Maidstone and Tunbridge Wells NHS Trust

Maidstone Hospital

Quality Report

Hermitage Lane
Maidstone
Kent
ME16 9QQ
Tel: 01622 224796
Website: www.mtw.nhs.uk

Date of inspection visit: 14-16 October 2014
Date of publication: 03/02/2015

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	Inadequate
Maternity and gynaecology	Good
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Maidstone Hospital is part of Maidstone and Tunbridge Wells NHS Trust and provides acute services to a population of approximately 500,000 living in the south of west Kent and parts of north-east Sussex.

Maidstone and Tunbridge Wells NHS Trust employs around 4,710 whole time equivalent members of staff with approximately 1,200 staff working at Maidstone Hospital.

We carried out an announced inspection of Maidstone hospital between 14 and 16 October 2014. We also undertook two unannounced visits of the hospital on 23 and 28 October 2014.

Overall, this hospital requires improvement. We found that maternity and gynaecology services were good. Urgent and emergency care, medicine, surgery, services for children and young people, outpatients and diagnostic imaging and those patients requiring end of life care required some improvement to ensure a good service was provided to patients. We found that critical care services was inadequate and significant improvement is required in this core service.

We rated this hospital as good for caring for patients. However, the hospital requires improvement in ensuring that it provides safe and effective care which is responsive to the needs of patients. The hospital requires significant improvement to ensure that it is being well-led as we found the current arrangements to be inadequate.

Our key findings were as follows:

Safe:

- The concept of learning from incidents varied from service to service. Whilst some departments had grasped the important role that incident reporting and investigation had in improving patient safety, this ethos was not replicated throughout the hospital.
- The anaesthetic department utilised an independent incident reporting tool which fell outside the auspices of the trust's quality and risk strategy; there was a lack of robust oversight of this reporting tool into the overarching trust-wide governance structure.
- Medicines management required improvement in some areas including, but not limited to the storage and administration of medicines.
- Some junior medical staff were not aware of their statutory duty of candour; this had been recognised as an area of risk by the trust and there was a plan in place to heighten staff awareness.
- Medical cover within the Intensive Care unit was not consistent with national core standards.
- We identified that the trust had failed to adhere to national standards and guidance regarding water safety; specifically this related to lapses in the trusts governance of legionella testing. We have warned the trust and have asked for timely improvements to be made in this area.
- The application of early warning systems to assist staff in the early recognition of a deteriorating patient was varied. The use of early warning systems was embedded within the medicines directorate, whilst in A&E, its use was inconsistent.

Effective:

- The use of national clinical guidelines was evident throughout the majority of services. The Specialist Palliative Care Team had introduced an end of life pathway to replace the existing Liverpool Care Pathway.
- There was lack of clinical guidelines within the ICU setting and staff were not routinely using national guidance for the care and treatment of critically ill patients.

Summary of findings

- The A&E generally performed poorly with regards to the management of patients presenting to the department in severe pain with fractured neck of femur injuries. However, post-operative patients reported that their pain was well managed on the wards.
- The pre-operative management of children and adults was not consistent with national guidance. There were inconsistencies in the advice patients were offered with regards to nil-by-mouth times, with some patients experiencing excessively long fasting periods.
- Whilst staff were afforded training in understanding the concepts of, and the application of the Mental Capacity Act (MCA), we found that staff were not routinely implementing the MCA policy into their practice.

Caring:

- Staff were caring and compassionate and treated patients with dignity and respect.
- Patients considered that they had been given sufficient information and counselling by qualified healthcare professionals to enable them to make informed decisions about their care and treatment.

Responsive:

- Patient flow across the hospital was poor. Patients deemed fit to be discharged from intensive care units frequently experienced significant delays in being transferred to a ward and elective surgical patients were cancelled due to a lack of available beds.
- The accident and emergency department consistently met the national target of ensuring that patients were admitted, transferred or discharged within four hours. However, patients could expect to experience delays of 60 minutes or more before receiving treatment within the A&E.
- The provision of interpreting services across the hospital was poor.
- There was an insufficient number of single rooms at Maidstone hospital to meet people's needs.
- Capacity issues within the hospital led to a high proportion of medical "outliers". The result of this included patients being moved from ward to ward on more than one occasion, alongside late night transfers.
- All medical specialities were meeting national standards for referral-to-treatment times, including all national cancer care waiting time standards. However, some surgical patients were experiencing delays of more than 18 weeks from referral to treatment. The hospital had responded to this by introducing additional surgical lists on Saturday mornings.

Well-led:

- The hospital values "Pride" were known by some staff, but not all. The majority of directorates lacked a clear vision or strategy which led some staff to being frustrated. Whilst staff were keen to develop clinical services, initiatives were hampered by financial restraints and cost improvement plans which were not aligned with quality governance measures.
- The ability of the senior directorate management teams to effectively lead their respective service was varied. Whilst the directorates of medicine, maternity and end of life were rated to be well-led, the same could not be said for the remaining five services.
- The application of clinical governance was varied, with some services lacking any formal, robust oversight.
- Staff engagement was varied throughout the eight core services; some staff spoke positively whilst others reported examples of departmental silo working, favouritism and poor visibility amongst the senior management team.
- Risk registers were poorly applied in some clinical areas which led to some risks not being escalated to the executive board. Where risks were escalated, there was evidence that the trust was taking action to try and resolve issues.

We saw several areas of outstanding practice including:

- The Maidstone Birth Centre had developed, designed and produced the Maidstone birth couch, which was used by women in labour.

Summary of findings

- On Mercer Ward, the role of dementia care worker had been created to focus on the needs of people with dementia and their families. An activities room had been designed, furnished and equipped to meet the specific needs of people with dementia, and was widely used. This project was the subject of an article published in the professional nursing literature.
- The breast care service provided very good care from before the initial diagnosis of cancer through to completion of treatment. Good support and holistic care was provided to patients requiring breast surgery.

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

The trust must:

- Make arrangements to ensure contracted security staff have appropriate knowledge and skills to work safely with vulnerable patients with a range of physical and mental ill health needs.
- Ensure that intensivist consultant cover is adequate.
- Ensure that sufficient numbers of ward rounds take place in the intensive care unit (ICU) to ensure the department complies with national standards.
- Ensure that once a decision to admit or discharge a patient to or from the ICU is taken, this takes place within four hours.
- Ensure that discharges from the ICU to other wards do not take place at night.
- Ensure that the governance structure within the ICU supports a framework to ensure clinical improvements using a multidisciplinary approach.
- Review the existing management arrangements for the Riverbank Unit to ensure that the unit operates effectively and efficiently.
- Take action to ensure that medical and nursing records are accurate, complete and fit for purpose.
- Ensure that staff and patients have access to a competent and independent translator when necessary.
- Ensure that the water supply is tested for pathogens and that appropriate systems are in place for monitoring water quality and water safety.
- Take action to ensure that all patient clinic letters are sent out in a timely manner.

The trust should:

- Arrange for the safe storage of medicines so that unauthorised access is restricted.
- Make sure that medical staff complete training in safeguarding children at the level appropriate to their grade and job role.
- Make sure that a sufficient number of consultants are in post to provide the necessary cover for the ED.
- Ensure that up-to-date clinical guidelines are readily available to all staff.
- Review the arrangements for meeting the needs of patients presenting with mental health conditions, so they are seen in a timely manner.
- Review the way complaints are managed in the ED to improve the response time for closing complaints.
- Review the governance arrangements for nursing staff in the ED to ensure effective leadership and devolution of responsibilities.
- Review the current provisions of the ICU outreach service, to ensure that the service operates both day and night, in line with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations.
- Ensure that medical care services comply with its infection prevention and control policies.
- Develop robust arrangements to ensure that agency staff have the necessary competency before administering intravenous medicines in medical care services.
- Develop systems within the directorate of speciality and elderly medicine to ensure that the competence of medical staff for key procedures is assessed.
- Ensure that systems are in place to ensure that the system of digital locks used to secure medicines storage keys can be accessed only by authorised people.

