being full. The number of closures and diverts was raised as a concern at the last inspection and we saw there had been little change at this inspection. Because of lack of capacity or staffing women were still regularly diverted 30miles between the Trusts two main birthing hospitals or further afield to other Trusts.

## Are maternity and gynaecology services effective?

**Requires improvement**

Maternity and gynaecology services at the Queen Elizabeth the Queen Mother Hospital (QEQM) were rated as requires improvement in terms of delivering effective care.

# Maternity and gynaecology

Although the hospital was not using a maternity dashboard the data was being collected. However the information was not yet being collated and used to inform maternity services. Audits were taking place, but the lack of midwives with auditing responsibilities and the leadership issues over the past year meant that there had been a loss of focus on improving the quality of care through robust auditing.

We found that although the inpatient wards and community midwives offered a seven day service they were not always supported by other services such as radiology. This limited the responsiveness and effectiveness of the service the hospital was able to offer.

We found that in general training for staff was good with newly qualified staff being well supported. There was still a shortage of midwifery supervisors but the situation was improving. The hospital had undertaken a considerable amount of work in reviewing and updating policies to ensure they were up to date and met best practice guidance. The policies were readily available to staff through the Trust's intranet however there had been no auditing of best practice against the hospital's policies and procedures.

There was effective multidisciplinary working both within the hospital and with outside agencies. Breast feeding across the Trust was well supported. The hospital had achieved stage one accreditation in the Baby Friendly which demonstrated that there were systems in place to promote breast feeding.

**Evidence-based care and treatment**

- At the last inspection we found that the clinical guidance and policies used by staff were out of date together with the information leaflets for patients. Since then considerable work had been undertaken on reviewing and updating the policies. There was a midwife in post with responsibilities for ensuring the guidelines were up to date. We were told by the clinical governance lead that there were now only 6 policies that required updating and these were in hand awaiting medical input.
- We reviewed a wide sample of policies and procedures and found them to be up to date and reflected current best practice and national guidance. For example the hospital's policy for caesarean section referenced best practice guidelines from the Royal College of Obstetricians and Gynaecologists, the Centre for Maternal and Child Enquiries (CMACE), the National Institute for innovation and Improvement, the National Collaborating Centre for Women's and Children's Health and the National Institute for Health and Clinical Excellence (NICE).
- Staff were able to access national guidelines through the trust's intranet, which was readily available to all staff. Midwifery staff demonstrated the ease of accessing the system to look for the current trust guidelines.
- The local CCGs undertook a review of the maternity services in February 2015 where it was noted that there were unclear guidelines and processes in place. The CCG's investigation of serious incidents had concluded that staff on occasion had failed to follow national guidelines. We noted that there had not been any auditing of compliance with the Trusts policies or best practice guidelines.
- The trust had recently commissioned an independent service review by the Royal College of Gynaecologists and Royal College of Midwives to start during the summer and had appointed a senior midwifery manager from a neighbouring trust to support the acting head of midwifery and start a problem solving exercise to help to identify issues within the obstetric division and look at improving service delivery.
- The specialist services division had produced clinical audit plans for 2015/2016 which were presented to the Clinical Audit Committee and signed off by the Quality Committee in April.
- There was a local audit programme in place to monitor the quality of care and treatment. The monthly specialist services audit programme report identified that in May 2015 there were 34 women's health audits to be undertaken during 2015/2016. However the trust did not have a midwife with responsibilities for overseeing the audit programme and we noted that there were six obstetric audits behind schedule and nine waiting to be registered.
- We found some local auditing had taken place during 2014/2015 although there wasn't a dedicated audit midwife in post. For example we noted an anti-natal audit of screening data 2014/2015 had taken place. This included data for sickle cell and thalassaemia, infectious diseases, Downs Syndrome and fetal anomalies. The audit identified at 13% had missing information on form.

- A report on the progress of the 2014/2015 audit programme identified that gynaecology services had conducted six audits with obstetrics undertaking 40 audits. A number of the obstetric audits were abandoned due to insufficient data or relevant staff leaving although collecting the data was a national requirement.
- Doctors told us about monthly 'audit days' which were attended by the doctors and senior management team.
- We saw that minutes from clinical governance meetings were available on the intranet and posted on staff notice boards. For example minutes of the perinatal mortality meeting was available for staff on the staff notice board in the labour ward.

**Pain relief**

- In the maternity services midwives told us there were no problems in obtaining pain relief or other medication for women.
- All the women we spoke with who had recently given birth or those who provided feedback about their birth experiences told us they had received pain relief as required.
- The women we spoke with on Birchington Ward (Gynaecology) told us there were no concerns with their pain management with staff responding promptly and anticipating any requests for analgesia.

**Nutrition and hydration**

- The hospital provided meals and light refreshments for inpatient women. We were told that light refreshments were also offered to the women's partners. There were facilities for making toast and light snacks in all the inpatient units.
- Staff told us that snack boxes were available for women to ensure that whatever time of day they felt hungry food was available.
- We saw that patient records included nutritional assessments where appropriate and dietary supplements were provided if needed.
- Mothers on the postnatal ward were pleased with the support they received with breastfeeding their babies.
- We spoke with the dedicated breast feeding midwife who worked across the hospital sites. She told us about the support offered to new mothers and was proud to tell us that the Trust had achieved stage one accreditation in the Baby Friendly Initiative which is a UNICEF programme to promote breast feeding. Stage one accreditation demonstrated that there were systems in place to promote breast feeding.

**Patient outcomes**

- The Trust was not using the maternity dashboard developed by the Royal College of Obstetricians and Gynaecologists to help obstetric services to plan and improve their maternity services.
- Although the Trust was not using a maternity dashboard they were taking part in a Clinical Maternity Network pilot. A draft copy of the data used was available for the period April 2014 to March 2015. The information provided gave some basic data for obstetric care across the Trust. It did not identify individual hospitals, did not always give percentages and did not include metrics for safe care or red flags which alerted staff to possible problems. For example from the data provided it couldn't be identified if the booking targets were being met or if the number of incidents of shoulder dystocia was within acceptable limits. Shoulder dystocia happens when the baby's head has been born, but one of the shoulders becomes stuck
- We looked at the data collected for the previous two months and noted that information was collected on all birth statistics and was then available to inform clinical governance and strategic planning. For example in June 203 births took place in the consultant led unit, 46 on the midwifery led unit and 17 took place at home. In June there were three water births in the consultant led unit and 24 in the midwifery led unit and two water births at home.
- We saw that the proportions of delivery methods for example normal delivery and assisted delivery using medical devices were similar to the national averages.
- However the overall caesarean section rate was higher than the national average of 23%. Trust wide the proportion of caesarean sections for 2014/2015 was 26.6% with 15.1% emergency and 11.5% elective caesarean sections. The overall rate of caesarean births at the QEQM Hospital was 29.6% (June 2015). The acting head of midwifery told us the cause of this was being investigated.
- The number of women with third and fourth degree tears was noted to be around the national average of 2.9% for unassisted deliveries but was 6.8% for assisted deliveries. The rate was noted to be higher at the QEQM

than at the William Harvey Hospital for May and June 2015. The Royal College of Obstetricians and Gynaecologists states the overall incidence in the UK is 2.9% (range 0–8%).
- Between April 2014 and March 2015, 51 women suffered a severe postpartum haemorrhage (blood loss during or immediately after birth) which was within acceptable national limits
- The hospital recorded that 5.5% of women or their babies were readmitted as an emergency following discharge from the hospital.
- All women who were assessed as low risk were given a choice to deliver their baby in the midwife led unit. Approximately one third of women who started their labour in the midwife led unit were transferred to the consultant led labour suite during labour. Staff told us this was due to the criteria used to admit women to the unit.
- The QEQM Hospital performed poorly in the National Neonatal Audit Programme 2013

**Competent staff**

- The nursing and midwifery staff we spoke with told us that in general training and support was good. They told us that there were no problems with accessing training. All mandatory training was provided through e-learning but some staff. Training was a mixture of on-line and face to face practical training which worked well. They told us that staff were allocated time to undertake the training. We saw evidence of the training and support available on the ward notice boards. This included mandatory training and education available from outside sources such as the Royal Colleges.
- The Trust told us they had recently started a new induction process for new staff.
- Midwives were required to complete two development days per year. These were arranged by the Practice Development Midwife. One of these days was running at the Buckland Hospital the day we inspected. We saw the agenda for the last two of these development days which included updates on Female Genital Mutilation and mental health issues.
- Staff told us how the lead midwives helped to disseminate good practice and gave the example of the bereavement midwife training staff on how to give bad news.
- The maternity service supported the newly qualified midwives in achieving competence in clinical skills by the support of clinical skills facilitators. These were more senior midwives who helped teach and assess the junior midwives with their clinical skills.
- Staff could only use equipment, for example for blood pressure and blood sugar monitoring, once they had training on it and were familiar with it. We saw evidence of staff equipment competencies signed off on the labour ward.
- Staff across women's services told us that the Trust was currently using a lot of agency and bank staff, and that although they always tried to use the same agency staff, there was no robust system in place for checking their competencies for example drug administration competencies.
- We found that the majority of staff had received their annual appraisal. 93% of staff at the QEQM Hospital had received an appraisal by June 2015. All of the staff we spoke with across the obstetrics and gynaecology services with had completed their annual appraisals.
- Midwives have a statutory duty to undertake regular supervision with a supervisor of midwives. There should be one supervisor of midwives to every 15 midwives and her role is to protect the public through the safe provision of evidence-based midwifery care. We were told that there had been a problem in having enough supervisors for the number of midwives and that on occasion the ration had risen to 1:20. However the managers and supervisors we spoke with told us that the situation was improving. One new supervisor told us how she had been supported in her new role with a low caseload until she was ready to increase the number of midwives who reported to her.
- All the medical staff we spoke with were aware of their revalidation dates, and told us that they had had appraisals in the past year.
- We spoke with the doctors, who told us that training opportunities were available but coordination with study days and on call rota needed to improve. They told us that it was difficult to maintain their neonatal resuscitation skills but the midwives supported them and additional training and support was available.
- Patients told us the staff were professional, skilful and 'A real credit to the NHS'.

**Multidisciplinary working**

- The minutes from the perinatal and maternal morbidity meeting demonstrated effective multidisciplinary working, particularly when investigations required input across the specialities.
- Staff across the maternity and gynaecology services told us how well all the disciplines worked together. Medical staff told us that there was no 'Silo working' with a 'Good working relationship' with the midwives.
- From the records we reviewed we saw evidence of good multidisciplinary working between other NHS Hospitals. For example where abnormalities were suspected during routine scanning patients were referred to other NHS hospitals where specialist services available.
- However we heard instances where medical colleagues had not worked together effectively. Staff told us that there had been issues with some consultants not agreeing with other consultants' treatment plans and changing them. This had the potential for confusion for staff and lack of continuity for patients.
- We found that across the trust communication was encouraged to encourage health and social care professionals to work together.
- The Trust had policies in place which promoted multidisciplinary working.

**Seven-day services**

- At the QEQM Hospital the consultant led labour ward, St Peter's Unit, Kingsgate and Birchington Wards (Gynaecology) were open for 24 hours throughout the seven day period.
- The maternity day care unit was open seven days a week. Monday to Friday 8am to 8pm and 8-4 at the weekends. Women were given contact numbers for each of the maternity departments and labour wards where there were staff available to answer questions and provide advice.
- Women were able to access emergency gynaecology care by reporting to the emergency department. However there was also a gynaecology assessment unit for urgent gynaecological care which could be accessed direct.
- However, we found that not all of the support services offered a comprehensive seven day service.
- Midwives and doctors told us that although the radiology service offered an out-of-hours service, in reality, it was very difficult to obtain emergency XRays done out of hours. Staff gave the example of difficulties when accessing emergency interventional radiology service for women who have a major postpartum haemorrhage. Trust wide there was a known capacity issue with the radiology department. The Trust was aware of these issues which appeared to the department's risk register.

**Access to information**

- The majority of locations where women were seen and treated had a wide range of information readily in the form of leaflets, booklets and posters. These included general information on the ward, information on various conditions, and support groups in the community, together with public health information.
- The hospital's website also provided information, and signposted to further sources of information and helpful advice.
- The hospital produced a booklet for patients who had experienced bereavement. However this booklet was for people who had lost an adult and was not appropriate for women and their families who had lost a child. For example the booklet described how to access the deceased property and jewellery, the documents needed such as the deceased utility bills and driving licence, viewing the body in the mortuary and talking about the deceased life and accomplishments. Receiving this type of impersonal literature following the loss of a baby does not demonstrate personalised care or acknowledge the families distress at losing a child.
- Staff told us they gave written information to the women using the service about the tests performed. We saw examples of information leaflets such as contraceptive and infection control advice.
- There were 'Parent craft' sessions held once a month, where mothers could get support and help prepare for their baby's birth, breastfeeding and aftercare.
- There were notice boards around the hospitals which gave information for staff about training opportunities, staff meetings minutes, and the results from audits and incidents.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.

- Staff told us that training on the MCA 2005 and Deprivation of Liberty Safeguards (DoLS) was available and the Trust had held conferences on the MCA and DoLS. However from the training data provided it couldn't be verified that staff had attended this.
- There had been no deprivation of liberty application for the women's health services in the past year.
- The inpatient wards had information on the mental capacity act 2005 available including how to assess capacity for day to day decisions.
- Birchington Ward (Gynaecology) took medical outliers and this sometimes included confused patients or those living with dementia those living with dementia. We were told that a dementia link nurse was available to support the staff if needed.
- The majority of staff were able to describe the process of obtaining valid consent, but were less familiar with the DoLS. The records we examined provided evidence that valid consent was obtained before any invasive procedure and the risks and benefits of the procedures were clearly documented on the consent forms.
- Staff we spoke with did not always understand the MCA 2005 and had not attended training. They told us that they would ask the trust's safeguarding lead, who assumed overall responsibility for the process. For example on Birchington Ward (Gynaecology) we queried a patient's records where it was documented that the patient's family should always be present as the patient didn't understand. There was no capacity assessment available or assessment if the family was the appropriate body to provide support.

## Are maternity and gynaecology services caring?

Good

We rated the maternity and gynaecology services at the Queen Elizabeth the Queen Mother Hospital as good for caring, because the majority of women and their partners we spoke with, or who contacted us, were positive about their experience of the care provided to them, and told us they were treated with kindness and compassion. There were exceptions where women felt they were not treated with kindness or understanding during their pregnancy or the birth of their baby.

During our inspection we observed staff being friendly towards patients, and treating them and visitors with understanding and patience, and observed treatment that was provided in a respectful and dignified manner.

Women across the obstetric and gynaecology services told us that they were usually involved in decisions about their care, and were kept up to date with their progress. Emotional support was provided by staff in their interactions with patients, together with support from specialist lead midwives.

Patients told us that the staff were friendly and knowledgeable offering professional and caring support throughout their birthing experience.

**Compassionate care**

- We spoke with six women and two of their partners currently receiving care, who all told us they had had a "Good experience" and that the midwives at the QEQM Hospital were "kind and attentive". Women who had recently given birth told us the experience was "Much better than expected" and that the midwives were "Second to none"
- Women receiving gynaecological interventions told us that staff were helpful and very friendly. They told us they had been looked after very well and were grateful for the support they had been given at a difficult time.
- Before the inspection women contacted us to tell us about their birth experiences. The majority of women had positive experiences and they told us staff were "calm", "helpful", "relaxed" and "kind". One woman told us "They've been incredible throughout"
- During our inspection, we saw staff talking with patients in a respectful and caring manner, taking time to explain options to patients.
- Patients told us that they were treated with dignity and respect by all members of the care team. We observed staff knocking on doors before entering, and curtains being pulled around beds before treatment or private conversations took place.
- The Friends and Family test scores for maternity at East Kent University Hospitals FT EKHUFT were overall in line or above the England average. The highest scores were within the post-natal and community setting and the lowest scores were from the post-natal ward.
- We saw that Friends and Family information was not always displayed on notice boards around the wards and departments however we noted the information

displayed on Birchington Ward (Gynaecology) indicated that 97% of patients would recommend the ward to family and friends and 68 patients had completed the survey in the last month. The scores for June 2015 indicated a similar positive response for maternity care with 100% of respondents recommending the labour ward, post natal wards and 96% recommending antenatal care.

- Birchington Ward (Gynaecology) displayed the 'You said – we did' information where the actions taken following patients raising concerns were highlighted. Issues such as noise at night and broken blinds were addressed and information shared on the notice board.
- The Trust scored 'the same as other trusts' in the majority of questions in the 2013 CQC survey of women's experiences of Maternity Services.

**Understanding and involvement of patients and those close to them**

- In the 2013/14 CQC survey of women's experiences of Maternity Services the trust scored better than other trusts in respect of mothers being given appropriate advice and support at the start of their labour and the involvement of their partner during labour and birth.
- We spoke with women who had recently given birth. They told us that they had been kept informed during the labour and said that the Midwives were 'amazing', 'really kind and 'gave good advice'. They told us they had received lots of information and help with breast feeding.
- In the antenatal clinics women told us they had no problems with the service provided. They told us they were given convenient appointment times and were general seen close to this time, everything was explained.
- On Birchington Ward (Gynaecology) women told us how the nurses explained what was happening to them and kept them informed.
- We noted that a number of incident reports over the past year documented issues with communication. We noted that ineffective involvement of patients in treatment and decisions was raised as a concern in the February CCG report into the maternity services at the Trust.

**Emotional support**

- Women could receive emotional support from various sources during their stay in the hospital.
- There were specialist nurses available to offer support and advice for both normal pregnancy and birth and when additional support was required, for example; genetic counselling and bereavement.
- The bereavement lead midwife offered support to women and their families who had suffered bereavement at any time during pregnancy. The bereavement lead midwife linked in with the fetal medicine unit and was able to offer support and counselling to women following discharge from hospital services. We were told that the service was flexible and operated according to the needs and wishes of the patients.
- We were told that frank and balanced discussions took place between the consultant, the women and their partner regarding options once abnormality detected. Women were given time to come to decision and if requested further discussions about results and counselling for inheritance studies was undertaken by the fetal medicine midwife. Any concerns about blood tests would result in a referral to geneticist and support offered.

## Are maternity and gynaecology services responsive?

Requires improvement

We found that some of the responsive aspects of the maternity and gynaecology care provided at the Queen Elizabeth the Queen Mother Hospital (QEQM) required improvement.

At the previous inspection we found there was a lack of capacity with the maternity units across the Trust closing on many occasions. There had been no change in this situation with over 88 closures or diverts happening in the past year. This reduced the choice available and meant that women in labour had to travel more than 30 miles to the next available hospital.

There also remained a problem with the lack of capacity with the x-ray departments' Trust wide, which meant that ultrasound scans were often delayed. This meant that women sometimes missed 12 and 20 week ultra sound and anomaly scan dates and were at risk from undiagnosed fetal anomalies.

We saw there was also a lack of obstetric theatre capacity as the QEQM Hospital only had one obstetric theatre. This meant that if a patient required emergency obstetric surgery elective patients were delayed. At the QEQM there were no dedicated facilities to care for women who had lost their baby during pregnancy or birth.

Both the midwife led unit and the consultant led unit had rooms with pool facilities and a variety of couches for women in labour. These were well situated and well maintained to offer women a real choice in how they wished to give birth.

The trust covered a large geographical area and maternity services had been arranged to provide ante and post natal care as close to the women's home as possible. Clinics took place in hospital settings but also in community settings such as GP surgeries and children's centres. The community midwives also offered a home birth service.

There were effective pathways of maternity care across the county. Women were able to access prompt antenatal care and there were systems in place for routine antenatal screening. There were pool facilities for women in labour both in the hospital and for women at home. This meant that women had the choice for a water birth no matter where they chose to have their baby.

There was good communication between the hospitals and the community with the community liaison officers coordinating the care of women and their babies.

There were arrangements in place to assist pregnant women with specialised needs, with specialist midwives available to support women in hard to reach groups.

The complaints system had been reviewed and the senior midwifery staff were now involved in addressing complaints and concerns and feeding back any issues to staff supported by the governance framework.

**Service planning and delivery to meet the needs of local people**

- The trust covered a large geographical area and maternity services had been arranged to provide ante and post natal care as close to the women's home as possible. Clinics took place in hospital settings but also in community settings such as GP surgeries and children's centres. The community midwives also offered a home birth service.
- Women were told they had a choice of giving birth in a midwife-led unit, a consultant led hospital birth, or a home birth. However in reality the choice was limited by geographical location, capacity of the maternity unit and the fitness of the mother and baby.
- Although the majority of obstetric interactions took place in the community we were told there was little cohesion across the county. The new community matron was working with midwives and local stakeholders to benchmark clinics, the on calls and care packages to ensure the same package of care was offered across the county to provide equity.
- The trust met formally with the commissioners, in order to inform the planning and delivery of local services. However concerns had been raised by commissioners that changes in the community midwifery provision had reduced the midwifery cover in parts of the county. One GP practice had raised concerns that they had received no official notification of the changes. The issue was raised at the EKHUFT Contractual Performance Meeting in January 2015.
- Between 09:00hrs and 16:00hrs, women who attended the emergency department for a suspected gynaecological problem were referred directly to the gynaecology assessment unit on Birchington Ward (Gynaecology). Outside of these hours patients were assessed by the emergency department staff and then referred to the gynaecology team if required. The patient remained in the emergency department until either admitted or discharged.
- Early pregnancy units and day surgery for gynaecology patients were provided on three sites at Kent and Canterbury Hospital, The William Harvey Hospital and the Queen Elizabeth the Queen Mother hospital. This meant that there was reasonable access across the county for women with gynaecology problems in early pregnancy.
- Inpatient acute gynae-oncology services were centralised at the Queen Elizabeth the Queen Mother Hospital for the whole of East Kent.

**Access and flow**

- We saw evidence of effective pathways of maternity care across the county. Women were able to access prompt antenatal care and the majority of women were booked before 12 weeks and six days and therefore received first trimester screening.

# Maternity and gynaecology

- There were systems in place for routine antenatal screening was in place which was managed by screening coordinators.
- During our inspection the day care ward was noted to be particularly chaotic with one midwife and a midwifery healthcare assistant attending to women who were constantly arriving at the unit; those with appointments, those who had dropped in and two women who were unwell and were waiting for the on call registrar to attend them. The phone was ringing constantly. There was no band 7 on duty or administrative support. Throughout this the staff remained calm and focused. They told us "it's not too bad today".
- Birchington Ward (Gynaecology) offered an early pregnancy assessment, which accepted patients directly if they fit the criteria. Women phoned for an appointment or accessed the unit via the emergency department out of hours.
- Terminations of pregnancy under 16 weeks pregnancy for fetal abnormality were undertaken either through the day surgery unit or Birchington Ward (Gynaecology). This was undertaken in liaison with the fetal medicine unit.
- Women accessed the main x-ray department for routine ultrasound scans and emergency radiological interventions; however staff told us there were capacity issues within the radiology department. There was a shortage of sonographers resulting in delays in ultrasound scanning. This meant that women sometimes missed their 12 and 20 week ultra sound and anomaly scan dates. The ultrasound scans are used as part of the screening process for Downs's syndrome and other fetal abnormalities. There was a risk that a baby with Downs Syndrome or other fetal abnormalities could be missed as scans carried out at other times during the pregnancy are less accurate.
- There were processes for midwives to refer women directly for consultant opinion at all stages of pregnancy and childbirth.
- When a women began labour she contacted the labour wards and let them know. The call was then triaged and the woman given advice about what to do next in accordance with their birth plan.
- Staff told us that the majority of women telephoned the delivery suite direct unless they went to the midwife led unit. The labour ward coordinator undertook a daily ward round at 8am every morning to coordinate the whole unit's activities, however we were told this was not always possible due to staffing considerations.
- The QEQM hospital only had one obstetric theatre at the QEQM for both emergency and elective cases. This frequently led to frequent delays to the elective caesarean list which was often not completed until late in the afternoon. On some occasions was a delay in the treatment of an emergency patient because an elective case was in progress. This had the potential for serious and significant clinical consequences. Staff told us that the obstetrics division sometimes used the main hospital theatres however as this was some distance away from the maternity department there were risks associated with a long transfer time. We noted this was included on the divisional risk register.
- On the gynaecology ward staff told us there were limited facilities for women who required surgery during pregnancy for such procedures as removal of retained products of conception as other surgical procedures took priority.
- Although Maternity Bed Occupancy fell in the last quarter of 2014/15, the bed occupancy rate was consistently worse than the England average. This meant that staff were under significantly more pressure when admitting and discharging patients.
- Maternity Units across the trust were closed 88 times over 2014/15. The unit was closed for a time during our inspection due to the special care baby unit being full. The unit closed for a variety of reasons including the labour wards being full, the neonatal intensive care and special care baby units being full and insufficient staff available. This reduced the choice available and meant that women in labour had to travel more than 30 miles to the next available hospital. During peak traffic times this could add a considerable amount of time to their journey to hospital.
- Patients told us how stressful and expensive it was to travel between the hospitals, how difficult it was travelling on the rural roads and the congestion and delays caused by delays on the motorway caused by Operation Stack (the diversion in place for the channel tunnel and cross channel ports).
- Managers told us that patient acuity tended to stop the flow through the department. Without a maternity dashboard they told us they didn't know what deliveries

were pending so made resourcing problematical. We saw there was a brief one page proforma on diverting patients or closing the unit to aid staff when the maternity unit was over stretched.

- The system for electronically allocating new born babies an NHS number was not functioning and this was being done manually. This resulted in delays and was potentially a risk for babies being discharged without an NHS number and being required to attend clinics following birth. The discharge clerk told us there was currently a back log of 20 baby notes waiting to be made up.
- Birchington Ward (Gynaecology) took outliers from other specialities such as medicine and surgery. We were told that these outliers were usually appropriate patients that the ward staff could appropriately care for, however unplanned admissions at night created problems with providing adequate staff and support.

**Meeting people's individual needs**

- We found that across the trust the clinical environment for looking after women's health was not always safe or meet best practice guidelines but was compromise between the available space and clinical function. For example there was a single obstetric operating theatre for both emergency and elective procedures. There was no second dedicated theatre. This led to frequent delays to the elective caesarean list and could cause delay in the treatment of emergency patient. Although staff told us a second theatre in the main theatres could be made available, this was not always possible and was a distance away. We were told that in extreme circumstances an emergency operation was performed in the obstetric anaesthetic room if no other theatre was available.
- There were no dedicated facilities for caring for bereaved women and their partners. This did not meet best practice recommendations. The Department of Health recommends that women and their families should have access to appropriate facilities should they suffer bereavement where they can grieve the loss of their baby at any stage of pregnancy. A woman who has lost her baby should not be accommodated on a ward/bed room where there are new mothers. Outpatient facilities should include quiet spaces for counselling in the event of bad news and the in-patient facilities should be away from the birthing area and include a separate exit from the ward, for use in the event of bereavement. This level of bereavement facility was not available at the QEQM Hospital.
- The delivery rooms on the labour ward were not en-suite which meant that women in labour had to cross the corridor to use communal facilities and there were no facilities for partners who often stayed for the duration of the women's stay in hospital due to distance.
- However both the midwife led unit and the consultant led unit had rooms with pool facilities with a variety of couches for women in labour. There were also portable pools for women to use in their own homes. These were well situated and well maintained which meant women had a real choice for a water birth no matter where they chose to have their baby.
- The labour ward included a three bedded induction room with a television area and access to an outside space. Staff told us this was especially valued by the women and their partners. The midwife led unit had four rooms, two with pools and provided a non-clinical environment with lamps, music systems and a bed settee for partners. There were facilities for patients and visitors to make hot refreshments if needed.
- There were arrangements in place to assist women with specialised needs such as bariatric equipment for women with a high BMI (Body Mass Index).
- Staff on the midwife led unit told us how they had helped to support women with special needs in labour. We saw feedback from patients with severe physical limitations who praised the staff for their help and support in safely delivering their babies.
- The ultrasound sonographers told us that where they identified a fetal abnormality during the ultrasound procedure there was rarely a fetal medicine midwife available to support the patient. They told us that previously a specialist midwife was available but now they were 'rarely in the building'. There was no immediate referral pathway to support women if the fetal medicine midwife was not available.
- There were lead midwives with responsibilities for hard to reach groups and vulnerable women such as those at risk from domestic violence and teenagers. Although there were no formal systems in place to access hard to reach groups, initiatives were starting to take place with midwives using social media and the internet to start dialogue and reach out to these groups.

- The trust had guidelines in place to help care for expectant mothers with mental health problems. A screening tool was used to help identify vulnerable women who may then be referred to local mental health services via the community mental health intake team. Mental health care plans were drawn up with input from the mental health team and shared with all healthcare professionals and a copy placed in the notes held by the patient. Joint visits were undertaken with the midwives and a mental health worker. We were told that midwives were supported with advice and consultation from the mental health team. Should a women's mental health condition deteriorate during pregnancy there were psychiatric pathways to refer to the mental health crisis resolution team.
- Staff told us that telephone translation services were available, although none of the staff we spoke with had accessed them. They told us they usually worked with the family, unless there were known tensions. Using a relative is not good practice, unless the patient specifically requests it, as there are issues of confidentiality. It is not always possible to be certain that the interpretation is correct and unbiased. Staff on the midwife led unit told us they used 'Flash cards' for many of the common words used.
- We saw that information leaflets were available in other formats such as Braille, large print or audio and the Trust could provide documents in various languages on request. The trusts website provided over 50 information leaflets relevant to pregnancy and childbirth.
- The Trust provided us with a copy of the bereavement leaflet given to women who had lost a baby during pregnancy or labour. We noted that the leaflet was a generic information leaflet and not suitable for parents who have lost a child. For example the leaflet talked about the removal of pacemakers, collecting the patient's property and jewellery, taking details of the person's occupation and pension to the registrar. This is not suitable or appropriate and may be distressing for a parent.