Summary of findings

- Develop systems to ensure that medicines are stored at temperatures that are in line with manufacturers' recommendations.
- Ensure within medical care services that patients' clinical records used in ward areas are stored securely.
- Ensure that the directorate of speciality and elderly medicine further monitors and embeds a robust system of medical handover that ensures patients' safe care and treatment.
- Review the ways in which staff working in medical care services can access current clinical guidance to ensure it is easily accessible for them to refer to.
- Review the way in which in medical care services it authorises and manages urgent applications under the Deprivation of Liberty Safeguards.
- Ensure that patients have access to appropriate interpreting services when required.
- Ensure that the directorate of speciality and elderly medicine reviews its capacity in medical care services to ensure capacity is sufficient to meet demand, including the provision of single rooms.
- Consider reviewing the processes for the capturing information to help the service better understand and measure its overall clinical effectiveness.
- Review the current arrangements for the providing elective day case surgical services to ensure parity of services across the hospital campus.
- Ensure that the provider reviews the quality of root cause analysis investigations and action plans following a serious incident or complaint and improves systems for disseminating learning from incidents and complaints.
- Ensure that the provider monitors transfers between sites for both clinical and non-clinical reasons. The monitoring process should include the age of the patients transferred and the time they arrived after transfer.
- Consider collating performance information on individual consultants. Where exceptions are identified, these should be investigated and recorded.
- Provide written information in a format that is accessible to people with learning difficulties.
- Reduce delays for clinics and reduce patient waiting times.

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 	Learning outcomes from a recent never event were not implemented in the department. The arrangements for the storage of medicines did not restrict unauthorised access. The department did not have enough medical staff trained at the appropriate levels for safeguarding children. An insufficient number of consultants were in post to provide the necessary cover for the department. Security staff were trained in control and restraint under their Security Industry Authority licences only and had not completed patient-specific training courses to improve their awareness when they supervised patients presenting with behaviours that were challenging, including patients with mental ill health and dementia. Clinical guidelines available in the department were out of date, and no action had been taken to review the department's deteriorating performance against College of Emergency Medicine audits. Patients were left waiting for treatment for longer than the expected national average, and the department was failing to meet its target for closing complaints by an agreed response date. There was a lack of strategic oversight and planning for driving improvement in the department. Nursing leadership was uncoordinated, and nursing staff did not consider themselves involved in governance. Overall, staff provided a caring and compassionate service. We observed staff treating patients with respect. Patients and their relatives and carers told us that they felt well-informed and involved in decisions and plans of care.
Medical care	Requires improvement 	Policies related to MRSA were not being followed by staff, and aspects of medicines management needed strengthening. Patients' records were not always stored securely, and systems for handover between medical teams were not robust. Services were not always effective, because current clinical guidance was not easily accessible for staff to

Summary of findings

follow, and national audits showed that patients with stroke or diabetes were receiving below average quality care. Systems for authorising the deprivation of people's liberty were not robust. Medical care services were not as responsive as needed. Capacity in the service was insufficient to meet demand. Arrangements for the provision of translation services also required improvement. Staff provided care in a compassionate and kind way that preserved patients' dignity. Patients felt supported psychologically and involved in their care and treatment. Staff felt supported by their leaders and managers to provide high quality care. We observed a culture focused on meeting the needs of individual patients and their families. Service leaders at all levels had systems to assess how well they were doing and were aware of any challenges they faced.

Surgery

Requires improvement

The quality of care in the surgical services at Maidstone Hospital required improvement overall. There was very limited learning from incidents. What learning there was appeared to be localised and reliant on local managers. Some medical records were incomplete, disorganised and not completed in accordance with the standards set by the Royal College of Surgeons. Evidence of water testing was provided following the onsite inspection. However, legionella testing had not been carried out as scheduled.

The main barrier to providing highly effective care was that the hospital's occupancy levels at times was over 100%. The hospital could not accommodate all the surgical patients that were admitted, which meant some patients due for elective surgery were, at times, not admitted and were sent home on the day of the operation. However, most people admitted for surgery received good care and had good outcomes.

Patients reported that they received very kind and attentive care from staff. Most patients and relatives we spoke with assured us that the staff, particularly the nursing staff, were always gentle and provided sufficient assistance.

The trust presented a clear vision but this was not well understood by all staff. Although some

Summary of findings

consultants were very happy with the support they received from the trust, others clearly were deeply unhappy. A strong team of band 7 nurses was said to be supportive and approachable.

Critical care

Inadequate

Significant improvements were required to ensure the safety of patients in critical care. No admission guidelines were in use to show the benefits of, and criteria for, admission to the ICU. Improvements were required to ensure that all incidents were reported through the same trust-wide system and were acted on promptly.

Although the ICU was obtaining mostly good quality outcomes, there was some lack of compliance with national guidelines.

Governance systems were inadequate; for example at mortality and morbidity meetings, not all deaths were discussed, and there was no record of the meetings that had taken place. Improvements were also required to the leadership of the ITU to ensure that the national best practice guidelines were followed, for example the core standards for intensive care units (2013).

Infection control and medicines management systems were found to be safe. Staff cared for patients in a compassionate manner and treated them with dignity and respect. Both patients and their relatives were very satisfied with the care provided. However, patients who were ready to be discharged to a ward environment were often delayed for up to a week because of a lack of ward beds, breaching same-sex accommodation, and in many instances were discharged home directly from the ICU.

There were inadequate facilities for patients who were fit to be transferred to wards; for example, there were no separate male/female toilet or bathroom facilities.

Maternity and gynaecology

Good

Systems were in place to ensure that safety was a priority for maternity and gynaecology services. Women and their babies were treated in a well-equipped environment. National evidenced-based best practice, professional standards and expert guidance were routinely used to ensure that mothers' needs were assessed and care delivered that was safe and effective.

Summary of findings

Feedback from people who used the maternity service was positive about how staff treated them. Women who wanted to give birth at the Maidstone Birth Centre (MBC) were assessed to ensure they were suitable for a low-risk-environment birth. Staff were engaged with innovative practices; they were making changes that had a direct impact on women and improved their experiences.

Services for children and young people

Requires improvement

The children's and young people's service at Maidstone Hospital requires improvement to ensure that children receive appropriate, evidence-based and effective care.

We found that nursing staff provided compassionate and empathic care both to children and their families. The environment in which children were cared for was appropriate; however there was insufficient evidence to determine whether regular cleaning audits were carried out to ensure the unit was being appropriately cleaned. There were some inconsistencies in the frequency with which medical and electrical devices were serviced. We also found that although medicines were stored appropriately on the ward, we had concerns about the chain of custody of controlled drugs; this was attributed to the informal nature with which keys to the controlled drug cupboard were stored at night and over the weekends, when the Riverbank Unit (children's day assessment and day-case ward) was closed.

The directorate used a combination of National Institute for Health and Care Excellence (NICE) and royal colleges' guidelines to determine the treatment it provided. However, there were discrepancies in the pre-operative management of children undergoing surgery with regards to nil-by-mouth guidance.

We could not fully determine the overall effectiveness of the service; this was because of the limited evidence and limited audit activity undertaken by the children's directorate that was specifically related to the Riverbank Unit. From the information collated, we identified that the department was not always performing in line with national standards; this was especially true for the management of children with diabetes.