**Learning from complaints and concerns**

- The complaints process was outlined in information leaflets, which were available on the ward areas. We saw information on raising complaints readily available on all the wards and departments we inspected.
- Since the last inspection the Trust had put into place a new complaints policy. They also made it easier for patients and relatives to raise concerns either in person, by phone, by email or in writing.
- The senior nursing staff and managers told us that complaints were discussed at clinical governance meetings and information disseminated to staff through team meetings, briefings and the governance feedback bulletin 'Risky Business'. Band 7s now trained to respond to complaints so now more timely completion
- We examples of this in the June copy of 'Risky Business' where two complaints were highlighted together with the learning to be taken forward.
- Staff on both the obstetric and gynaecology wards were aware of the trust's complaint policy and how to facilitate patients if they wished to raise a concern or a formal complaint. They told us that they usually received feedback from any complaint they had been involved with. The ward staff told us they rarely received complaints. They told us that feedback was usually positive.
- Patients across women's services told us they would raise any issues or concerns with the ward staff in the first instance, but they knew there was a formal complaints process available if needed. We spoke with patients who had raised concerns, and they told us they felt listened to and their concerns addressed.
- Analysis of complaint themes over the past year showed that obstetrics and gynaecology received the greatest number of complaints in the specialist services division. Problems with communication, clinical management, staff attitude and delays in care were the highest recorded complaint themes for obstetrics across all the Trusts sites.

## Are maternity and gynaecology services well-led?

**Requires improvement**

We found the well led aspects of the maternity and gynaecology services offered at the Queen Elizabeth the Queen Mother Hospital (QEQM) required improvement.

Since the last inspection the midwifery service had been through a period of instability of leadership which led to a great deal of staff dissatisfaction and unrest. The Trust had

identified there had been a culture of bullying and harassment within the trust. They told us of the actions and initiatives that were taking place to address these concerns. The lack of leadership, culture of bullying and lack of strategic direction was felt throughout the midwifery team and although centred on the William Harvey Hospital, had impacted on the obstetric service at the QEQM Hospital. However since April 2015 a number of interim, acting and substantive posts had been filled and although a number of staff remained unhappy, progress was being made to stabilise the midwifery service. These issues had not affected the gynaecology services which had benefited from stable leadership for some time.

There was not a formalised vision and strategy for women's health services and hadn't been for the past two years, although work was starting on developing a common vision and framework for the community midwifery team.

Since the last inspection the governance framework had been revised and a governance lead midwife was in post working full time. There was now a system for reporting patient safety and clinical governance issues from the wards to the Board through the Clinical Governance Committee. Quality and performance data was starting to be used to inform service provision. Action logs were now in place that were regularly monitored, reviewed and updated.

The trust had various means of engaging with patients and their families. These included various surveys, support groups, the Friends and Family Test, inpatient surveys and the 'How Are We Doing?' initiative. The majority of feedback was positive and was reported back to staff, the trust board and commissioners, in order to inform priorities for improvements.

The Trust engaged with staff through team meeting, briefings, emails, team building exercises, conferences and a launch of a staff charter to encourage positive work place behaviour. The majority of staff were encouraged by these initiatives and told us the Trust was a good place to work and getting better.

Because of the leadership issues in the midwifery services in the past year there had been little focus on innovation and developing practice. However now the senior management team was becoming more settled managers were starting to involving staff in developing the service for the future.

**Vision and strategy for this service**

- We spoke with the acting head of midwifery, senior midwives and nurses in the midwifery and gynaecology teams. They told us that there wasn't a formalised vision and strategy for women's health services.
- In the absence of a formal strategy the acting head of midwifery told us that she was working to ensure there were 'the right staff in place across the trust at the right time'. The senior midwives we spoke with were aware of this priority and were working to ensure this was happening.
- However at the time of the inspection there was not a formal vision and strategy for maternity and gynaecology services and had not been for the past two years.
- The lack of leadership and strategic direction was felt throughout the midwifery team. For example front line staff told us they would carry on 'muddling through' until they were told otherwise.
- There was a lack of visibility of the consultant midwives. We spoke with one consultant midwife but did not get clarity on her role or remit although a job description was available.

**Governance, risk management and quality measurement**

- The acting head of midwifery told us that since the last inspection the governance framework had been strengthened and formalised. There was now a full time maternity governance lead who reported to the specialist services governance framework and through the trusts governance framework to the Board.
- We spoke with the governance lead who told us about the new governance framework and how they were working to embed a robust reporting culture within women's health. It was acknowledged that there was underreporting of incidents and actions were being taken across the Trust to encourage staff to report more non clinical incidents and near miss events.
- The Trust provided detailed information regarding the governance and reporting arrangements in the specialist services division. We saw that there was now a robust reporting system, with final accountability at board level.
- The Trust confirmed that although there had not been a formal written report sent to the Board detailing the maternity issues, the acting chief nurse and director of

quality and medical director had verbally reported the situation to the Board in June. We saw evidence of this recorded in the Board minutes. The minutes confirmed that external support was being provided to the midwifery service together with an external review.

- We saw from the minutes of various governance and risk management meetings that a range of patient safety and quality issues were reviewed monthly, including clinical effectiveness, reports from other sub committees such as mortality and morbidity meetings, health and safety, audits, quality and performance data, and infection control. Patient experience, training, HR, trends from complaints, patient surveys, risk and governance committee details were also reviewed monthly. We saw that action logs were in place to detail what should be done, by whom, in order to improve the service.
- We attended the specialist services divisional board meeting held during our inspection. This was the first meeting held since April 2015.We noted that governance, risk management and quality measurement were discussed. This included staffing and cultural concerns together with financial considerations and action plans. We noted that the majority of issues found at inspection were discussed in this forum.

**Leadership of service**

- Since the last inspection the midwifery service had identified serious issues with leadership and management. Although a new head of midwifery had been appointed, issues had been identified which meant they were currently on extended leave. The acting deputy head of midwifery was now acting as interim head of maternity and gynaecology. The senior midwifery team and clinical director acknowledged that there had been a loss of focus during the period when the head of midwifery was not actively in post.
- Between September 2014 and March 2015 there had been a period of instability of leadership which led to a great deal of staff dissatisfaction and unrest. Although this centred on the William Harvey Hospital, the effects were felt throughout the midwifery service including at the QEQM Hospital. During this period many midwifery staff had contacted CQC to inform us of the problems with the leadership. We were told that there were problems with staff attitudes, bullying and behaviours that were dealt with inappropriately.
- During the early part of 2015 a number of band 8 midwives had either left the service or been suspended. However since April 2015 a number of interim, acting and substantive posts had been filled and although a number of staff remained unhappy, progress was being made to stabilise the midwifery service.
- We spoke with the matron for obstetric services at the QEQM Hospital, who explained how they were moving the service forward through supporting the new band seven nurses, regular meetings, celebrating excellent practice at 'Afternoon tea' sessions for staff and organising staff appraisals, training and supervision. She told us of the excellent support the senior management team had given her since being appointed.
- Feedback from staff was that the leadership within the midwifery service was enthusiastic but inexperienced. This was acknowledged by the senior managers we spoke with, who told us about the actions they were taking to address this, such as having an experienced head of midwifery from outside the organisation mentoring the acting head of midwifery; ensuring new staff in management positions were undertaking leadership training and putting in place forums where the managers could meet and discuss any issues.
- We spoke with the Clinical Director for Woman's Health who had joint responsibility with the Head of Midwifery for overseeing clinical risk management throughout the maternity service. The clinical director had been in post for over eight years. They were focused on the medical aspect of women's health services and did not appear to undertake an active role in general clinical risk management and leadership of the service.
- The gynaecology services had benefited by having stable leadership for some time although gynaecology services were poorly represented at senior management level. To address this, the ward sister for gynaecology services had been promoted to matron and was now taking forward women's health issues.
- Staff told us that members of the Trust's senior management team were not visible on the wards. Staff told us their immediate line managers were visible as they were always on the wards and units and were well aware of the stresses and pressures they were under.
- We were told by staff working throughout the midwifery service that the consultant midwives were not a visible presence. They told us they did not see them supporting

the senior management team or the midwives on the 'floor'. For example staff working in the midwife led unit told us they had never seen a consultant midwife on the unit and didn't know what their role was.

**Culture within the service**

- The Trust had identified there had been a culture of bullying and harassment within the trust. They told us of the actions and initiatives that were taking place to address these concerns. This included team building exercises, improved communication; improved visibility of senior management team, education and development of nurse managers.
- The action to address the issues had been poorly handled within the maternity department resulting in many staff leaving the service, suspended or off sick. This resulted in a lack of leadership within the department for the past six months. From April 2015 the deputy head of midwifery had been appointed to acting head of midwifery, a number of appointments had been made at matron level and the service was recovering from the damaging past few months.
- We were told that although a bullying culture had been identified within the maternity department, at QEQM this was more linked to entrenchment of behaviour. Staff felt this was due to staff getting stressed when busy and then 'snapping' at colleagues.
- We were told that staff in the gynaecology services had not experienced these bullying behaviours.
- We received much feedback from midwifery staff relating to the past and present culture within the service. We spoke with some staff who told us that they had never known moral so low, that although the midwifery team got on well the lack of permanent leadership and direction over the past few months had meant that staff were still leaving or on long term sick. One midwife told us "I love my job but I really need things to change".
- Staff told us that in general there had been an improvement in the bullying culture as it had been recognised and was being addressed. However some staff told us that the attitude of one particular manager was very 'Blunt' which could be perceived as bullying. They gave examples of the way they were spoken to in front of patients and inappropriate language being used. They told us "We are still too scared to raise things because we have to work with the people after".
- We spoke with passionate and committed staff who spoke enthusiastically about the positive changes made by the new management teams. They told us "Things are finally falling back into place we feel more valued and listened to". They told us of regular team meetings to support new managers and leadership courses to develop their management skills. They told us that changes instigated by the interim chief executive were welcome and noticeable. One member of staff told us how they had chatted to the new chief executive at a development day and how he was visible and encouraged informal chats.
- We were told that the sickness rate had improved and was currently between two to three percent. With non-qualified staff slightly higher than qualified. This was an improvement from earlier in the year when sickness peaked at 23%.
- During the past year there had been 55 episodes of stress-related sickness taken by midwives. Staff sickness was above expected levels and had been for over a year. We were told that sickness absence had not always been managed in line with the Trust policy. The total number of individual midwives who were off with stress during the past year was 43.

**Public engagement**

- The trust had various means of engaging with patients and their families. These included various surveys, such as the Friends and Family Test, inpatient surveys and the 'How Are We Doing?' initiative.
- Feedback and comments from patients were also shared with patients and the public on posters around the hospitals, and in monthly updates available on the trust's website.
- The new 'How Are We Doing?'/Patient Experience survey questionnaires were now in use at all trust locations.
- The results of the surveys, feedback from complaints and the Patient Advice and Liaison Service, as well as patient comments, were reported back to staff, the trust board and commissioners, in order to inform priorities for improvements.
- There was a local maternity services liaison group where patients were asked to share their views or ideas on how to improve the local maternity services locally.
- The hospital held Birth After Thought sessions to debrief women following their birth experience. However the information from these sessions was not collated and disseminated for learning.

# Maternity and gynaecology

**Staff engagement**

- Following the last inspection the Trust had developed a staff charter from staff feedback on what a good working environment felt like. The aim was to encourage people to become more aware of the way they behave. A 'Respecting each other' campaign was started to encourage staff to sign up to the Staff Charter.
- Senior managers told us that during the past few months there had been a significant amount of support offered to staff once the scale of the leadership problem was realised.
- There were staff notice boards available throughout the maternity and gynaecology departments giving staff information about local and trust wide issues including training, development and team meeting minutes. This included the 'Women's Health' monthly update. We saw on the labour ward staff had given feedback on areas they would like improved. This included 'more time with patients, less paperwork; more positive praise and more staff and equipment'.
- We heard that regular staff meetings were held in all the departments however some midwives told us that they were always too busy to attend. Other staff told us the midwife meetings were poorly attended because of the large distances involved for staff to travel when they were not on duty. They gave examples of 26 mile round trips. However they told us that the minutes were emailed to all staff.
- We saw that minutes of the meetings were kept and made available to staff who could not attend.
- In the community we heard that team meetings now had a structured agenda and that midwives were encouraged to become 'Leads' in areas that they were passionate about.
- Although there were a lot of staff who remained unhappy following the leadership issues, feedback from staff was generally positive.
- We were told that staff working in obstetrics and gynaecology across the Trust were wearing an assortment of uniforms. It was raised as an issue affecting building a cohesive team and there was now a concerted effort to involve staff in choosing a new uniform for the division.

**Innovation, improvement and sustainability**

- The Trust had opened Improvement and Innovation Hubs to give staff the opportunity to learn about and to contribute to the Trust's improvement journey.
- A nurse, midwife and allied health care professionals conference was held to celebrate innovation and best practice. We were told how 'Care Giver' awards had been started to celebrate and acknowledge the work done by staff.
- However the leadership issues in the midwifery services meant that staff focus for the past year had been on maintaining a safe service and the day to day work, not developing innovative practices.
- However now the senior management team was becoming more settled managers were starting to involving staff in developing the service.
- We saw that lead midwives were working with other trusts for support and to improve practice. For example the lead bereavement midwife was looking at the records kept by other NHS trusts in order to improve documentation.

# Services for children and young people

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

## Information about the service

The children and young people's service at QEQM comprised a 20 bed children's ward with one high dependency bed. The children's ward cared for both medical and surgical patients. There was also a neonatal unit consisting of a 14 bed special care baby unit (SCBU) which included two high dependency beds and an outpatients department. A number of clinics were held every week in the outpatients department to see paediatric referrals and patients discharged from hospital requiring follow-up. QEQM treated 3,194 patients between July 2013 and June 2014.

Within the children's ward there was a two bed children's admissions unit (CAU) which was opened in 2014 and was managed by a children's advanced nurse practitioner (ANP). This enabled children to be assessed and treated directly by a paediatrician following referral from a GP; and meant children could avoid longer waits in the accident and emergency department.

We spoke with 11 parents, three young people and 20 staff, including consultants, doctors, nurses and support staff. We observed care and case-tracked two patients and looked at care records of three post-operative, acute and medical patients. We reviewed other documentation, including performance information, provided by the trust. We received comments from parents and people who contacted us to tell us about their experiences.

## Summary of findings

The children's and young people's service at Queen Elizabeth The Queen Mother Hospital (QEQM) requires improvement.

We found the safe and well-led domains required improvement. We identified some potential risks to children's safety due to an insufficient number of nursing staff in Rainbow ward and in the Special Care Baby Unit (SCBU).

There had been no never events and two serious incidents over a one year period. The latter had been thoroughly investigated and lessons had been learnt.

The environment was reasonably clean and tidy. There had been no incidents of Clostridium difficile (C.diff) or meticillin-resistant Staphylococcus aureus (MRSA) infection. However, the building was not always kept in a good state of repair.

The trust were using the Kent and Medway procedures for safeguarding. However, the trust did not have a children's and young people's safeguarding policy that was specific to the trust and provided trust specific guidance for staff. This meant staff would not have access to a safeguarding policy that was specific to the trust.