Summary of findings

			The children's directorate lacked a formal vision or strategy, and some staff were unaware of the trust's values. The overall leadership of the Riverbank Unit was poor. There was little in terms of consistent management oversight of the unit. There was limited evidence to demonstrate that incident reporting was an embedded practice within the unit, with only eight incidents being reported over a six-month period. Although the directorate's senior management team was aware of issues such as contractual issues with third party transport providers, these had not been listed as issues that posed operational risks to the effectiveness of the service.
End of life care	**Requires improvement**		The specialist palliative care team (SPCT) was available five days a week for face-to-face contact, and the hospice provided telephone out-of-hours and weekend cover. Medicines were provided in line with guidelines for end of life care. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms were not consistently completed in accordance with trust policy, and there were no standardised processes for completing mental capacity assessments. The SPCT provided four study days per year for trained nurses, and trust staff were able access palliative care study days provided by the hospice in the Weald. Medical end of life training was delivered as part of the doctors' formal education programme. Leadership of the SPCT was good; quality and patient experience were seen as priorities. All patients requiring end of life care were referred to the SPCT. However, often no specialist input was required by the team. Patients were cared for with dignity and respect and received compassionate care. There was a multidisciplinary team approach to facilitate the rapid discharge of patients to their preferred place of care. Relatives of patients receiving end of life care were provided with free car parking.
Outpatients and diagnostic imaging	**Requires improvement**		All the patients we spoke with told us they had been treated with dignity and their privacy protected.

Summary of findings

They spoke highly of the staff in outpatients and radiology. Patients found staff polite and caring. However, many patients complained to us about waiting times in outpatient clinics.
Staff were reporting incidents, and these were discussed at the clinical governance meetings within the directorates. Systems were in place to reduce the risk and spread of infection. Medicines were stored and administered safely. The department held its own training records, which were up to date and demonstrated that most staff had attended mandatory training.
The trust had met its national targets and consistently performed higher than the national average with regard to radiology waiting times. There had been a backlog in reporting computerised tomography (CT) and magnetic resonance imaging (MRI) scans for several months, but there was evidence at the visit that these were being resolved. An ongoing backlog in clinic letters being sent out had not been resolved. There was a risk of patients receiving delayed or inappropriate treatment, and considerable stress caused to staff.
Staff demonstrated a commitment to patient-centred care, and we found many examples of such care and attention to patients' conditions and preferences.

Requires improvement

Maidstone Hospital

Detailed findings

Services we looked at
Urgent & 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 & Diagnostic Imaging

Contents

Detailed findings

Background to Maidstone Hospital

Maidstone Hospital is an acute general hospital and part of Maidstone and Tunbridge Wells NHS Trust. It has 401 beds. This Care Quality Commission (CQC) inspection was not part of an application for foundation trust status.

Maidstone Hospital is in the borough of Maidstone, Kent, and serves the population living in south west Kent. The population of Maidstone is mainly white (97.3%), and the highest ethnic minority is Asian, making up 1.1% of the local population. Maidstone ranks 117th out of 326 local authorities for deprivation. (The local authority that ranks first is the most deprived and the one ranked 326th is the least deprived.) Life expectancy for both men and women is slightly higher (better) than the England average.

Maidstone Hospital is one of two locations of Maidstone and Tunbridge Wells NHS Trust. The trust also provides services from Tunbridge Wells Hospital at Pembury.

Our inspection team

Our inspection team was led by:

Chair: Professor Edward Baker, Deputy Chief Inspector, Care Quality Commission (CQC)

Head of Hospital Inspections: Heidi Smoult, CQC

The team of 41 included CQC inspectors and analysts and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics and palliative care medicine; consultant surgeon; anaesthetist; physician; junior doctor; midwife; surgical, medical, paediatric, board-level, critical care and palliative care nurses; a student nurse; and experts by experience.

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 (A&E)
- 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 group, 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 carried out an announced visit between 14 and 16 October 2014 and unannounced visits on 23 and 28 October 2014. We observed how people were being cared for and talked with 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 staff and pharmacists. We also interviewed senior members of staff at the hospital.

The Care Quality Commission (CQC) inspection model focuses on putting the service user at the heart of our work. We held a listening event in Maidstone on 9 October 2014, when people shared their views and experiences of Maidstone Hospital.

Detailed findings

Facts and data about Maidstone Hospital

Key facts about Maidstone Hospital

Maidstone Hospital is one of two registered acute hospital locations of Maidstone and Tunbridge Wells NHS Trust.

Context

- Around 264 beds
- Serves a population of around 500,000
- Employs around 1,200 whole-time equivalent (WTE) members of staff

Activity

- Around 249,069 outpatient attendances per annum
- Around 58,871 urgent and emergency care attendances per annum

Key intelligence indicators

Safety (trust level data – not broken down by location)

- Two Never Events in last 12 months (one in surgery, one in radiology)
- Strategic Executive Information System (STEIS): 118 serious untoward incidents (April 2013 to March 2014)
- Elevated risk for the percentage of Central Alerting System (CAS) alerts with closing dates during the preceding 12 months that the trust had closed late
- Clostridium difficile: 35 cases overall – target of 42
- MRSA: three cases overall – target of 0

Effective

- Hospital Standardised Mortality Ratio (HSMR) indicator – no evidence of risk
- Summary Hospital-level Mortality Indicator (**SHMI**) – no evidence of risk

Caring

- NHS Friends and Family test (July 2014) – average score for urgent and emergency care was 55, which was better than the national average of 53. The response rate was 10.14%, which was worse than the national average of 20.20%.
- The average Friends and Family score for inpatients was 71, which was worse than the national average of 73. The response rate was 50.70%, which was better than the national average of 38%.
- The average Friends and Family score for maternity (antenatal) was 76, which was better than the England average of 62. The average score for maternity (birth) was 96, which was better than the England average of 77. The average score for maternity (postnatal) was 100, which was better than the England average of 65.
- Cancer Patient Experience Survey – the trust as a whole had a 90% rating for 'Patient's rating of care' as 'excellent'/'very good'. This was higher than the threshold for the lowest 20% of trusts (86%), but lower than the threshold for the highest 20% of trusts (92%).
- CQC Adult Inpatient Survey – no risks were identified in the trust as a whole in the nine questions asked.

Responsive

- A&E, four-hour target – met the 95% target in the previous 12 months
- Referral-to-treatment times – met the admitted and non-admitted pathways' target times
- Cancer: two-week wait – met the national target
- Cancer: 31-day wait – met the national target
- Cancer: 62-day wait – met the national target

Well-led

- Staff survey 2013 (trust as a whole): 3.73. Slightly worse than the England average of 3.74.
- The results of the 2013 NHS Staff Survey demonstrated that Maidstone and Tunbridge Wells NHS Trust performance showed that the majority of scores were as expected in line with the national average over the 28 key areas covered in the survey, which included:
- as expected in 24 key areas
- better than average in 2 key areas
- worse than average in 2 key areas
- The response rate for the staff survey was higher than the national average with a response rate of 55% compared to 49% national average.

Inspection history

- Maidstone Hospital was previously inspected on 12 February 2014. The hospital was found to be non-compliant with outcomes 4 (care and welfare), 13 (staffing) and 16 (assessing and monitoring the quality of services).

Detailed findings

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	Good	Inadequate	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
End of life care	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Maidstone Hospital is also known as the accident and emergency (A&E) department. The ED does not treat trauma patients; these patients are taken to Tunbridge Wells Hospital at Pembury. The department saw 58,871 patients between 1 April 2013 and 31 March 2014. Of these patients, 81.1% were aged over 17, and 18.9% of patients were aged 0–17 years.

The ED is divided into areas depending on the acuity of patients. The resuscitation area has three bays plus a designated bay for paediatrics. There are nine active bays and five ambulatory care spaces for treating major cases ('majors'). There are eight examination rooms for treating minor cases ('minors'). Two of the rooms in minors are used for treating children. In addition, there is an ambulatory clinical decisions unit for up to five patients. A room near the reception is used for the assessment and triage of patients who self-present to the ED (arrived by means other than ambulance).

We visited the ED over two weekdays during our announced inspection. We observed care and treatment and looked at patients' records. We spoke with many members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We also spoke with patients and their relatives who were using the service at the time of our inspection. We received comments from our listening events and from people who contacted us to tell us about

Summary of findings

Learning outcomes from a recent Never Event had not been implemented in the department. The arrangements for the storage of medicines did not sufficiently restrict unauthorised access. The department did not have enough medical staff trained at the appropriate levels for safeguarding children.