We found gaps on the checklist for the resuscitation trolley in June and July 2015. The trolley had not always

# Services for children and young people

been checked daily and this had potentially exposed patients to the risk of serious harm, if an apparatus required for resuscitation had gone missing or was not in good working order.

There was consultant cover seven days a week and all acute patients saw a consultant within 24 hours.

Staff had received mandatory training. The trust had conducted a gap analysis in regards to safeguarding training and work was in progress to ensure staff were trained in accordance with statutory requirements.

Staff had yearly appraisals and felt supported by their line managers, including newly qualified staff and junior doctors. Mentorship was in place for student nurses, who had good learning opportunities.

Staff had access to trust policies and procedures, which were in line with national guidance. Some national clinical audits had been undertaken and improvements had been made in clinical practice as a result.

There was effective multidisciplinary working, both within the trust and with external services.

Patients had open access to the Child Care Unit, once they had been referred by the family doctor. This meant patients did not have to wait long to be seen and parents felt there was continuity of care on the children's ward.

Mothers of babies in the SCBU were complimentary about the medical and nursing staff and felt their baby had received appropriate care and treatment. Staff treated patients and their family with respect and dignity and were compassionate in providing care.

In view of the various concerns raised, such as a prolonged period with insufficient staff numbers, some reported incidents on Datix being open since 2013, slow response in addressing issues raised, we considered senior managers had not acted fast enough to rectify the shortfalls and to ensure patients received safe and appropriate care at all times.

## Are services for children and young people safe?

**Requires improvement**

There had been no never events and two serious incidents over a one year period. The latter had been thoroughly investigated and lessons had been learnt.

The trust were using the Kent and Medway procedures for safeguarding. However, the trust did not have a children's and young people's safeguarding policy that was specific to the trust and provided trust specific guidance for staff. This meant staff would not have access to a safeguarding policy that was specific to the trust.

We found gaps on the checklist for the resuscitation trolley in June and July 2015. The trolley had not always been checked daily and this had potentially exposed patients to the risk of serious harm, if an apparatus required for resuscitation had gone missing or was not in good working order.

There was consultant cover seven days a week and all acute patients saw a consultant within 24 hours. However, most units had insufficient trained nurses in relation to the national standards. The service had relied on deft movement of nurses between units but this did not fully compensate for having inadequate staffing, which had put patients at risk of receiving inappropriate care and treatment.

Staff had received mandatory training. A gap analysis had been completed and work was in progress to roll out safeguarding training to medical staff to an appropriate level.

There was appropriate cleanliness and infection control systems in place. There had been no incidents of Clostridium difficile (C.diff) or meticillin-resistant Staphylococcus aureus (MRSA) infection. The clinical areas were clean and tidy. However, the building was not always kept in a good state of repair.

### Incidents

- No never events had been reported by the trust for the children's service in the period from January 2014 to May 2015 (STEIS & Never Events, June 2014 to May 2015).

- There were two serious incidents reported in the period from January 2014 to May 2015 (STEIS and Never Events, June 2014 - May 2015). Root cause analysis (RCA) investigations of both these serious incidents had been done and the final reports had been completed. The reports included recommendations, the actions to be taken and the lessons to be learnt.
- The trust had recently updated its root cause analysis policy in regard to the timeframe for completion of investigations from 45 days to 60 days, in line with NHS England guidelines.
- One of the serious incidents occurred in 2014. Following the RCA, there were eight recommendations and an action plan for both medical and nursing staff to address. For example, clinical leads were to ensure all staff were aware of all guidelines applicable to their speciality and how to access them. A teaching session on managing fluid and electrolytes had been given on the trust-wide child health audit/teaching afternoon. All nursing staff were to receive annual equipment competency updates. We noted that by 10 March 2015, 60% of doctors had attended this training. Lessons had been learnt from the incident and improvements had been made. There was a system in place to ensure all staff were compliant with yearly mandatory resuscitation training updates. A chart had been developed to record patients' blood gas analysis to enhance the timely identification of trends by both medical and nursing staff during the care of a patient whose condition was deteriorating.
- The RCA for a second serious incident in 2015, identified improvements were needed in clinical practice. Lessons had been learnt and recommendations had been made, which included: A full set of observations would be recorded for every child on admission, including taking the blood pressure (BP), repeated as clinically indicated and repeated on discharge. Dioralyte would be prescribed before completing the administration details. Medical notes must be recorded in accordance with good professional practice and details of advice given must be documented in the medical notes. The format of the PEWS chart needed to be reviewed. We noted that a revised PEWS chart was being drafted.
- All staff we spoke with said that they had been encouraged to report incidents using Datix, an online reporting system. Staff we spoke with confirmed they were aware of the action plans resulting from the two serious incidents in 2014 and 2015.
- We viewed the Child Health Briefing Paper, June 2015, this gave an overview of the incidents that had been reported by acute paediatrics and neonates from January 2015 to June 2015. This identified the highest categories of incidents as: medication and care treatment for acute child health; and medical devices and medication for neonates.
- The incidents spreadsheet showed that over the period January 2015 to April 2015, 29 clinical incidents had occurred in Rainbow ward. However, the lessons learned on the incidents spreadsheet had not been updated in 16 cases.
- There had been monthly mortality and morbidity meetings where minutes had been taken. We were told only medical staff attended the meetings.

### Safety Thermometer

- Over the period June 2014 to June 2015, Rainbow Ward had had no falls with harm, no new pressure ulcers, no VTEs, and no urinary tract infections associated with catheters.

### Cleanliness, infection control and hygiene

- All the ward areas, including the outpatient units, were clean and tidy.
- We noted separate hand washing basins and a dispenser for disinfectant gel were available and within easy reach in all the units. We saw staff regularly washing their hands and using disinfectant gel between patients.
- Staff wore clean uniforms with arms bare below the elbow, as required by the trust's policy.
- Personal protective equipment (PPE) was available for use by staff in clinical areas. We observed staff wearing PPE such as disposable aprons and gloves when required.
- There had been no recent cases of Clostridium difficile (C.diff) or meticillin-resistant Staphylococcus aureus (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.

- We were shown the daily cleaning schedule for the ward and the kitchen that was the responsibility of domestic staff from a contractual cleaning company. There was also a daily round by the domestic supervisor, who completed the supervisor checklist for the ward and the kitchen.
- We observed a weekly cleaning audit carried out by the ward manager together with the quality officer from the contractual cleaning company. The quality officer told us prompt action would be taken to remedy any cleaning problems found. Feedback received after the audit showed there had been no concerns raised. Areas checked included all ward areas, staff and parents' locker rooms, toilets, bathrooms, sluices and the clinical waste disposal facility.

### Environment and equipment

- The environment of each children's ward throughout the trust had been audited quarterly during the matron's walk-round. In February 2015 it was noted in Rainbow ward that some of the bed chairs for parents had rips and an action was raised to ask for authorisation to replace them as soon as possible. The carpet in the staff area was found to be worn and an action was raised to find better cleaning materials or to replace the carpet soon. It was also found that there was dust on some low ledges, especially in cubicles and an action was entered to raise the matter with the contract cleaning company. It was noted that several walls needed to be repainted, especially in cubicles and the paint on some window ledges was peeling. An action was raised for the ward manager to take up the matter with the trust's Estates team.
- The matron's walk-round in May 2015 showed that nothing had changed regarding the bed chairs, the staff area carpet, and the repainting but the dust problem had been dealt with.
- On the day of our inspection we saw that redecorating was in progress in Rainbow ward.
- The children's ward and the SCBU were secure. The children's department was accessed by entry phone or swipe cards.
- All equipment in use had been appropriately checked and cleaned and had been serviced regularly. However, gaps were found on the resuscitation checklist for June and July 2015.
- In the SCBU, a designated nurse had responsibility for checking and maintaining the monitors, incubators and ventilator. Staff had to demonstrate their competence in using the equipment and records demonstrated this had been done.
- A healthcare assistant (HCA) was responsible for cleaning all the equipment.
- The resuscitation trolley had not always been checked daily and this had potentially exposed patients to the risk of serious harm, if an apparatus required for resuscitation had gone missing or was not in good working order.
- There was a dedicated parents' room with facilities for making hot drinks.
- There was a separate room for women who wanted to express milk for their babies.

### Medicines

- Medicines were stored safely and securely on the children's wards and in the SCBU, in line with legal requirements.
- Fridge temperatures had been checked and recorded daily to ensure medicines were stored in line with manufacturers' recommendations.
- We checked the controlled drug register and found the recording had been accurate and had been checked by two staff members.
- Staff explained the procedure followed for medicines prescribed through the electronic discharge notification (EDN) method of information transfer. The EDN notified the GP at the time of discharge of all information including medicines regarding the patient.
- Patients waiting for medicines to take away (TTAs) upon discharge sometimes had to wait three to four hours for their medicines to be delivered from the Kent and Canterbury Hospital, where there was a pharmacy.
- The resuscitation trolley was within easy access and was shared between the CAU and the rest of the children's ward. We were told it was checked daily by a designated nurse and an HCA. However, we found the resuscitation checklist had four days of gaps in June 2015 (05, 17, 21 and 28 June 2015) and three days of gaps in July 2015 (02, 08 and 13 July 2015). We further noted that staff had not always signed the checklist after checking the trolley. The ward manager cross-checked the resuscitation checklist with the daily generic equipment checklist for the same two months and found the member of staff had in fact checked the resuscitation

trolley on 17 and 28 June and 08 July 2015 and had signed the checklist for equipment but not the checklist for the resuscitation trolley. The ward manager had since agreed to review the number of forms in use daily to avoid confusion in recording.

### Records

- Patients' records had been maintained by both doctors and nurses in the children's department. We case-tracked two patients' records, one in CAU and one in the children's ward.
- The ward used a paediatric medical and nursing booklet with sections for historical information, the initial admission assessment, the registrar's review/ management plan, the nursing care plan/evaluation, a general observation chart, a specimen collection chart, a fluid balance chart and the discharge plan. We randomly checked three of these documents and found them appropriately completed and maintained by staff.
- Additional forms were used for risk assessments for patients at risk of falls or of malnutrition. Pain assessments were recorded on the back of the PEWS chart. We saw that the observation records, including the PEWS charts, had been kept up to date.
- We noted all patients' clinical notes in paper format were kept in cabinets or trolleys within the nurses' station.

### Safeguarding

- 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 were 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 and provided trust specific guidance for staff working at Queen Elizabeth The Queen Mother hospital (QEQM) 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.
- 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.
- Staff could describe the referral process for alleged or suspected child abuse and knew the names of the safeguarding lead and those within the safeguarding team.
- The trust worked in partnership with statutory agencies such as the Kent county council and police to safeguard vulnerable children.
- Safeguarding training was provided by the safeguarding team, who also monitored safeguarding cases and updates.
- 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.
- There was a named safeguarding lead doctor.

### Mandatory training

- The trust-wide paediatrics balanced scorecard (also called the dashboard) showed 79% of staff had been trained in infection control. This data related to the year from July 2014 to June 2015.
- Staff were given two mandatory training days per year and encouraged to use e-learning for most topics on other days. The e-learning topics included food hygiene, record keeping, confidentiality, safeguarding and diabetes. Other training topics included communication, the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty safeguards (DoLs).

- All staff on Rainbow Ward had been trained in Paediatric Immediate Life support (PILS) which included simulation training.
- Members of staff interviewed said they had received mandatory training in topics such as moving and handling, infection control, safeguarding vulnerable adults and children, MCA and DoLs. For new staff these topics were included during the induction period.
- There was a good range of nursing competency documents in place. We reviewed the competency documents for some staff and found they had been completed appropriately.
- The HCAs had good support to develop their knowledge and skills. They had core study days together with the nurses and specific training days on topics such as breastfeeding, nasogastric tube feeding, making feeds for infants and the care of children with diabetes.
- We spoke to some HCAs who told us they were able to get competencies signed off. One HCA showed us their vital signs competency certificate dated 06/02/2015 and their blood clinic competency certificate dated 02/03/2015.
- Skills training days had been organised by the practice development nurse. The training could be about equipment in use or updated training on clinical issues and diseases such as respiratory conditions, diabetes and oncology.
- There were systems in place for monitoring training. Staff had access to e-learning, trust policies and clinical guidelines. However, staff reported that they were experiencing IT problems in gaining access.

### Assessing and responding to patient risk

- The children's ward used the PEWS chart to assess a patient's condition and to help staff recognise a deteriorating patient. The PEWS chart used depended on the age of the child: under 1 year, 1-5 years, 5 -12 years and 12 years upwards.
- The PEWS chart had directions for escalation. For example, if the score was 2, the nurse in charge was to review the patient and commence hourly observation. If the score was 3, a doctor was to review the patient and half-hourly observation was to be undertaken. If the score was 4, the registrar was called to review the case and to consider informing the consultant. If the score was 5 or above, the senior doctor was to see the patient immediately. If the airway was compromised, the registrar from the intensive care unit would be called immediately.
- A member of staff explained how they used the PEWS chart and the appropriate action to be taken if the PEWS score was elevated. We reviewed two PEWS charts in the children's ward, which showed that observations had been recorded in the appropriate time frames.
- The 2014 audit of PEWS recording indicated that in Rainbow Ward at 06:00am, 68% of PEWS charts were correctly completed, 77% had the triggers scored correctly; 96% had the correct response recorded. At 18.00pm, 86% of PEWS charts were correctly completed, 86% had the triggers scored correctly, and 100% had the correct response recorded. The audit led to a trust-wide action plan, which included retraining of staff on the importance of filling in the PEWS chart correctly, since an incorrect score could result in the patient not receiving urgent care in a timely manner.

### Nursing staffing

- The trust-wide paediatrics balanced scorecard (also called the dashboard) reported that the staff sickness rate averaged 2.6% for the period from July 2014 to June 2015.
- The children's services at QEQM used the Royal College of Nursing (RCN) guidelines on staffing levels. The RCN guidance recommended a ratio of nurses to patients of 1:3 for children under two years of age at all times and, for other ages, a ratio of 1: 4 during the day and 1:5 at night. The trust had not been compliant with the RCN guidelines for some time.
- Rainbow ward was a 20 bed unit, which could include one or two high dependency unit (HDU) beds if urgent cases arose. On the day of the inspection, the ward had 18 patients, five of whom were under two years old. There were no HDU patients.
- The nurses in Rainbow ward were all trained in paediatrics and all staff had a choice of three shifts, namely an early shift (07:30 to 15:20), a late shift (12:40 to 20:00) or a long shift (07:30 to 20:30).
- The ward manager said the staffing complement on the day shift was usually four nurses (one band 6 and three band 5s). In the winter months there was an extra band 5 nurse to accommodate increased admissions. The level of staffing we observed on the day of the inspection conformed to this staffing plan, although we

noted that, by late afternoon, the number of patients was down to nine. However, most days the ratio of nurses to patients was 1:5, whereas the RCN guideline stipulated 1:4. The nurses were assisted by a health care assistant (HCA band 3), an activity play specialist (band 4 part-time) or a play leader (band 2 part-time) and a ward clerk.