An insufficient number of consultants were in post to provide the necessary cover for the department. Security staff were trained in control and restraint under their Security Industry Authority licences only and had not completed patient-specific training courses to improve their awareness when they supervised patients presenting with behaviours that were challenging, including patients with mental health conditions or those patients who presented with behaviours that were challenging associated with dementia. Clinical guidelines available in the department were out of date, and no action had been taken to review the department's deteriorating performance against College of Emergency Medicine audits.

Patients were left waiting for treatment for longer than expected as defined by national standards, and the department was failing to meet its target for closing complaints within an agreed response timescale. There was a lack of strategic oversight and planning for driving improvement in the department. Nursing leadership was uncoordinated, and nursing staff did not consider themselves involved in governance.

Urgent and emergency services

Overall, staff provided a caring and compassionate service, and we observed staff treating patients with respect. Patients and their relatives and carers told us that they felt well-informed and involved in decisions and plans of care.

Are urgent and emergency services safe?

Requires improvement

Learning outcomes from a recent Never Event had not been implemented in the department. Staff reported that whilst they had historically reported incicents on a regular basis, due to a lack of feedback, more recently they had reduced the number of incidents they reported. The arrangements for the storage of medicines did not sufficiently restrict unauthorised access, which increased the risk of misuse of medicines.

The department did not have enough medical staff trained at the appropriate levels for safeguarding children, which increased the risk of oversight for vulnerable children attending the ED. An insufficient number of consultants were in post to provide the necessary cover for the department.

Security staff were trained in control and restraint under their Security Industry Authority licences only and had not completed patient-specific training courses to improve their awareness when they supervised patients presenting with behaviours that were challenging, including patients with mental ill health and dementia needs.

Incidents

- We saw evidence of a shared learning opportunity from a radiology Never Event (May 2014) that resulted in wrong-side insertion of a chest drain where an alert card had been produced (an alert card is a form of communicating high level improvements from incidents). Never Events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken. However, the alert card was not available in the ED. The clinical director told us they emailed a colleague to obtain a copy to show us. The clinical director confirmed that the alert card had not been implemented in the department. Most of the doctors we spoke with were aware of the Never Event, but none of them had seen the alert card/ checklist in the department.
- The trust reported 17 serious incidents to the Strategic Executive Information System (STEIS) relating to the ED trust-wide between April 2013 and March 2014. The

most common type of reported incident in the ED trust-wide was delayed diagnosis. The next most common incident was slips, trips and falls. We saw evidence of root cause analyses of incidents that included identifying lessons learned, recommendations and actions taken.

- Nursing staff told us they had histrocially reported incidents frequently. However, staff told us they had recently reduced the frequency with which they reported incidents because they received little or no feedback, with no evident changes in practice. Junior medical staff said they did not use the incident-reporting system regularly. This was reflected in the trust-wide figures for incident reporting.
- We looked at the minutes of ED clinical governance meetings dated June, July and September 2014, which recorded that learning from incidents was discussed by senior medical staff.

Cleanliness, infection control and hygiene

- During our visit, we found the department to be visibly clean and tidy. We saw support staff cleaning the department throughout the day and doing this in a methodical and unobtrusive way. A member of cleaning staff described the cleaning schedule to us. We were also told about the system for routine cleaning checks to ensure that standards were maintained: a manager would check the department and any area found not to have been cleaned to a specific standard was noted and cleaned again.
- The ED had adequate hand-washing facilities, and we observed staff using them. However, information provided by the trust showed 75% compliance with hand hygiene audits in the ED for the year to August 2014 compared with the trust's plan for 100% compliance.
- Rooms were available for isolating patients who presented with possible cross infection risks.
- We observed staff appropriately use personal protective clothing, including gloves and aprons. We also observed staff following the trust's 'bare below the elbows' policy.
- Information provided by the trust showed that 87% of nursing staff and 72% of medical staff at Maidstone Hospital ED had completed mandatory training in infection prevention and control, against the trust's target of 85%.

Environment and equipment

- There was a good range of resuscitation and medical equipment. Equipment was visibly clean, regularly checked and ready for use.
- Each bed space within the resuscitation area was designed and configured in exactly the same way. This allowed staff working within that area to be familiar with the bed space, which ultimately led to improved working during emergency and resuscitation events.
- There was a specific area for the resuscitation of children. This contained a wide range of equipment so that children of all ages could be immediately resuscitated.

Medicines

- Medicine rooms in each of the majors and minors areas were accessible using a keypad. Intravenous fluids and medicines were stored in locked cupboards within the medicine rooms. However, keys for the medicine cupboards were held in a key safe inside the room (majors) or in a key safe outside the room (minors). A further key safe was in the resuscitation area, containing the keys for the medicine cupboards in that area. The same code was used for all key safes. The same code was used for keypads on doors of medicine rooms. We were told that only nursing staff knew the numbers for key pads and key safes. This arrangement increased the risk of unauthorised access to medicines and meant it would be difficult to audit which staff had accessed medicine storage areas in the event of a discrepancy or error.
- Nursing staff carried the keys to the controlled drug cupboards with them at all times.
- We found that controlled drugs and fridge temperatures were regularly checked by staff working in the department.
- Staff spoken with were aware of medicine-management policies for reference purposes.
- Medicine administration records we looked at were completed appropriately.

Records

- The department had a computer system that showed how long patients had been waiting, their location in the department and what treatment they had received.
- A paper record (referred to by departmental staff as a 'cas card') was generated by reception staff, registering

the patient's arrival in the department and recording the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- Specific pathway documentation (for example, for medical patients and surgical patients) was implemented for patients in the clinical decision unit or where admission to the hospital was anticipated. The documents were clear and easy to follow. There was space to record appropriate assessments, including assessment of risks and details of investigations, observations, advice and treatment and a discharge plan.
- We looked at the care records of 10 patients and found they had been fully completed.
- The trust's own audit showed good compliance was attained for ensuring that observation of vital signs for 20 patients were recorded during September 2014.

Safeguarding

- Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. There was access to patients' previous attendance history and to the child risk register.
- Information provided by the trust showed that 61.8% of medical staff and 93.8% nursing staff at Maidstone Hospital's ED were trained to in safeguarding vulnerable adults. The trust's own target was 85%.
- Information provided by the trust showed that 58.2% of medical staff and 59.1% nursing staff at Maidstone Hospital's ED were trained to level 2, and 53.3% of medical staff and 52.63% nursing staff were trained to level 3 in safeguarding children. The trust's own target was 85%.
- We found safeguarding checks were consistently completed in the children's care records we looked at, and junior medical staff showed us a resource folder that included safeguarding information.

Mandatory training

- Compliance with mandatory training by staff in the ED at Maidstone Hospital was good. For example, over 85% of all grades of staff completed health, safety and risk training, fire safety awareness, and clinical moving and handling training.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority ('blue light') call were transferred immediately through to the resuscitation area or to an allocated cubicle space. Such calls were phoned through in advance, so that an appropriate team could be alerted and prepared for their arrival.
- Patients arriving in an ambulance were brought into the major's area and assessed by a nurse, who received a formal handover from the ambulance crew. Based on the information received, a decision was made regarding which part of the department the patient should be treated in.
- Patients who walked into the department or who were brought by friends or family were directed to a receptionist. Once initial details had been recorded, the patient was directed to the waiting room. These non-ambulance patients were assessed by a triage nurse in arrival order unless the receptionist considered that a patient needed to be seen urgently. If, during the initial assessment stage, any patient was identified as needing urgent and more intensive intervention, they were transferred through to the resuscitation area or to another more appropriate area.
- During 2013/14 Maidstone Hospital achieved a time to initial assessment of less than 15 minutes for 95.8% of patients. This was slightly better the government target of 95%. Figures provided by the trust showed that performance in this criterion had deteriorated in the year to date for 2014/15; 93.8% of patients had been initially assessed within 15 minutes between April and September 2014.
- We observed that a 'patient at risk' (PAR) tool was used in the department for the escalation of deteriorating patients. We looked at the 'cas cards' of 10 patients and found that the PAR score was recorded for patients triaged to majors but was not recorded for patients in minors. We found that a PAR score was not consistently reassessed, which left patients at risk of not being escalated appropriately if their condition deteriorated.