- At the weekend, the staffing complement was three nurses (one band 6 and two band 5s) and one HCA (band 3). This gave a ratio of 3:20 which did not conform to the RCN guideline of 1:4.
- The night shift comprised three nurses (one band 6 and 2 band 5s). There was one HCA to cover a twilight shift (20:00 to 01:00) three nights per week. Most of the time the unit was full. This meant that the ratio of nurses to patients was usually 3:20 which was non-compliant since RCN guidelines stipulated a ratio of 1:5 at night.
- The ward manager confirmed the service was not compliant with the RCN guidance on staffing levels as on most days the ward was full. Patients were therefore exposed to the risk of harm due to there being an insufficient number of skilled and experienced staff on duty.
- We were told the escalation plan had been triggered quite frequently to compensate for the inadequate staffing level by assessing patients' acuity and discharging patients early, instead of having a sufficient number of staff on duty at all times to provide safe care.
- The escalation plan specified that the staffing at each children's unit was to be monitored and RAG (red, amber, green) rated. Rainbow Ward was considered to be in amber status if bed occupancy was in the range 80-90%. SCBU was considered to be in amber status if cot occupancy exceeded 90% or the staffing was not adequate in relation to the acuity of the patients.
- The escalation plan specified the manager to whom the nurse in charge of the shift must escalate the status. Actions were taken to increase staffing and reduce patient numbers. For example, staff might be redeployed from less busy areas, or staff might be asked to work extra hours. Out of area referrals might not be accepted. Red status denoted a serious situation where further admissions might have to be referred to another hospital.
- The ward manager stated there had been a review of the staffing level for Rainbow ward during the week of our inspection. The last review was 18 months ago in 2013.
- We were told a business case had been submitted to the trust during the week of our inspection to request an increase in the number of nurses on night shift and at weekends by one extra nurse (band 5). We have yet to know the decision to be made by the trust board and the timeline in regard to the inadequate staffing level.
- Staff felt they all worked very well as a team to maintain the service. We observed a dedicated team of staff working together. There was a named nurse for every patient.
- The Special Care Baby Unit (SCBU) was a 14 bed unit, with two HDU beds. The SCBU staffing usually comprised three nurses (one band 6 or band 7 and two band 5) and one HCA (not for patient care) for the morning, three nurses in the afternoon and three nurses at night. The ratio of trained nurses to patients was therefore 3:14 for patients requiring special care.
- The British Association of Perinatal Medicine (BAPM) guidance on staffing levels recommended a minimum nurse to infant ratio of 1:4 for special care, 1:2 for high dependency care and 1:1 for intensive care. BAPM guidance had therefore not been followed.
- In the SCBU, the day shift was from 07:30 to 20:00 hours and the night shift from 19:30 to 08:00 hours. There was a flexible working shift, namely 07:30 to 15:20 and 12:10 to 20:00 hours. In 2014, the vacancy rate was 25% but in 2015 the rate had been brought down to 10%.
- On the day of our inspection, there were 11 patients, with two in HDU.
- The SCBU manager said there were insufficient nurses at the peak time and that the SCBU was short of band 6 nurses at night.
- The two bedded Child Assessment Unit (CAU) situated in one of the bays within the children's ward was managed by three children's advanced nurse practitioners (CANP band 7) who covered shifts across sites with three other CANPs based at William Harvey Hospital. There was one CANP and one nurse (band 5) per shift (09:00 to 21:00) providing cover seven days a week at QEQM.
- The Children's Outpatient's Department (OPD) held clinic sessions during the week. There were clinics for fractures and ear, nose and throat (ENT) and an orthoptist's clinic and an ophthalmologist's clinic. OPD was managed by a ward manager. The clinics were staffed by HCAs and a play leader. Potentially there was a risk in there not being registered nurses on site. However, the OPD was situated next to the children's ward where there were paediatric nurses.

# Services for children and young people

### Medical staffing

- Doctors were available 24 hours a day. There were seven consultants employed and there was consultant cover seven days a week under the consultant of the week system. The consultant of the week worked the day shift from 08:30 to 17:00 on weekdays and at weekends. Another consultant was on call out of hours each night.
- Junior and middle grade doctors worked their shifts on days or nights and each was allocated either to the children's ward or the SCBU during the morning handover. One specialist registrar said that when the unit was busy they were able to get help and support from the consultant on duty. Another doctor (ST2) on six months placement said there were good learning opportunities for doctors and a good working relationship among staff.
- The consultant of the week conducted two ward rounds each day on weekdays and one each day at weekends, so all acute patients were seen by a consultant within 24 hours.
- Medical handovers between the night team and the day team took place in the morning and a consultant was present.
- Children for planned surgery were seen by their consultant prior to admission and were seen by the anaesthetist in the unit before surgery. There were three orthopaedic patients for surgery on the day of our inspection. Visits from the surgeons took place outside main ward rounds.
- Patients in CAU were seen by a registrar and senior house officer on shift each day, following the initial assessment by a children's advanced nurse practitioner (CANP).
- We observed two patients in CAU who were seen by a nurse (band 5) within minutes of arrival before they were seen by a CANP who then referred the patients to the registrar on duty. This was in line with the trust policy on waiting times in CAU.

### Major incident awareness and training

- Each ward had a copy of the major incident policy, which had been updated in April 2015.
- All staff had watched a seven minute video to highlight major incident awareness, which showed the types of incidents to be prepared for and the roles of the staff.

## Are services for children and young people effective?

Good

The trust's policies and procedures were based on guidelines from national organisations, such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH) and NHS England. The trust had recently updated its root cause analysis policy in regard to the timeframe for completion of the investigation from 45 days to 60 days, in line with NHS England guidelines.

The British Thoracic Society paediatric asthma audit had been carried out in 2014 and improvements had been made to clinical practice as a result. Other audits included the National Paediatric Diabetes Audit and the National Neonatal Audit Programme (NNAP) 2014. There were plans in 2015 to carry out clinical audits on a number of illnesses in children using NICE assessment tools.

The risk assessment tools used for screening malnutrition had been recently implemented for children's services. All staff had received training in nutrition and hydration.

The children's service was consultant-led at all times. Staff reported good multidisciplinary working within the trust and with other healthcare professionals.

Parents felt well informed and their consent was sought before their child was treated.

Staff had yearly appraisals. All staff felt supported by line managers, including the newly qualified staff and junior doctors. Mentorship was in place for student nurses, who had good learning opportunities.

### Evidence-based care and treatment

- The trust's policies and procedures were based on guidelines issued by national bodies, such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH). Local policies were written in line with these. Most policies and procedures were up to date but some were currently under review.

- For example, the trust had recently updated its policy regarding RCA and had changed its timeframe for completion from 45 days to 60 days, following the latest guidelines from NHS England entitled 'What is a Serious Incident' and 'Never Events Policy'.
- Staff knew where to find policies and local and national guidelines, which were available on the intranet. However, staff reported access to the trust's electronic system 'SharePoint' was a problem. Most medical staff used their own smart phone to access NICE and other national guidelines.
- At the QEQM site there were plans in 2015 to carry out clinical audits on a number of illnesses in children, which included asthma, headache, epilepsy, meningococcal meningitis and fever, using NICE assessment tools. The speciality lead for each audit had yet to confirm if the audit was to be undertaken.
- Rainbow ward also carried out a weekly cleaning audit, a hand hygiene audit, a mattress audit and a care plan audit. An infection control audit had been carried out every six months. We were told an action plan was put in place whenever an audit showed improvements were required to remedy concerns found. For example, the infection control audit in June 2015 found the containers for children's toys were dirty and needed cleaning. This was actioned and completed before a follow-up audit was done in July 2015.
- 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

- During our inspection we had not seen any patient requiring pain relief. However, a member of staff showed us the pain assessment scale that was printed on the back of the paediatric early warning score (PEWS) chart.
- We noted the score ranged from 1 to 5 with score of one for no pain and a score of 5 for severe pain.
- In SCBU, mothers were taught to use kangaroo care (a technique where the baby is held skin-to-skin with the parent) as a means of helping to stabilise neonates and to promote intimacy between mother and baby. We observed a nurse assisting a mother to engage her baby in kangaroo care.

### Nutrition and hydration

- The children's menu had a number of choices and the menu card was given to patients in the morning to select their menu for the day.
- Hot meals were served twice a day and sandwiches and snack boxes were available throughout the day. The housekeeper said they also prepared and cooked hot food on site such as chicken nuggets and other favourite dishes that some children preferred, which were not on the menu. One patient said, "The food is good here. I enjoy it."
- We saw that children had drinks by their bedside.
- There were facilities for parents to make their own hot drinks.
- The SCBU had a milk fridge with individually labelled containers of breast milk. Breastfeeding mothers were given a voucher to use in the canteen.
- Staff had received training on nutrition and hydration. We were told patients were risk-assessed for malnutrition using the Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) and the Malnutrition Universal Screening Tool (MUST). Both tools had recently been implemented. STAMP is a validated nutrition screening tool for use in hospitalised children aged from 2 to16 years.
- Patients with poor food and hydration intake were observed closely. The care pathway observation chart included a section for nurses to monitor the food and fluid intake of these patients. This ensured that patients' nutritional and hydration needs were monitored and maintained.

### Patient outcomes

- We were told the trust did not currently benchmark the children's services. A benchmark is a method or tool to enable a unit to measure their clinical performance quantitatively against established national standards.
- The National Neonatal Audit Programme 2014 (NNAP), which covered the period from October 2013 to September 2014, was a national survey based on questionnaires given to a sample of patients using local neonatal units, special care baby units and neonatal intensive care units. Units were given a ranking in comparison with other units of the same type. We examined the data for QEQM. On most questions, the hospital ranked at the upper end of the midrange 60% of units.

- The hospital had the best ranking of all the units in: (a) not locating the mothers of babies in SCBU in the same ward as mothers who had their babies with them. (b) providing adequate privacy for breastfeeding and/or expressing milk. It also had a high ranking in: (c) explaining infection control practices to mothers and visitors.(d) informing mothers of any changes in their baby's condition or care.(e) giving mothers information about parent support groups such as Bliss or other local groups.(f) informing mothers as to what to expect regarding their baby's progress and recovery.
- It had somewhat lower ranking than for other issues on the following: (g) mothers being able to speak to a doctor about their baby as much as they would like.(h) doctors being sensitive to the mother's emotions and feelings.(i) confidence and trust in the staff caring for the baby.(j) providing enough space for the mother to sit alongside the baby's cot.(k) mothers being able to get answers they could understand about their baby's condition and treatment.(l) information being provided on help available with expenses related to the baby's stay in the unit.
- The report on the Clinical Audit Programme for Specialist Services 2014/2015 showed that 24 audits had been scheduled relating to child health: Four of these had been abandoned and one had not yet been started. However, 10 child health audits had been completed for 2014.
- The British Thoracic Society paediatric asthma audit (A/098/12) was completed in August 2014. This led to the following actions: (a) to encourage discharge planning and the use of asthma management plans. (b) to encourage the use of follow-up appointments with the specialist asthma nurse.
- The service participated in the National Paediatric Diabetes Audit 2013/2014. The diagnostic HbA1c is a measure of a patient's blood glucose levels. When a diabetes patient is appropriately cared for, this level should be kept within a certain personalised range. The maximum level is normally 58 mmol/mol. The trust achieved this for 15.9% of diabetic children. This was somewhat worse than the England average of 18.5%. The median level of HbA1c of the trust's diabetic child patients was 72 mmol/mol. This was somewhat worse than the England figure of 69 mmol/mol.

### Competent staff

- All the nurses in Rainbow ward were trained in paediatric nursing.
- All the staff in Rainbow Ward were trained in paediatric immediate life support (PILS).
- Rainbow Ward had three advanced nurse practitioners and a nurse who were trained in advanced paediatric life support (APLS). Five other nurses were trained in European paediatric life support (EPLS).
- The matron for children's services told us that more staff were currently being trained in APLS and EPLS. It was planned to have a nurse trained in APLS or EPLS on duty 24 hours a day, seven days a week. The availability of training places meant this would be achieved within the next 12 months.
- There was an arrangement with a London hospital for four nurses to attend a two day oncology training course every year. This enhanced nurses' knowledge and skills in caring for patients with leukaemia or other forms of cancer.
- Nurses in the SCBU confirmed they had undertaken the neonatal course. One nurse had completed a degree in neonatal nursing in October 2016 and had worked in SCBU for 18 months. Another nurse was a qualified midwife who wanted some experience in the care of neonates. They had been working in SCBU for six months. Both nurses said they had received plenty of training and study opportunities and had been involved in cross-site working.
- Staff told us they enjoyed working in the SCBU. They said all the staff worked well as a team.
- The trust-wide paediatrics balanced scorecard (also called the dashboard) showed that 83% of appraisals had been carried out for the period from July 2014 to June 2015.
- However, the ward managers in Rainbow ward and the SCBU said they had carried out appraisals for all their staff. The results of the appraisals had been recorded. Staff told us they had had appraisals with their line manager.
- Newly qualified nurses were also supported by undertaking a preceptorship programme and receiving support from a practice educator.
- Mentorship was in place for student nurses. One student nurse said they had been advised to report bad practice but to date they had not observed any.

- Student nurses felt well supported and said they had good learning opportunities and opportunities to gain experience. They said they were able to get competencies signed off by their mentors.

### Multidisciplinary working

- There was multidisciplinary working within the children's services, with other services within the trust and with external organisations. For example, the QEQM worked with the South Thames Retrieval Service, which was a children's acute transport service which specialised in the inter-hospital transfer of critically ill children. QEQM also shared paediatric and oncology services with two London hospitals.
- There were good shared care arrangements with surgeons, and other services such as surgical and orthopaedic services. On the day of our inspection, there were three planned orthopaedic cases for surgery.
- The children's service had access to the child and adolescent mental health service (CAMHS). We noted a patient was referred to CAMHS and seen by the CAMHS team the day after admission, before they were discharged home. Further arrangements were made for the patient to be assessed in their home environment.

### Seven-day services

- There was a 24 hour consultant-led service with medical and nursing cover for the children's services, seven days a week, although the nursing numbers were currently inadequate.
- The child and adolescent mental health service, allied professionals and other services provided seven day cover between 09:00 and 17:00.

### Access to information

- Staff could access trust policies, procedures and guidelines via the intranet and e-learning to complete their mandatory training.

### Consent

- Parents said their consent was sought before their child was treated. They felt they were well informed and had been given clear information before they signed the consent form for surgery or medical treatment.
- The ward manager confirmed that there had been no cases subjected to Deprivation of Liberty Safeguarding (DoLs). 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 child.
- Staff had received training regarding Gillick competence. These guidelines helped staff to balance children's rights and wishes with the responsibility of staff 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. Staff were aware that young people aged 16 and 17 were presumed to have the competence to give consent for themselves and they would be given the opportunity to do so. The trust policy specified that children aged between 16 and 18 would be given the choice to be treated in the adult wards.

## Are services for children and young people caring?

Good

The parents and children we spoke with were complimentary about the service. They said the staff were caring and reassuring and were unhurried in explaining the child's condition and the options available for treatment. Parents felt involved in decision-making about the care and support their child received.

Staff were attentive to the needs of parents and children. They arranged to feed a baby while the mother needed to sleep. Play specialists were employed to keep children occupied.

### Compassionate care

- Parents were all complimentary about the service and the staff who cared for their child. Both children and parents were treated with compassion, dignity and respect.
- A patient on Rainbow ward said, "I am comfortable. The nurses are good." Other comments from parents included, "Both the doctors and the nurses are nice. I am happy with the care and treatment given to my (child)." Another parent told us,"It's a lovely service. The staff make you feel welcome; they are always smiling and positive about things; they respect you and are very polite. My (child) gets along with the staff; they play with my (child) and reassured me as well." Another parent said, "SCBU is very clean and tidy. The staff are always friendly and supportive."

# Services for children and young people

- Throughout our inspection we witnessed good staff interaction with patients and those close to them. In one of the bays, we observed good, friendly, and appropriate communication between a nurse and two parents whose child had been recently admitted.
- The Friends and Family Test survey carried out in Rainbow Ward from 01 June 2015 to 30 June 2015 had 100 responses and was extremely favourable, with 99% of respondents being Extremely Likely or Likely to recommend the service to their friends and family.

### Understanding and involvement of patients and parents

- In the children's ward, the SCBU and the Outpatients unit, there was a good range of information leaflets on display, including information on various medical conditions and leaflets on how to make a complaint and how to contact the Patient Advisory and Liaison Service (PALS).
- Parents felt well involved in the care of their child and decisions regarding their child's treatment. They were well informed before they signed the consent form for surgery or other treatment.
- One parent said, "They keep me informed of the various tests done (for the patient). There is a four weekly appointment either in the outpatient clinic or in Rainbow ward. I am also able to contact the other hospital, where the main treatment is given, at any time."
- There was a named nurse for every child on Rainbow ward. Parents were encouraged to visit and stay with their children.
- The husband of a patient who had had a caesarean section was allowed to escort his baby to SCBU. He felt the doctor had explained very well their baby's condition, why the baby needed mucus removed through a syringe and why the baby needed a nasogastric tube. He saw that the baby's label was checked. Later, the baby was returned to the mother in the postnatal ward. The husband felt all the procedures had been followed safely.
- In SCBU a room was provided for mothers to express milk in privacy. A parent said she had received information about the unit on admission and she felt she had been fully informed of the care given to her baby.

### Emotional support

- Generally, staff were caring and supportive and offered emotional support to parents and their child.
- We observed a nurse in the SCBU assisting a mother to bond with her baby.
- Mothers were able to stay in the postnatal ward longer when their babies were cared for in the SCBU. Mothers who were fit for discharge were given their postnatal checks in the ward before they went home. Mothers could visit their babies in the SCBU at any time and they were able to stay with their babies throughout the day. Mothers who breastfed their babies were given a meal voucher to purchase food in the hospital restaurant.
- In Rainbow ward, one parent said, "The staff offered to look after my babies so that I could sleep; they took over the night feeds so that I could have a break. I was given the family room to rest." Another commented, "They explained what is happening; the staff are gentle and they tried to comfort my baby. They give me time to decide on things; I didn't feel hurried; staff are reassuring and very helpful."
- There were two play specialists working in Rainbow ward who offered children emotional support through play and therapeutic activities.
- There was access to CAMHS for children requiring psychological and psychiatric assessment.

### Are services for children and young people responsive?

Good

Patients received care and treatment that was personalised. The social and educational needs of children were met. Children were given a choice of menu daily and the menus included cultural dishes.

Staff said they worked well with local GPs, local authorities and other healthcare professionals to serve the local community.

There were a number of outpatients specialist services to meet the needs of the local community, including clinics for children with asthma, diabetes, ear nose and throat infections and eye conditions. There was also a follow-up fracture clinic.

# Services for children and young people

The children's ward had no single-sex provision for adolescents. However, a female teenager would be accommodated in one of the bays for younger children, if the bay for adolescents was occupied by male patients.

Translation services were available for patients and families for whom English was not their first language.

Parents were provided with information through a variety of leaflets. There was a leaflet with details of making a complaint and one on contacting the patient advice and liaison service (PALS).

There had been three formal complaints at QEQMH over the period January 2015 to July 2015. Of these, one was not upheld, one was partly upheld and for one the investigation was still in progress.

### Service planning and delivery to meet the needs of local people

- Both doctors and nursing staff said they worked well with local GPs, local authorities, and other healthcare professionals.
- We saw that a patient was seen by the CAMHS team within 24 hours of admission to Rainbow ward and a follow-up home visit by the Home Treatment Team (HTT) was arranged following discharge.
- There was good rapport with the community nursing service to ensure children with complex needs or who required continuing care were visited by the appropriate community team when they were discharged from the hospital.
- The OPD had a number of clinics to meet the needs of the local communities.

### Access and flow

- There was a good flow of patients in Rainbow ward, including day cases and inpatients, made up of medical and surgical cases, both elective and non-elective. Staff confirmed there had been no incidents of surgery being cancelled on the day.
- The children's ward provided a phlebotomy service twice a week and patients were given appointments to attend. The HCAs were well trained to run the clinic.
- Families did not have to wait long for appointments, once the patients were referred by their GP, as there was open access to the CAU, where children were seen by a nurse and a children's advanced nurse practitioner as soon as they arrived and usually by a doctor within one to two hours. This avoided the need to go to Accident and Emergency (A&E).
- Parents reported their child had received good continuity of care on the children's ward.
- Parents were aware of the plans for their child's discharge and felt well informed. They were given information about the community nursing service and referred to them if required.
- There were high rates of patients not attending clinics. The rates were RAG rated. Average rates were 10.74% for first appointments and 12.56% for follow-up appointments, placing these statistics in the red RAG status. The trust aimed to keep both rates below 7%. Rates between 7% and 10% were given amber RAG status and rates of 10% or above were given red RAG status. In December 2014 the trust began to roll out a new booking policy aiming to improve these rates by requiring parents of patients to actively confirm that they intended to keep an appointment.
- The paediatric balanced scorecard (or dashboard) trust-wide data from July 2014 to June 2015 showed 9.3% of non-elective patients were readmitted within 30 days. There were no elective paediatric patients readmitted within 30 days. The scorecard also showed the utilisation of theatres was somewhat low at 69%, being just in the red RAG band.
- The average cot occupancy of SCBU from April 2014 to March 2015 was 59.8%, peaking at 83% in January 2015, but falling to 36% in June 2014 and August 2014. For HDU, the average cot occupancy over the same period was 43.1%, peaking at 98% in July 2015, but falling to 5% in September 2015.

### Meeting people's individual needs

- Care and treatment records were personalised.
- The trust used the red book system. This was a book that the parent was asked to bring to each of the child's appointments, so that the doctor or nurse had a full picture of the child's medical history and could add an entry for the current appointment. This helped ensure that the child received appropriate care and treatment.
- Children with learning disability were given additional support by registered learning disability nurses who were accessible when required.
- Children had a choice of menu each day. The menus included cultural dishes reflecting the local community.

# Services for children and young people

- Children were given educational support during the week. All activities were documented in accordance with educational guidelines.
- In the children's ward, there was a three bed bay for teenagers but there was no single sex provision for adolescents. However, the ward manager said a female teenager would be accommodated in one of the bays for younger children if the bay for adolescents was occupied by male patients.
- The children's ward had an activity room with books, toys and games to entertain children in the ward. Two play activity specialists covered the ward to assist children in the play area.
- In the bay for teenagers there was a pool table. DVDs, games and play stations were also available.
- In the children's ward, parents could stay overnight, next to their child's bed.
- Children with mental health issues were given access to CAMHS. Support was available for patients with a learning disability or physical needs.
- Translation services were available for patients and families for whom English was not their first language.
- There were information leaflets available for many different medical conditions, including diabetes and blood glucose testing.
- In the SCBU, parents had access to leaflets explaining visiting times and ward routine and providing medical information to help mothers care for their babies.
- The fracture clinic was situated in a newly refurbished environment. We saw a child playing with the toys and games provided in the waiting room. The plaster room was well equipped for children. We observed the efforts the staff had made to make the plaster casts child friendly.
- The risk register of the Children's Services Improvement and Assurance Board identified on 06 February 2015 that there was no separate children's waiting area in the Ophthalmology department.
- There was no dedicated bay for surgical patients in the children's ward. However, in the day surgical unit, there was a dedicated bay for children having day surgery. The unit had three children's trained nurses to support patients and their families.

### Learning from complaints and concerns

- Staff said any concerns or complaints raised would be discussed at team meetings and any lessons learnt.
- Complaints had been investigated and responded to within 28 days, in accordance with the trust's complaints policy and procedures.
- There had been three complaints at QEQM over the period January 2015 to July 2015. Of these, one was not upheld, one was partly upheld and one investigation was still in progress.

## Are services for children and young people well-led?

**Requires improvement**

The trust had a vision statement and a strategy with a number of priorities, one of which was to improve the quality of the service. The trust had undertaken work on a children' and young people's strategy. Staff told us this strategy had been abandoned in the week prior to our visit

There were issues with staffing levels and the way incidents were managed which meant a high standard of clinical quality would be unlikely to be achieved.

There was a clinical governance system in place. There had been regular clinical audits. Risks had been identified and had been entered in the risk register, and had been assessed and responded to. However, evidence showed needed actions that had been correctly identified were often not carried out in a timely manner by middle managers. This meant improvements were not forthcoming.

Staff found their line managers supportive. Multidisciplinary working was effective. Regular staff meetings had been held to address local issues and to see if any lessons could be learnt. However, the child health matron and the SCBU matron each covered four locations and had to prioritise their visits to each location. This meant managers were dividing their time between multiple locations. Staff at QEQM said they did not often see the matrons.

The trust was accredited to Stage One in the Unicef Baby Friendly Initiative, concerned with promoting breastfeeding and was due to be assessed for Stage Two and training was in progress towards this end.

# Services for children and young people

### Vision and strategy for this service

- 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 experiences and clinical effectiveness.
- The trust had undertaken work on a 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 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.

### Governance, risk management and quality measurement

- Systems were in place for clinical governance. There was a monthly clinical governance meeting, at which issues were discussed by senior staff members and decisions were made to improve care and services.
- Local management and staff teams had regular meetings to address local issues and to discuss lessons learnt from RCA investigations of serious incidents and other relevant matters that arose. Information from the trust was also cascaded down to frontline staff at these meetings.
- Risks had been identified and a risk register had been kept of identified risks, such as an insufficient staffing level. However, the staffing issue had not been resolved.

### Leadership of service

- There were clear line management arrangements. Staff knew the chief executive, the senior matron, the director of nursing and the general managers of the directorate. We were shown the organisation chart, which was on the notice board.
- Junior doctors and registrars said the consultants were approachable and supportive.
- Staff said they found their line managers supportive and felt they managed the units as well as they could to ensure patient care was not unduly affected by the inadequate staffing level.
- Staff said they did not often see the matrons. The senior matron was based at William Harvey hospital, the children and young people's matron was based at QEQM. Both matrons managed other locations across the trust, and this involved considerable travel. It was therefore difficult for them to have sufficient presence in all the locations to influence significantly the care provided. A matron said they tried to see the band six nurses every two to three months to improve communication across the wards.

### Culture within the service

- The trust had embarked on an improvement agenda. This included the launch of a culture change initiative in January 2015. As an aspect of this teams and departments were encouraged to get to know each other, develop better working relationships, and to facilitate channels of communication between departments and teams.
- However, often needed actions had been correctly identified but there had been undue delay in carrying them out, to the detriment of the service, for example, some reported incidents on Datix had been open since 2013 and in May 2015 there were 232 cases on Datix that needed to be reviewed and themes had yet to be identified. This meant that improvements had not been forthcoming.
- Although an environmental audit had been undertaken every three months, the premises had not been maintained in a timely manner. For example, the environment audit on Rainbow ward in February 2015 stated that several walls and window ledges had paint peeling off, there were ripped bed chairs and worn out carpet, which could be seats of infection. A request for action was made but three months later in May, the same problems remained. There seemed to be little effort made to ensure the required action was carried out promptly.
- The recent staffing review, which led to a business case being submitted to the trust executive board at the time of our inspection, was done after a lapse of 18 months. Often the escalation plan was used when the staffing level was a problem and some patients would be reassessed for early discharge.
- A high standard of clinical quality would be unlikely to be achieved in the children's service until the issues regarding staffing levels and incidents were addressed. The backlog of reported incidents on Datix needed to be processed urgently and appropriately, so that themes were identified and improvement plans were delivered in a timely manner.

# Services for children and young people

### Public engagement

- Patients and their families gave positive feedback about the care and treatment received.
- The results of the Friends and Family Test (FFT) were publicised on the information boards in children's services.

### Staff engagement

- Frontline staff felt they provided good care and interacted well with patients and the community they served.
- Staff we spoke with told us the trust had held focus groups with staff in regards to the trust's change agenda. Staff told us the trust had held a number of focus groups in the past 12 months.

### 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 Unicef Baby Friendly Initiative is concerned with promoting breast feeding among new mothers. The trust has been accredited to Stage 1 since April 2012. The trust was now due to be assessed for Stage 2 and training was in progress towards this end.
- The Children's Services Improvement and Assurance Board met regularly to discuss possible risks and to discuss what action needed to be taken to improve the service.

# 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

Queen Elizabeth the Queen Mother Hospital (QEQM) had a specialist palliative care (SPC) team led by a nurse consultant in palliative care medicine 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 hospice. There were 818 deaths in the Queen Elizabeth the Queen Mother Hospital from April 2014 to March 2015.

We visited a variety of medical and surgical wards including: Minster, Seabathing, St Augustines, St Margarets, Fordwich, Deal, Bishopstone and Critical Care. 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 service of five patients. We observed care on the wards. There were no patients receiving end of life care on the day of our visit. We received comments from public events we attended and from people who contacted us individually to tell us about their experiences. We spoke with 42 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. Patient records demonstrated discussion with patients and families regarding care and treatment. 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.
- Staff told us that they reported incidents such as falls.
- We were told of a recent serious incident regarding nasogastric feeding that was under investigation and had prompted discussions within the medical and nursing teams.
- 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, one of which related to Queen Elizabeth the Queen Mother Hospital (QEQM) with appropriate action and learning completed.
- The Trust reports for April 2014 to July 2015 consisted of 19 incidents, ten of which related to QEQM. All had actions and learning recorded with two making reference to confusion regarding recent changes to the last rights procedure. One was the same incident as that on the contracted company report. Over half the incidents reported during this period were reported at this hospital but it was not clear whether there were more incidents or better reporting by staff.
- 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.

### Environment and equipment

- The mortuary had a 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 electrical works undertaken on 18 June 2015. A chiller hire collection notice was dated 30 April 2015.
- 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

### Medicines

- One of the clinical nurse specialists was a nurse prescriber which meant that, for the end of life care patients they were managing, appropriate medicines could be prescribed and administered in a timely manner.
- 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 five patient records. We found that record keeping was of a good standard. DNACPR forms were dated and signed by senior doctors, were clear whether the patient had mental capacity or not and demonstrated discussion with patients and/or families. These decisions and discussions were also documented in the patient record.
- The trust had a specialist palliative care referral form and we saw these well completed in patient records we looked at.
- We saw the multidisciplinary checklist summary for patients being discharged from hospital at the end of life with rapid discharge home guidelines and that these had been completed.
- 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.
- Mortuary staff provided relevant training that formed part of the mandatory training programme for porters who worked in the mortuary.
- 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.