Nursing staffing

- Nurse staffing levels were based on historical establishments, which had been reviewed over time to take account of changing demand. No specific staffing tool was used.
- During each day shift, the department was supported by seven registered nurses and one clinical support worker. At night, this reduced to six registered nurses and one

clinical support worker. There was also a 'twilight shift' with one registered nurse between 7.30pm and 2am. This staff member covered the main A&E (resuscitation, majors and minors), triage and the clinical decision unit.

- Two emergency nurse practitioners were on duty in the department each day, providing cover between 8am until midnight, and were usually allocated to the minor's area.
- The ED matron was on maternity leave, and the post was being covered by the matron from the women and children's directorate. Nursing staff told us that the matron spent less than one day each week in the department.
- The trust employed 183.8 whole-time equivalent (WTE) qualified nurses in the ED for the year to date against a target of 196.2. The nurse vacancy rate in the ED trust-wide was 2.3%.
- The sickness absence rate among the ED staff at Maidstone Hospital was 3% for the year to date, which was slightly lower (better) than the trust's planned rate of 3.3%.
- The turnover rate for ED staff for the year to date was 7%, which was lower (better) than the trust's target rate of 10.5%.

Medical staffing

- Insufficient numbers of ED consultants were in post trust-wide. There were 9.6 WTE consultant posts across the trust plus one long-term locum and one middle-grade 'acting up' In a higher grade post There was one member of medical staff on maternity leave and one vacant post. The clinical director told us that 14.6 posts were required to operate safely.
- Between Monday and Friday, a consultant was present in the department between 8am and 5pm; on three of these days there was consultant cover until 10pm.
- At weekends and overnight there was one consultant after 10pm covering both sites seven days a week, operating on an on-call basis.
- The trust informed us that in recent weeks, and as a response to cost pressures, the ED at Maidstone Hospital had consultant cover over weekends with the trust's own staff paid to cover to offer addition senior cover.
- We looked at the consultant rota for the six weeks before our inspection, which confirmed the consultant hours worked.
- Middle- and junior-grade doctors were on duty 24 hours a day in the department.
- Concern about the availability of competent and reliable middle-grade locum doctors was included as a moderate risk on the trust's risk register. This was mitigated by the use of established agencies, local governance mechanisms and regular locum doctors.

Major incident awareness and training

- The hospital had a major incident plan, which had last been reviewed in September 2011 (with updates to sections in October 2012 and September 2014).
- The trust provided the planned programme for exercises simulating major incidents. We also looked at some of the reports collated following simulation exercises. Records provided by the trust showed 76% of staff had completed chemical, biological, radiological and nuclear (CBRN) training.
- Staff in the ED were well-briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly, they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material or hazardous materials and items.
- Information provided by the trust showed that 92 staff across the trust, including 49 staff from the ED at Maidstone Hospital, held a current CBRN permit and formed the decontamination team. Additionally, contact details were also available for staff from Darent Valley Hospital who held a permit.
- The department was not secure. All areas of the department were accessible by the public. There was no facility to 'lock down' the department to isolate it in the event of an untoward incident as is recommended during major incidents Hospital security staff were based in a room near the hospital's main entrance, away from the ED.

Security

- We spoke with security staff about their role in the ED. They described their role with patients presenting with behaviours that were challenging, such as those intoxicated by substance misuse and patients with mental ill health, including dementia needs. Staff said they assisted with patients who absconded from wards or the ED. Security staff told us it was sometimes

necessary to restrain patients for their own safety or for the safety of others. However, we found security staff had limited training for the patient groups they worked with in the ED.

- The trust told us 100% of security staff had completed conflict resolution training and 70% had completed restraint training. Security staff told us they received training in control and restraint under their Security Industry Authority licences. (The Security Industry Authority is responsible for regulating the private security industry in the UK.) Security staff expressed concern that the training required for licences they held for 'manned guarding', 'door supervision' or 'security guard' were appropriate for dealing with the general public but not for patients presenting with behaviours that were challenging because of the patients' ill health.
- Security staff had not received any awareness training specific to conditions the patients they worked with might present, such as mental ill health or dementia.
- Security staff told us the trust had recently provided Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Information from the trust confirmed that 30% of security staff had completed the training. The trust confirmed that 60% of security staff had completed level 1 safeguarding training.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Clinical guidelines available in the department were out of date, which left patients at risk of receiving treatment that did not meet current best practice guidelines.

No action had been taken to review the department's deteriorating performance against College of Emergency Medicine audits, which meant best practice was not promoted.

Evidence-based care and treatment

- The department used a combination of National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment it provided, and a range of clinical care pathways had been developed in accordance with this guidance.
- Clinical guidelines were accessible on the hospital's intranet for staff. However, some of the guidelines we saw in use in the department were out of date, including those for treating patients presenting with atrial fibrillation. One senior doctor told us that quick reference cards were available in the department, but they were not used because they were "out of date and hard to find".
- A junior doctor told us they knew of no departmental guidelines to help with minor injuries, sepsis or chest pain, and the only source of help would be to ask senior doctors
- We asked a senior nurse to describe the process for updating the clinical guidelines in the department. We were told, "There isn't one."

Pain relief

- The ED participated in two CEM audits, which included the management of moderate or severe pain caused by renal colic and the management of fractured neck of femur.
- Of patients who presented to the Maidstone ED complaining of pain as a result of renal colic, 64% had a pain score recorded. This placed the ED in the lower quartile (quartiles are the values that divide a list of numbers into quarters) when compared nationally. The CEM standard was 100%.
- Of patients who presented in severe pain with renal colic, 48% were provided with analgesia within 20 minutes of arrival. This placed the ED in the upper quartile when compared nationally. The CEM standard recommends that 50% of patients presenting in severe pain with symptoms of renal colic should receive analgesia within 20 minutes, 75% within 30 minutes, and 98% within 60 minutes of arrival in the ED. The department was placed in the upper quartile for patients receiving analgesia within 30 minutes (62%) and 60 minutes (90%).
- Of patients who presented to the Maidstone ED in severe pain with fractured neck of femur, none were provided with analgesia within 20 minutes of arrival. This placed the ED in the lower quartile when compared nationally. The CEM standard recommends that 50% of patients presenting in severe pain with fractured neck of

femur should receive analgesia within 20 minutes, 75% within 30 minutes, and 98% within 60 minutes of arrival in the ED. The department was placed in the lower quartile for patients receiving analgesia within 30 minutes (0%) and in the middle quartiles for patients receiving analgesia within 60 minutes (33%). The percentage of audited patients who were provided with analgesia wholly in accordance with guidelines was worse in the 2012 audit compared with the 2009 audit. The CEM recommended that the trust should review its processes for recording pain scores. We requested evidence of action taken in response to the outcome of the audit, but none was provided.

- No pain score was recorded in nine out of the 10 paediatric records we reviewed.

Nutrition and hydration

- We observed staff providing drinks and snacks to patients during our inspection.
- We observed that intravenous fluids were prescribed and recorded, as appropriate.