### 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. However, some wards had limited side rooms, such as St Margarets ward.

# End of life care

- 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.
- We also found that some wards were using a flow chart together with the end of life care folder.
- We were told of an example where nursing staff considered a patient for end of life care but this decision was not made by the medical staff. Concerns regarding prompt identification of patients who have entered the last stages of their life were identified in audits carried out such as the snapshot audit of cardio pulmonary resuscitation attempts.
- We saw evidence where end of life care needs were identified 24 hours before death. Delayed identification has the potential to limit assurance that care and management, including preferred place of death, are carried out in line with the patient's wishes.
- We also saw examples where there had been extensive multi-disciplinary input from physiotherapy, speech and language therapy and dietician during the active phase of management. There was evidence of identification of deterioration.
- We visited one ward out of hours on the unannounced visit. Whilst the two registered nurses were one bank and one agency staff they had worked previously on the ward. The three non-registered staff were also not permanent. However, a patient on end of life care had arrived on the ward with their syringe pump and pain relief prescribed and a DNACPR in place. The staff set up the pump and we saw that the patient had been regularly monitored and was comfortable. The patient was awaiting placement in the community.
- 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 ongoing 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.
- 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 QEQM from the hospice. The hospice is on the hospital site so there was easy access to the medical support. 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 ongoing 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.
- We saw evidence of an end of life care audit carried out on Sandwich Bay ward in October 2014 and again in

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April 2015. The audit included knowledge and competency in use of syringe drivers, the principles of caring conversations and understanding of the discharge home to die guidance.

**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.
- We saw examples where dietary needs had been catered for and patients' food and fluid intake monitored in the patient records we looked at.

**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. QEQM results demonstrated 92% for completion of the reason for DNACPR and 100% signed by a health care professional, to 56% 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.
- A junior doctor told us that they had a personal interest in EOLC. They had spent a week shadowing at the local hospice, using part of their annual study leave.
- A registrar demonstrated anticipatory medication prescribing and stated that they felt confident in managing end of life care.
- On Deal Ward we saw that the ward manager and deputy were trained as syringe driver super users so that they could train other staff on the ward.
- We saw an example of staff competencies in medical devices that included infusion devices and syringe driver. There was a relevant list of devices for all registered and non-registered nursing staff.

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- Two non-registered nurses had attended an end of life session run by the hospice. Documents from the study day were on the ward as support and information for nursing and medical staff.
- We were provided with evidence that 31 QEQM 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. 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. One of the five porters involved in transferring deceased people told us that they did not wear gloves when assisting nursing staff on the wards. This was an infection control concern as they came into contact with bodily fluids. This was raised immediately with the managers concerned and the trust so they could take action. The process and guidance produced by the contracted company in June 2015 specifically stated that disposable gloves be used before handling a body.
- 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 William Harvey Hospital 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.
- We were told that the gastroenterology team worked closely with the hospice and were well supported by the clinical nurse specialists and the substance misuse nurse.

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- 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.
- We observed good working relationships between mortuary staff, the police and undertakers. They also worked with pathologists, both internal and external.

**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.
- 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.
- We saw that the Sandwich Bay ward manager had organised “tool kits” so that staff could access relevant information in one place on the nurses’ station. These tool kits included the end of life care conversation form, fast track discharge paperwork, relative support booklet and prompts for staff.
- 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.
- 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 (DoC) 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.
- One junior doctor we spoke with demonstrated good knowledge of DoC and described a recent example of an apology and explanation regarding a delay in diagnosis for a patient.
- We saw a total of five DNACPR forms that were filed in the front of the patient notes, fully completed, signed by a senior doctor and demonstrated discussion with the family.

## 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.

# End of life care

Patient records we reviewed evidenced discussions with patients and families regarding DNACPR decisions and management of care and treatment.

**Compassionate care**

- 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. 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.
- Other wards had quieter en suite side rooms to support patients at end of life.
- The viewing area in the mortuary was clean and of a neutral décor. 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**

- There were no patients receiving end of life care for us to speak with on the day of our visit.
- However, we saw clear recording of discussions with patients and their families regarding DNACPR decisions and management of care and treatment in the patient records we looked at.
- We found an example where a copy of the palliative care notes had been provided to a patient's family. The SPC team worked with families to ensure they were as involved as they wished to be.
- 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.
- The SPC team, including the 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. It was a contemporary chapel for all faiths or no faith. There was a memorial book. 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 Kent and Canterbury 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.

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- 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.

## 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.

### 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.
- 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 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

# End of life care

- 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.
- The Chaplain was available on site from 9am to 5pm Monday to Friday. An on-call service was provided for out of hours.
- There were 72 spaces in the mortuary fridges, three of which were wider to accommodate bariatric bodies.
- 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 QEQM) that was coordinated by WHH mortuary staff. This ensured that arrangements could be made for requesting extra spaces if this was required.
- A daily list for post mortems was prepared and the bodies placed in the fridges that had doors at both ends to facilitate transfer into the post mortem room. This was the largest and busiest mortuary within the trust.

### 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 16 complaints of which five concerned QEQM. Four of the five complaints were not upheld following investigation.

## 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 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.
- We were told that the improved office space for specialist palliative care nurses facilitated more efficient working.

**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 ongoing 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

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.
- Staff stated that there had been no consultation prior to the changes.
- 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.

**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 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 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 of which 249,172 appointments were at QEQM. Of these appointments 62% were follow up appointments, 30% were first appointments, 7% were appointments that patients did not attend, and 1% were cancelled by the patient.

Outpatients services were undergoing an improvement programme which included the reduction of the number of facilities used for out-patient clinics from 15 to six; William Harvey Hospital (WHH) in Ashford, Kent and Canterbury Hospital (KCH) in Canterbury, Queen Elizabeth Queen Mother Hospital (QEQM) in Margate, Royal Victoria Hospital (RVH) in Folkestone, Buckland Hospital in 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.

Outpatient services are located over two floors with three outpatient areas. They all shared one reception desk located at the entrance to the department.

The trust offered outpatient appointments for all specialties where assessment, treatment, monitoring and follow up were required. The hospital offered clinics in haematology, colorectal, ear, nose and throat (ENT), urology, general surgery, rheumatology, respiratory, endocrinology, medicine, neurology, dermatology, diabetes, pain, vascular, and gastroenterology.

During our inspection we spoke with nine patients, two relatives, and 49 members of staff. Staff spoken with included reception and booking staff, clerical and secretarial staff, nurses of all grades, doctors, allied health professionals and consultants. We observed care and treatment. We received comments from our staff focus groups and we reviewed performance information about the department and trust.

The radiology services at this site provide general x-ray, MRI, CT, obstetric and general ultrasound. The department offered a seven day a week service, from 8am to 8pm, Monday to Friday and 8am until 4pm at weekends. The department performed 179,000 examinations in the year 2014/15. The Trust sent us information on issues such as performance, and data from focus groups, which we analysed before inspection. During the inspection, we observed interactions between patients and staff as well as inspecting the environment where services were provided.

# 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, 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 through structured audit and review

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.

As a part of the strategy, the trust had reduced 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.

Outpatients and diagnostic imaging departments at Queen Elizabeth Queen Mother Hospital were providing safe care to patients. 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 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 the 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

Outpatients at Queen Elizabeth Queen Mother Hospital were providing safe care to patients. There were systems in place, supported by adequate resources, to enable the department to provide good quality care to patients attending appointments. We spoke with staff of all grades and disciplines across the outpatient areas and were told that the majority felt the department was adequately staffed to meet patients' needs.

We found that the environment was safe and the required safety checks were being completed and recorded. The department was 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.

There was room for improvement in the dirty utility area of Walmer A and B. The room currently used was not fit for purpose and posed a cross contamination threat. We observed that 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 also well maintained in line with appropriate legislation and guidance. Systems for ensuring staff had appropriate training were well embedded, but at the time of reporting we had not received the mandatory training data that had been requested.

**Incidents**

- During the last year there had been one serious incident reported in outpatients about an appointment delay. We were told that all incidents were investigated and were given evidence of this including action plans which showed learning from incidents.
- The matron told us they received regular reports of incidents and this enabled them to identify themes and trends and take corrective actions. 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.
- Incidents were reported via an electronic incident reporting system in line with Trust policy. 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 informed us they were encouraged to report incidents which occurred in their working area. All of the staff we spoke with were 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 services 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 an evidence of learning as a result of incident reported and investigated by the department.
- The matron demonstrated a knowledge of duty of candour regulations and their responsibilities in relation to this.
- In the imaging diagnostic department, staff we spoke to reported they had received training in reporting incidents and were aware of how to record and report incidents on the electronic reporting system. They advised us that the system automatically sends them feedback once the issue has been dealt with and closed. 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.

# Outpatients and diagnostic imaging

### Cleanliness, infection control and hygiene

- Concerns raised about the dirty utility in the Walmer A and B areas of outpatients had not been addressed since our last inspection. The dirty utility did not have a door, leaving open access into a patient waiting area. The area also stored both dirty and clean equipment and was being utilised as a multipurpose storage area. This remained on the risk register as it had been at our last inspection. Staff were not aware of any plans to address this matter. This did not comply with HBN 00-09 "Infection control in the built environment section 3 storage" which states that "clean and dirty areas should be kept separate and the workflow patterns of each area should be clearly defined. The design and finish of ancillary areas should facilitate good cleaning. They should have facilities for hand-hygiene and sufficient storage for supplies and equipment."
- The overwhelming majority of staff we observed in the outpatient clinics and diagnostic imaging department 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. We observed staff in the outpatient clinics 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 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 clinic areas and diagnostic imaging department 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 diagnostic 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 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. We noted that green labels were placed on the equipment that had been cleaned and was ready for use.
- The department audited sharps disposal bins monthly to ensure that they complied with best practice. Where issues were raised during audit, they were dealt with directly by the nurse managing the audit.
- We observed that there was a check list in place in the department to provide assurance that equipment and rooms had been cleaned. Despite having this in place, the check list had not been completed for the week prior to our inspection.

### 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. In the diagnostic imaging department the resuscitation trolley had a daily check list. However, over the last three month period, there were 17.5 days where there were gaps on the checklist and there was no evidence that the trolley had been checked on these days.Other equipment was visibly clean, regularly checked and ready for use.
- Audits of resuscitation trollies were completed monthly across outpatients and diagnostic imaging departments. Review of these audits evidenced that staff took remedial action where they found issues during these audits.
- We observed 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.
- 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.

# Outpatients and diagnostic imaging

- 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.
- The matron and sister completed a monthly environmental audit where they inspected the 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.
- 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%.
- We observed that the diagnostic imaging departments environment was spacious and that x-ray was conveniently situated close to the emergency department . We witnessed a patient receiving a very efficient service coming through the emergency department in to radiology and then back again.
- The ultrasound waiting area was full, but every patient had a seat. Equipment was serviced regularly and a service contract was in place. We looked at a wide variety of equipment and it had all been checked within a year.
- The Ionising Radiation Regulations 1999 state that designated areas must ensure that levels of ionising radiation are adequately monitored for each area and that working conditions in those areas are kept under review. We observed compliance with radiation regulations during our visit. The department displayed clear warning notices, doors were shut during examinations and warning lights were illuminated when in use.
- Staff reported some difficulties with the computer system, for example taking a long time to login, as well as the system regularly crashing. We were advised that this was being dealt with at an operational level.

**Medicines**

- Medicines were stored in locked cupboards in the outpatients department. 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. We looked at temperature records and saw they 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. We found the medications stored in the department were within their expiry date and stored securely. This ensured the efficacy of the medications stored.
- 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**

- 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. All staff reported a marked improvement in the availability and quality of patient health records.
- 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.
- 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 48 hours 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 made 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 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.
- There was a system where temporary notes were highlighted on the system and when the originals were found they were merged and duplicates destroyed.
- The department was 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 in diagnostic imaging department were stored securely on a Picture Archiving Communication System (PACS). Staff had access to previous examination results on this system, enabling 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. 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.
- 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 attending regular meeting to ensure they were updated with most recent best practice guidance. They shared their learning with the rest if 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 they had gained from this training
- Staff advised us that safeguarding is a part of their mandatory training. In the diagnostic imaging department we witnessed a child who was in a considerable amount of pain being brought into the department without their parents present. We witnessed a thorough assessment of the child's

competency in order to consent to an investigation, treatment was given as soon as possible. We saw that staff are available throughout the day to provide a chaperone service.

**Mandatory training**

- 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.
- Staff knew how their training was monitored and confirmed that managers reminded them when training was overdue and needed to be completed.
- 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.
- 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%.

**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 that staff were assigned to monitor the waiting area in radiology, this meant that they were able to assess and monitor potentially unwell patients.

**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.
- 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 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.
- The senior sister in diagnostic imaging department reported that they are currently at 49% staffing. Due to staff shortages she was standardising staff skills in order that they could be transferred to different sites if required.

**Medical staffing**

# Outpatients and diagnostic imaging

- 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.
- 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, the matron used this data to discuss changing the templates to reflect this demand with divisional leads and consultants.
- The General Manager informed us that the interventional radiology staffing level is currently on the risk register as the numbers are so low, but that this is a national problem and there are plans in place to recruit from abroad. A radiologist is available at weekends across the sites in order to answer any queries from staff, however some staff advised us that there is often a delay of two to three hours for CT requests to be dealt with.

### Major incident awareness and training

- The trust had a business continuity management plan which had been approved by the management team. 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. We observed that patients received effective care and treatment in line with national guidelines.

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. Patients were provided with sufficient information about their treatments and had the opportunity to discuss any concerns.

QEQM ran a one stop clinic for Dermatology and Urgent Skin Cancers, and cardiology. 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 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.

### Evidence-based care and treatment

- 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 OPD assessed each patient who accessed the service to established whether they would benefit from a referral to the smoking cessation service. Staff would refer patients to the service when indicated.. 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%.
- At QEQM staff were piloting best practice guidance assessments on patients going through the department regarding their alcohol intake. Patients who were indicated were offered a referral to alcohol services.
- 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 (a weighted scoring system based on indicators such as; temperature, BP, heart rate, oxygen saturation) to allow a graded response to patients who became unwell in the department.
- Staff in the department demonstrated a working knowledge of NICE Guidance for recognising and responding to acute illness in adults in hospital. Staff advised us that the World Health Organisation (WHO) checklist for non interventional radiology was being completed. In addition to this, an audit is completed each month to ensure that the WHO checklist documentation is securely stored on the computer system. We observed patient identification checks being carried out prior to examinations being done. We observed IR(ME)R checklists being completed prior to examinations being undertaken in accordance with IR(ME)ER (Medical Exposure) guidelines.

**Pain relief**

- The diagnostic 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 the 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 on-going 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 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.