Patient outcomes

- The department participated in national CEM audits so that it could benchmark its practice and performance against best practice and other A&E departments. Audits included consultant sign-off, vital signs in majors, renal colic, fractured neck of femur, severe sepsis and septic shock. However, there was limited evidence that the trust had developed or implemented action plans in response to the outcome of the audits.
- We noted that in 2013/14, the percentage of attendances resulting in admission was higher than the national average (27% compared with England average of 22%). At the time of our inspection, it was not clear why the service scored higher than the national average; the trust was required to undertake further work to identify any contributing factors and to determine whether any additional action was necessary to address the issue.
- The rate of unplanned re-attendance to the ED within seven days was consistently above the England average.
- The number of ambulance handovers delayed by over 30 minutes during the winter period of November 2013 to March 2014, compared with figures for all trusts in England, was better than the expected standard.
- Results from the 2013 CEM clinical audit relating to consultant sign-off were compared with the same audit in 2011 to determine whether the ED had made any improvements. The CEM consultant sign-off audit measures a number of outcomes, including: whether a patient has been seen by an ED consultant or senior trainee in emergency medicine before being discharged from the ED when they have presented with non-traumatic chest pain (17 years of age or older); children under one year of age presenting with a high temperature; and patients returning to the ED within 72 hours of being discharged by an ED. We found the department's performance significantly worsened between 2011 and 2013.
- During 2011, the number of patients seen by a consultant was 8% compared with a national average of 12%. This had worsened in 2013 to 2% of patients being seen by a consultant; this was worse than the national average of 14%.
- During 2011, the number of patients who were discussed with an ED consultant before discharge was 14% compared with a national average of 12%. In 2013, this had worsened to 0% of patients being discussed with a consultant compared with the national average of 13%.
- The number of ED notes reviewed by an ED consultant following a patient's discharge was 100% in 2011 compared with a national average of 7%. This worsened significantly in 2013, with 0% of ED notes being reviewed compared with the national average of 7%.
- The number of ED notes reviewed by an ED consultant following discharge was 100% in 2011 compared with a national average of 7%. This worsened significantly in 2013, with 0% of ED notes being reviewed compared with the national average of 7%.
- We asked the trust for evidence of action taken in response to the CEM audits. We were shown the trust's own audits for vital signs and pain scoring in children. We saw no other evidence or action plans.

Competent staff

- The percentage of nursing staff with completed appraisals in the ED was 50.7% for the year to date against the trust's target of 90%.
- We spoke with junior doctors, who told us the trust organised weekly teaching sessions, but there was limited departmental teaching, which comprised mostly ad-hoc discussions on patients .

- The trust had two WTE paediatric nurses in post, and these rotated internally between the two hospitals (Maidstone Hospital and Tunbridge Wells Hospital).
- Information provided by the trust showed that 10 nursing staff in the Maidstone Hospital ED had a current European Paediatric Life Support (EPLS) certificate, and seven more nursing staff held a Paediatric Immediate Life Support (PILS) certificate.
- We saw evidence that nursing staff were supported in maintaining their competence. Training and education included a minor injuries course, intravenous fluids and cannulas, venepuncture, plastering, triage, mentorship and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) regulations. Ten per cent had completed foundations of emergency care training.
- Information provided by the trust showed a variable uptake of training in information governance. For example, 83.2% of nursing staff, 50% of administrative staff and 48.5% of medical staff in the ED had completed the training.
- Junior doctors spoke positively about working in the department, and said they were supported.
- Bank and agency staff received a local induction before starting their shift. We spoke with an agency nurse on duty at the time of our inspection, who confirmed this.

Multidisciplinary working

- We observed good working relationships between the nursing and medical staff within the ED; however, there were no multidisciplinary handovers.
- During the day, the mental health crisis team worked within the department to assess and treat patients with acute mental ill health conditions.
- There appeared to be a good working relationship between the ED team and members of other specialties such as surgery and medicine.

Seven-day services

- The department had access to radiology support 24 hours a day, with full access to computerised tomography (CT) and magnetic resonance imaging (MRI) scanning.
- We checked the rotas and spoke to the medical team and senior nurses, who could show that there was a seven-day working approach. However, sufficient consultants were not always present after 5pm. There was consultant presence until 10pm for three days a week.

Access to information

- The department had a computer system that showed how long patients had been waiting, their location in the department and what treatment they had received.
- A paper record (referred to by departmental staff as a 'cas card') was generated by reception staff, registering the patient's arrival in the department and recording the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the document.
- Staff could access records including test results on the trust's computerised system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that verbal consent was obtained for any procedures undertaken by staff, and a range of written consent forms were available including, for example, for people with parental responsibility to consent on behalf of children who were not Gillick competent.
- Records provided by the trust showed that 77% of nursing staff and 62.2% of medical staff had completed training in the Mental Capacity Act (MCA) 2005.
- There were no Deprivation of Liberty Safeguards applications made through the ED in 2013/14 or the year to date.
- The staff we spoke with had sound knowledge about consent and mental capacity. However, patients' capacity and any best interests' decisions were not consistently recorded in the patients' records we looked at.

Are urgent and emergency services caring?

Good

Overall, staff provided a caring and compassionate service. We observed staff treating patients with dignity and respect. However, there were isolated cases when confidentiality during private conversations with patients was breached. Patients and their relatives and carers told us that they felt well-informed and involved in decisions and care plans.

Compassionate care

Urgent and emergency services

- Throughout most of our inspection of the ED, we saw that staff treated patients with compassion, dignity and respect. However, on two occasions we observed patient consultations in the minors area where the door was left open and confidential conversations could be clearly overheard by other staff and patients passing by. We also observed one incident when a staff member interrupted a consultation to make an enquiry. No introduction or apology was made.
- Two questions in the CQC Adult Inpatient Survey 2013 related to people's experience in the A&E department: 'While you were in the department, how much information about your condition did you receive?' and 'Were you given enough privacy when you were being examined or treated in the department?' The trust scored about the same as other trusts in response to both of these questions.
- The Friends and Family test is a single-question survey that asks patients whether they would recommend the NHS service they have received to friends and family who needed similar treatment or care. We found that staff encouraged patients to complete the survey. The response to the survey was better than the national average. Maidstone and Tunbridge Wells A&E departments consistently scored better than the national average.
- Comments from patients we spoke with included, "Everyone's been very kind. I'm very impressed."
- We looked at eight patient feedback cards that were completed on the day of our visit. Seven responses were very positive about staff and the care received.

Understanding and involvement of patients and those close to them

- During our visit to the ED department, patients and relatives told us that they had been consulted about the patient's treatment and felt involved in their care.
- Several people attending our listening events shared positive experiences about using the ED.

Emotional support

- We observed staff giving emotional support to patients and their families.

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

(for example, to feedback?)

Good

The ED at Maidstone Hospital consistently failed to meet the national target for 'time to treatment in less than 60 minutes', but consistently met the national four-hour waiting time target. The total time in the ED for patients was consistently significantly higher than the national average across the trust. The department was failing to meet its target for closing complaints within an agreed response time.

Meeting people's individual needs

- There was a separate waiting area for children, which was being used on the day of our inspections.
- Children's needs were met by the provision of age-appropriate toys and activities, a separate waiting area and different pain-scoring tools.
- Staff had access to translation services by way of a telephone interpreter system.
- Patient information and advice leaflets were available in English but were not available in any other language or format. However, it was important to note that the demographic of the local population was predominetnly white British where English was their first language.
- The department had a room with soft furnishings that provided a quiet and private area for waiting friends and relatives. A room was available for private discussions with relatives, and an adjoining room was available where relatives could spend time with their loved one in the event of their death.
- There was sufficient seating in the waiting room, and reception staff had a direct line of sight of the area.
- The department had a room to accommodate a patient presenting with mental ill health. However, we found an intravenous drip stand and a long cord on the call bell which could be used as a ligature and was therefore a risk in that room.