**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. 90.19% of nursing staff across outpatients were up to date with their annual appraisal. All staff we spoke with told us they were well supported by colleagues and by their managers.
- Staff throughout the outpatients 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 who ensured that competencies were in place and up to date for all staff. Staff in the diagnostic imaging department were assessed annually when their registration was verified.

- Staff were 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 health care assistants, 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. The 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 undertake modules that were specific to their own working environment. The matron was ensuring that these modules would assist with the department's 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 that would improve pre-assessment clinics. This would enable when 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 at the same appointment reducing the need for separate appointment at the hospital.
- Outpatient audited the checking process for trained nurses being updated with 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**

- QEQM ran a one stop clinic for dermatology and urgent skin cancers, and cardiology. 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.

**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.
- The 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.
- Services in diagnostic imaging department are available seven days a week for twelve hours a day, however there was no reception staff available after 4pm, and no

assistants were available to work at weekends. However, 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. The department was able to obtain leaflets in other languages and in large print format when required.
- Examination details and results are stored on the PACS system.

**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.
- 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.
- 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.
- 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.
- Mental Capacity Act assessments were completed, comprehensively as and when required, to determine whether a patient can or cannot consent to treatment.

## 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 with patients being treated with dignity and respect at all times. We observed 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.

# Outpatients and diagnostic imaging

- 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.
- 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.
- 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.
- The 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 them 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.
- Staff in the diagnostic imaging department told us that they had identified issues over dignity and confidentiality for cancer pathway patients as there was no room on the door where they had their pre assessment checks. A door had been put on the treatment room as a result of this.
- We saw kind and caring interactions with patients at the reception desk and in the waiting areas of outpatients and the diagnostic imaging department. When patients booked into the reception desk, they received a coloured folder which correlated with the type of examination they required. This enabled staff to guide them to the correct area without having to look at their personal or examination details and preserved dignity and respect. There was a discrete area for patients following a virtual colonoscopy which is an example of good practice in this area.

**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.
- 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.
- 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. We were told by staff that patients were given a leaflet on timescales and how to obtain their breast screening results.

**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.
- 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 the breast screening area there were posters and leaflets available as well as details of a local breast screening charity. Staff in the antenatal obstetric unit told us that they felt that didn't have enough support when breaking bad news to patients.

## 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, 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.

We observed some delays in patients being seen at their appointed time. Delays in clinics were explained to patients, with staff following a protocol which ensured that they told patients about clinic delays, the reasons for these. Patients were kept informed and comfortable with beverages, and when required, food.

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.

Opthalmology 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.

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 Opthalmology and Cardiology but planned to roll it out to all other specialities by the end of March 2017.

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.

# Outpatients and diagnostic imaging

We have requested waiting times for each diagnostic speciality and time to report for each examination, but at the time of writing had not receive the data requested.

**Service planning and delivery to meet the needs of local people**

- Patients told us they were allocated enough time with the doctors when they attended their appointments, and that their appointments were not rushed. They said doctors were well informed about patients' medical history, and patients' medical records were available.
- 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 QEQM site 878 patients were seen in clinic. Of these patients 78.02% of patients were seen within 30 minutes, 12.39% were seen within 30-40 minutes, 4.87% were seen within 40-50 minutes, 1.69% were seen within 50-60 minutes and 0.53% were seen within 60 - 90 minutes. No patients had to wait above 90 minutes for their appointment. We are unable to compare this to results nationally as this data is not collected.
- 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 patients about waiting times and when to offer them refreshments or food. The 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.
- 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. The matron then communicated with the sisters to ensure that they could support this clinic activity with the staff and ensured that staff were available for the clinics that were required. The 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. These 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. The department also undertook pre and post-operative hearing assessments where a planned operation could affect hearing. We were told there were dementia champions in all audiology clinics across the trust. The radiology department at this hospital undertake their own patient satisfaction survey. They display the results of this on their waiting room notice board. We requested the results of this, but at the time of writing had not yet received the data.

**Access and flow**

- Hospital Episode Statistics for December 2013 – December 2014 showed that 249,172 outpatient appointments were made at QEQM Hospital. We noted that 62% of patients attended their follow up appointment, with 30% attending their first appointment. The data showed that the hospital's ratio of follow-up to new appointments was lower than the England average. Out of the total appointments made, 1% had been cancelled by patients and 7% 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, 7% of patients at QEQM did not attend their appointments, which is parallel with 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 in order to minimise the waste of resources. For example, texting had been used to remind patients of their appointment date and time. Measuring the non-attendance rate is 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.
- Government targets are that 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.
- The results of the 2015 Consultants survey showed that 124 consultants responded to the survey Trust wide,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.
- Latest RTT times published by NHS England published on 9th July 2015 showed that overall the Trust performed below the NHS standard of 92% with 88.4% of patients starting their treatment within 18 weeks. These statistics are reported at trust level and were not broken down by hospital site.
- Audiology referrals were triaged by a manager. On the day of inspection, the oldest referral in the department was dated 21 June 2015. They adhered to the 18 week pathway but 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 un-breached. Patients were then given a follow up six to eight weeks after the fitting of the aid. If at this appointment the patient was, well further follow up would be a phone call although if necessary the patient would be seen in clinic. Audiologists complete the letters to GP's which were sent the same day as the appointment in clinic.
- More detailed analysis showed that the following 11 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%), Opthalmology (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%).
- 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 implement 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) limitations, the true follow-up capacity gap was not visible. Partial booking had 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 three 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. That 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 two 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.
- 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 two weeks of the referral as recommended. The Trust was operating above the set operating standard of 93% for the two 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 trust's 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.
- 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.
- 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 which 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 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 once completed and agreed by specialties that this document would have clear protocols and key performance indicators (KPIs) around the timeframes for triaging referrals.
- During 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 eighteen 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.
- 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.
- 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.
- 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%.
- Medical secretaries at the hospital were not consistently able to send GP letters following clinic appointments within the trust's policy timescale of three working days. On the day of our inspection, Head and Neck medical secretaries were covering work for 22 doctors across three specialities. There was one full time medical secretary, one part time medical secretary and an admin assistant to cover this workload. As a consequence on the day of our inspection the medical secretaries in this speciality were typing letters from 29th May 2015 and had 105 outstanding tapes with around 20 letters dictated on each tape. However, we also spoke with medical secretaries from Neurology, Trauma and Orthopaedics, Breast, Urology and General Surgery who reported that they were mostly able to send GP letters within the three day expected target.
- Some medical secretaries told us that they had problems finding follow up appointments for patients within the timescale expected by their consultant. Head and Neck secretaries told us on the day of our inspection that the next follow up slots available for ENT were October with one ENT consultant having no follow up appointments available for a year, they reported a similar picture for Maxillio Facial appointments. Trauma and Orthopaedics medical secretaries told us that they found some consultants lists harder to find spaces in than others but reported that the issues around finding follow up slots had improved since longer clinic hours had come into effect. Urology secretaries reported a struggle to find follow up appointment slots with two consultants not having any free spaces until November. Colorectal/Upper GI secretaries reported only struggling with appointments that were required within three

months. However, they said that follow ups were generally within six months which was manageable. Neurology and Breast secretaries reported no issues with finding patients follow up appointment slots.

- Staff informed us that if a patient arrived on the wrong day or time for their appointment, they will always find a way to fit them in. The management team advised us that they have a management teleconference every morning to establish the numbers of inpatients requiring x-rays. This enabled them to organise planning and gave management the opportunity to discuss any capacity issues for the day. A number of the radiographers are qualified to write reports on x-rays and as a result of this, emergency department x-rays were reported within 24 hours. However, staff told us there were sometimes delays in reporting diagnostic tests. At the time of reporting there were 379 diagnostic tests waiting to be reported on.
- 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 was 25 days, CT was 15 days and non obstetric ultrasound was 19days. Overall this was less than the average wait times at the time of our inspection.

**Meeting people's individual needs**

- Staff ensured that patients who may be distressed or confused by the outpatient environment were treated appropriately. Patients 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.
- The environment in the reception area of the outpatient department allowed for confidential conversations. With the exception of fracture clinic we found that patient waiting areas were busy but were large enough to ensure that patients were able to sit in comfort.
- Breast screening charity leaflets were available in the waiting areas.

**Learning from complaints and concerns**

- Complaints were handled in line with the Trust's 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.
- The matron encouraged staff to contact them where 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.
- Following a root cause analysis of an incident, where a significant problem was identified involving paper referral a project group had been established to implement an electronic booking system. Staff advised us that they had identified concerns with regards to the variation in pathways for patients, and as a result of this the radiology nursing team are currently standardising pathways across the Trust.

## 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.

# Outpatients and diagnostic imaging

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. The 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 it.

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.

The matron was very proud of the staff and the department's successes, but equally keen to drive improvement in the patient experience throughout the department, and to share good practice in outpatient areas that were not directly managed by them.

There was an open culture in the 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 senior management team in radiology had a clear vision and strategy for the diagnostic imaging service. At this site the teams reported that they felt supported and worked well together. We were told several times that staff delivering care felt disconnected from the senior management team.

**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 were approved by the board in June 2014 following public consultation. These were to reduce the number of facilities used for out-patient clinics from 15 to 6,to offer a wide range of services across most specialties including diagnostic support, to extend clinic hours from 07.30 -19.00 and on 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 out-patient 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 displayed 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.

# Outpatients and diagnostic imaging

- There were regular team meetings to discuss issues, concerns and complaints across the division. We saw copies of monthly minutes from the diagnostic imaging department which detailed incidents and actions, this was being fed back to the patient safety board and to staff at monthly team meetings. We saw evidence that incident analysis was leading to a change in policy and practise.
- The Trust 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**

- 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 Opthalmology 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 told us the felt optimistic following the arrival of the new Chief Executive.
- The matron was able to talk us through succession planning arrangements for a dermatology nurse who was leaving the service to retire. The department was training another nurse with required competencies to replace the nurse on retirement.
- 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 360o 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 told us there was a lot of support for the radiography led reporting.

**Culture within the service**

- There was a positive culture amongst staff and 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.
- The 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. The 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. The 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".
- 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 ID on them. We were also given an example of a Band 2 HCA stopping a clinic where they felt someone with a learning disability did not have the understanding to consent and didn't have an advocate with them to assist with the situation.

# Outpatients and diagnostic imaging

- 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.
- The 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 the occupational health department 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 throughout our visit. The 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.
- The 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.
- Senior managers in the diagnostic imaging department commented that there was some legacy issues from shift rearrangements that occurred two years ago. There was also consideration by the senior management team that the drop in wages, and additionally, the shift changes may have contributed to staff dissatisfaction . Amongst the senior management team there was disbelief in the most recent staff survey results. There were comments that there may have been some isolated cases of bullying, which had been dealt with informally, but not brought to their attention.

**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. The matron actively recruited patients who had made a complaint about the department to join the group, and gave an example of a patient representative with hearing difficulties who had greatly improved the facilities and awareness in the department around this disability.

**Staff engagement**

- 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 outpatienrs. 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.

- Some staff informed us that their appraisal was very out of date and felt unsupported in their development . Some diagnostic imaging staff also raised concerns to us around the quality of training and competency of students.

**Innovation, improvement and sustainability**

- Ophthalmology were a service that had been identified by the Trust as experiencing difficulties meeting patient demand and requiring improvement. As a results 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 involved an increase in staff numbers and new equipment to support these staff. The strategy took 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 recommended the introduction of an electronic patient record system in the form of "software which will drive both efficiency increases and cost savings". The system could 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.
- The outpatient improvement team had made changes to the ways in which follow up appointments were being made in some speciality groups In order to improve patient experience and choice. 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 the 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 opthalmology 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 in collaboration with the trust wide Ophthalmology Matron. The programme helped staff to look at critically at their service along with celebrating good patient care. This programme was being piloted at WHH and QEQM but was about to be rolled out to WHH.

# Outstanding practice and areas for improvement

## Outstanding practice

- The pre-operative joint clinic is recognised as enhancing patient outcomes.
- The care pathway for patient discharged with ridged cervical collar in place is acknowledged for contributing to on-going response care to individuals.
- 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 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 inspiring support to staff working hard to maintain and improve the service.

## Areas for improvement

### Action the hospital MUST take to improve

- The trust must take action to ensure that HTM 05-01 is complied with in operating theatres, particularly with respect to; risk assessment; the environment, and staff training.
- The trust must take action to remove the decommissioned autoclave from theatres.
- There must be sufficient numbers of suitably qualified, skilled, and experienced midwifery staff available to deliver safe patient care in a timely manner.
- The environment and facilities n which patients are cared for must be safe, well maintained, fit for purpose and meet with current best practice standards.
- There must be sufficient equipment in place to enable the safe delivery of care and treatment, that the equipment is regularly maintained and fit for purpose to reduce the risk to patients and staff.
- The Trust must ensure the hospital has sufficient capacity to cope with the number of women in labour and new born babies on a day to day basis.
- The wards must be supported in providing a full seven day service by appropriate numbers of support services such as radiology, physiotherapy and pharmacy.
- There must be robust systems in place to monitor the safe management of medicines to ensure that national guidelines are reviewed appropriately and their implementation monitored.
- 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 ensure that the mandatory training targets and agreed actions are achieved.
- Consider how it can address staffs knowledge and understanding with respect to the Mental Capacity Act (2005) and deprivation of liberty safeguards.
- Ensure that all safety checks on equipment are carried out.
- Ensure that required signatures are included in CD registers.
- Ensure that temperature checks are monitored and recorded on fridges used to store medicines and food supplements.
- Consider how it may improve the environment in the day surgical unit.

# Outstanding practice and areas for improvement

- The trust should consider how it may move forward with the implementation of the dementia care work to bring it to fruition.
- 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.
- Standardising inotropic infusions to avoid the risk of potential drug errors when staff engage in cross site working.

- **Action the hospital SHOULD take to improve**

1. There should be a formal vision and strategy for women's health services to enable the development of a modern maternity service which is woman centred, underpinned by a sound evidence base and benchmarked against best practice standards.

2. Methods of maintaining the stability of leadership within the maternity department should be established.

3. The routine administrative burden on maternity staff at weekends and out of hours should be reduced in order to free midwifery staff to look after patients.

4. Staff should be encouraged to report non-clinical incidents in order that action can be taken to protect patients from avoidable harm.

5. The electronic system for allocating NHS numbers to new born babies should be functioning, in order to avoid the risk of babies missing screening tests through a manual process with insufficient printers available.

6. There should be a robust system in place to measure, monitor and analyse common causes of harm to women during pregnancy and childbirth.

This section is primarily information for the provider

# Requirement notices

## 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.

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>There was evidence of inconsistent incident reporting that impacts on learning across the specialties in respect of end of life care. The trust must ensure that staff have the knowledge and skills required to comply with the organisational systems and processes. Regulation 17 (1)(2)(a)(b)(f)<br><br>The trust must seek and act on feedback from patients, families and carers for end of life care services. Regulation 17 (2)(e)(f) |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>Sufficient numbers of suitably qualified, competent, skilled and experienced end of life care staff must be deployed to ensure the quality of service for all end of life care patients seven days a week. Regulation 18 (1) |

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.