Access and flow

Urgent and emergency services

- NHS England winter pressures daily situation reports data for the trust between 4 November 2013 and 30 March 2014 showed 52 occasions when ambulances waited more than 30 minutes to hand over. This figure was much better than other trusts nationally.
- The national target is for 95% of patients in ED to wait less than four hours to be admitted, transferred or discharged. The ED at Maidstone Hospital consistently met this target. In 2013/14, the target was achieved for 97.8% patients. The department's performance has been sustained in the year to date, meeting the target for 98% of patients.
- The percentage of patients who leave the department before being seen is recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they have to wait. At Maidstone Hospital ED, performance was around 3%, which was about the same as the national average (month by month for the year ending 2014).
- We found that the total time in the ED (average per patient) for the trust was consistently significantly higher than the national average (month by month for the year ending May 2014).
- The ED at Maidstone Hospital consistently failed to meet the national target for 'time to treatment in less than 60 minutes', achieving it for 45.6% patients in 2013/14 against a national target of 50%. The department's performance had worsened in the year to date, meeting the target for 38.1% of patients.
- We were told that access to mental health services were good during the day. We saw appropriate mental health referral practices. Staff from the mental health liaison team had an office base in the department and were easily available to assess and treat people with mental ill health. However, at nights and weekends, staff from the mental health liaison team were not on site; staff reported that patients who presented with mental ill health needs may wait a number of hours to be seen by specialist staff. Staff further reported that patients with mental ill health ocassionally experienced delays in the EDfollowing a decision to admit them, while a bed was found for them.
- We looked at eight patient feedback cards which were completed on the day of our visit.. One respondent was dissatisfied with the length of wait and felt that staff had not kept them informed about their care journey or the why they had been kept waiting so long.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. If a patient or relative wanted to make an informal complaint, they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service (PALS), which would formally log their complaint and attempt to resolve their issue within a set period. PALS information was available within the ED.
- Staff we spoke with were familiar with the complaints process and told us they directed dissatisfied patients to the PALS service when appropriate.
- Formal complaints were investigated by the matron and/or a consultant, and responses were sent to the complainant. Information provided by the trust showed that the department was not meeting the target for closing complaints within an agreed time (25 days or as negotiated between the trust and the complainant).
- We saw that learning points from complaints were discussed at A&E governance meetings and at nursing staff meetings.

Are urgent and emergency services well-led?

Inadequate

There was a lack of strategic oversight and plan for driving improvement in the department. Staff were unable to locate the department's local risk register or risk assessments to show us. The clinical director and matron were aware of the three risks on the trust-wide register, but oversight of items held locally appeared to be limited.

We found that action plans were not developed or implemented in response to any deteriorating performance in the department. Nursing leadership was uncoordinated and nursing staff did not consider themselves involved in governance.

Vision and strategy for this service

- The clinical director told us there was no written vision or strategy for the ED. Staff confirmed they were not were not aware of a vision or strategy for the ED.

- We were told that although there was no formal strategy, performance and the workforce were identified as the issues with an impact on the directorate.

Governance, risk management and quality measurement

- We noted that the 'patient at risk' (PAR) tool in use was not consistent across the trust in the ED. At Tunbridge Wells Hospital, we were told that the PAR scoring tool on the 'cas card' was no longer in use, but staff at Maidstone Hospital ED continued to use it and were unaware of the change at Tunbridge Wells Hospital.
- We saw a risk and governance report dated 6 October 2014. The department had three identified risks on the trust-wide register. The risks related to the paediatric pathway, medicines management and the use of locum doctors in A&E. We asked to see the risk register in the department, because we were told the department maintained risk assessments locally which fed into the trust-wide risk register. However, we found that only 'red' risks were fed into the trust-wide risk register. The clinical director, the clinical director's secretary and several nurses were unable to locate the department's local risk register or risk assessments to show us. The clinical director and matron were aware of the three risks on the trust-wide register, but oversight of items held locally appeared to be limited. Band 7 nursing staff told us that governance, risk management and quality assurance were the responsibilities of the matron and they did not think these were their responsibility.
- We saw evidence that trust-wide risks were discussed at departmental meetings, but no evidence of any other local risk being discussed. Monthly clinical governance meetings were held within the directorate and all medical staff were encouraged to attend, including junior doctors.
- We looked at the minutes of the meetings for the three months before the inspection and noted that complaints, incidents and audits were discussed.
- However, We found that action plans were not developed or implemented in response to any deteriorating performance in the department. Furthermore, the governance systems were insufficiently robust to demonstrate that appropriate action was taken to address the reduction in incident reporting as well as resolving the issue of staff not receiving feedback following an incident.

Leadership and culture within the service

- The trust-wide directorate of acute and emergency medicine was led by a triumvirate, including a clinical director (an ED consultant), a nursing lead (matron) and a general manager. The general manager had been on sick leave for several months and an interim general manager took up post in the week of our inspection. The ED matron was on maternity leave and the post was being covered by a matron deployed temporarily from another directorate. The recent changes meant there was some instability in the leadership of the directorate.
- Nursing staff in the department expressed concern about a lack of clarity in leadership. We were told that the matron was present in the department for one day a week, and so for most of time no senior nurse was coordinating the band 7 activity. We were told this caused friction among nursing staff.
- Staff told us the clinical director had a strong presence on the 'shop floor'. They felt the clinical director demonstrated integrity and was very approachable.
- Staff told us there was an open and honest culture.
- Staff told us the culture of the department was "we've always done it that way here" rather than an approach promoting change or improvement.

Public and staff engagement

- We observed staff actively encouraging patients to complete the Friends and Family test. This resulted in a response rate of 41.2% in the year to date trust-wide, which exceeded the trust's target for a 25% response.
- No evidence was displayed in the department of changes made as a result of patient feedback (for example, 'You said, we did') or patient-led assessments of the care environment (PLACE).

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 Maidstone Hospital, medical care services are managed predominately by the directorate of speciality and elderly medicine. Specialties include gastroenterology, respiratory medicine, cardiology, endocrinology, elderly care and stroke. Acute medicine is managed by the directorate of acute and emergency medicine, and the service is provided on the medical assessment unit. Cancer services are managed by the directorate of cancer and haematology. Medical care services have a bed complement of 226 beds (of which 188 are inpatient beds with 38 for day cases) and provide around 16,400 spells of care per annum at the hospital.

To help us understand and judge the quality of care in medical care services at Maidstone Hospital, we used a variety of methods to gather evidence. We spoke with about 10 doctors including consultants, 18 registered nurses including ward managers and specialist nurses, three allied health professionals and three care support workers. We spoke with support staff including housekeeping staff. We also spoke with around 25 patients and eight patient relatives. We interviewed the directorate management teams for speciality and elderly medicine and for the directorate of cancer and haematology. 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.

During our announced inspection we visited Lord North, Mercer, John Day, Foster Clark, Jonathan Saunders, Culpepper and Watman Wards. We also visited the acute stroke unit and the coronary care unit.

Medical care (including older people's care)

Summary of findings

Policies relating to MRSA were not being followed by staff, and aspects of medicines management needed strengthening. Patients' records were not always stored securely. Systems for handover between medical teams were not robust. Services were not always effective, because current clinical guidance was not easily accessible for staff to follow and national audits showed that patients with stroke or diabetes were receiving below average quality care. Systems for authorising the deprivation of people's liberty were not robust.

Medical care services were not responsive, and the service had insufficient capacity to meet demand. Arrangements for the providing translation services also required improvement.

Staff provided care in a compassionate and kind way that preserved patients' dignity. Patients felt supported psychologically and involved in their care and treatment. Staff felt supported by their leaders and managers to provide high quality care. We observed a culture that focused on meeting the needs of individual patients and their families. Service leaders at all levels had systems to assess how well they were doing and were aware of any challenges they faced.

Are medical care services safe?

Requires improvement

Systems for managing patients colonised with MRSA were not being adhered to. Medicines were not always stored securely, and arrangements for ensuring that medicines were stored in environments to keep them in optimal condition were not complied with or were lacking. The systems for ensuring that agency nurses were competent to give intravenous medicines were unclear and put patients at risk. Patients' confidential medical records were not always stored in a way that minimised the risk of unauthorised access. Handover systems between doctors covering the 24-hour period were not robust to ensure that patients were not put at risk of inappropriate care.

Methods for reporting safety incidents were effective, and any incidents were investigated for lessons learned. The results of and learning from investigations were disseminated to staff. Patient slips, trips and falls were the greatest concern for all staff, but systems and arrangements were in place to reduce this safety risk. Most patients experienced harm-free care as measured by the national NHS Safety Thermometer tool.

Patients were cared for in clean, hygienic environments that were well maintained. There was, in the main, compliance with the Government's code of practice on the prevention and control of infections and related guidance. Equipment was properly maintained and fit for purpose.

Overall numbers of nurses, doctors, therapists and other staff were adequate to meet patients' needs. Staffing levels were kept under review and changed in response to emerging concerns or circumstances. However, junior doctors expressed concern regarding their workload at night and the negative impact this could have on patients' safety. Staff received mandatory training designed to ensure they could carry out their jobs safely. There were adequate arrangements to safeguard patients in vulnerable circumstances and children.

There were systems to support staff to recognise and appropriately treat patients whose condition was deteriorating. There were plans that ensured the service was resilient in case of a major incident or an event that compromised the hospitals ability to provide services.

Medical care (including older people's care)

Incidents

- Medical care services reported no never events in the year leading up to this inspection. (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 44 serious incidents requiring investigation during 2013/2014, with 10 between April 2014 and August 2014. Slips, trips and falls accounted for 24 (54%) of these incidents. Since April 2014, medical care services had reported 288 falls resulting in injury.
- All staff we spoke with were aware that falls accounted for most of the reported safety incidents. We noted there were arrangements for intervening when the number of falls on a ward exceeded thresholds. On Foster Clark Ward we saw how the trust had responded to an increase in the incidence of falls by providing a period of increased incident monitoring and associated actions. The ward manager explained that by focusing on falls, including risk assessment, footwear and the use of movement sensor mats, the number of falls had dropped from 11 the previous month to none in the preceding two weeks. This showed that actions were taken when the monitoring of incidents indicated an emerging problem.
- The trust's policy stated that incidents should be reported through a commercial software system that enabled incident reports to be submitted from wards and departments. All staff we spoke with across medical care services at Maidstone Hospital were aware of the requirement to report any incidents, knew how to use the system and could demonstrate its use to us.
- Staff we spoke with on Watman Ward were able to describe recent incidents on the ward, the actions that had been taken and staff learning. Staff told us that they were encouraged to complete incident forms. Staff also said they would feel confident about reporting an error they had made to their manager; they said that colleagues who had made errors had been well supported by the ward manager.
- Staff on Watman Ward told us that agency nurses were also able to access the incident reporting system. We saw evidence that agency nurses reported incidents.
- When ward managers had investigated incidents, they communicated any learning from these incidents through ward meetings and in the staff communication folder. The staff communication folder was in the office and accessible to staff, who were encouraged to read it. We saw examples of feedback on investigated incidents; staff told us they valued the feedback given. We also saw examples of incidents such as Never Events that had occurred in other services and had been discussed to disseminate learning across the organisation.
- The directorate of speciality and elderly medicine held mortality review panel meetings. The records of patients who died were reviewed by a named consultant, and if they met a pre-determined criterion they were discussed at the review meeting. We did not see minutes of these reviews, but noted that cases were discussed at directorate board meetings, and that these discussions generated learning and action points.
- The management team of the directorate of cancer and haematology told us that mortality and morbidity meetings were held monthly for deaths that met certain criteria set by the directorate and or for 'near misses'. We saw minutes of mortality and morbidity meetings and noted that points to reflect on and learn from were clearly identified to improve the care of patients

Safety thermometer

- Medical care services at Maidstone Hospital participated in the NHS Safety Thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas.
- We spoke with the management team of the directorate of speciality and elderly medicine. The team thought that Safety Thermometer data was of a lesser quality than other data already made available to ward managers, because of the methodology used. Therefore, Safety Thermometer data was not routinely circulated by the team. However, the matron and management team reviewed Safety Thermometer data. We saw that key elements of the data were incorporated into performance dashboards for the directorate of speciality and elderly medicine.
- Safety Thermometer data for medical care services demonstrated that between April 2014 and August 2014, 95.7% of patients experienced harm-free care in the directorate of speciality and elderly medicine. In the directorate of cancer and haematology, 97.2% of patients experienced harm-free care. Both directorates performed better than the target of 92%.

Medical care (including older people's care)

- Between April 2014 and August 2014,the number of patients receiving a venous thromboembolism risk assessment exceeded the target of 95%.
- The trend over time shows that the numbers of patients experiencing pressure ulcers and/or catheter-related urinary tract infections have fallen.

Cleanliness, infection control and hygiene

- We observed that the environment was visibly clean and well-maintained. Patients told us they were satisfied with the standards of cleanliness. One patient said, "It's very nice and clean here."
- We were told that audits of cleaning were carried out, and we saw the results of these displayed in ward areas. We noted that the audit results did not indicate any concerns. We looked at composite cleaning audit data collated in September 2014; the average six-week rolling score for medical care services was about 98%.
- We looked at the results of patient-led assessments of the care environment (PLACE). Maidstone Hospital achieved a cleanliness score of 98.87%. The detailed reports for medical care services did not identify any concerns regarding cleaning standards.
- Training in infection prevention and control (IPC) formed part of the mandatory training programme for all staff. Uptake of IPC training was 88.5%.
- Hand hygiene was audited monthly. In medical care services, compliance rates for the period April 2013 to August 2014 averaged 95%. In the same period, the average compliance for staff being 'bare below the elbows' was 99%. We observed staff decontaminating their hands in line with the World Health Organisation's "five moments for hand hygiene" guidance. Adequate hand-washing facilities and hand sanitisers were available in clinical areas.
- We saw that supplies of personal protective equipment such as disposable gloves and plastic aprons were ample, and we observed staff using them when necessary.
- The cleanliness of commodes was audited. During the period April 2013 to August 2014, the average score for the commode cleanliness in medical care services was 90%. We found commodes and sanitary ware to be visibly clean.
- We saw that equipment shared between patients was labelled with a distinctive green label indicating that it had been decontaminated and was ready for use. Staff we spoke with understood this labelling system.
- We observed that clinical and domestic waste was segregated in different-coloured bags and that waste in ward areas was correctly stored. An audit of the management of 'sharps' waste in February 2014 achieved a compliance rate of 98%. We observed that sharps management complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- In medical care services, there had been one case of MRSA bloodstream infection since April 2014. The target set was for no cases. Audits of the MRSA decolonisation protocol showed a compliance rate of 61%, and 60% compliance with the trust's MRSA pathway. This meant that compliance with the trust's systems and processes needed to be more robust to protect patients from MRSA infection.
- On Watman Ward we saw a patient who had been identified as being colonised with MRSA and was being nursed in an open bay. We found that the trust's policy specifies that such a patient should not have been nursed adjacent to a patient with a catheter. The patients either side of the patient with MRSA had catheters in situ. This presented an infection risk to those patients.
- In medical care services, nine case of Clostridium difficile diarrhoeal illness had been reported trust wide since April 2014. We saw that nurse's risk assessed patients in relation to the risk of acquiring C. difficile, and that this assessment resulted in actions being taken to protect patients from this risk, for example increased cleaning regimes.
- In May 2014, three recent cases of glycopeptide-resistant enterococci were reported on Lord North Ward.

Environment and equipment

- General health and safety and fire safety training formed part of the mandatory training programme. Of staff, 90.3% had attended health and safety training and 87.9% had attended fire safety training. This exceeded the target of 85%.
- The results of patient-led assessments of the care environment (PLACE) for Maidstone Hospital achieved a score of 89.97% for condition, appearance and maintenance. The detailed reports for medical care services did not identify any concerns regarding the care environment.
- Staff told us that electrical medical equipment was well maintained centrally by the EME department. Staff

praised the library system in use and said they were usually able to access equipment when needed. We saw that all electrical medical equipment had a registration label, which meant the department was aware of its existence and that it was maintained in accordance with the manufacturer's recommendations.

- We saw that all portable electronic equipment had portable appliance testing labels attached, indicating that it had been safety tested in the previous year.
- We observed a system of applying coloured labels to patient-lifting equipment such as hoists, to show that it had been serviced in line with the manufacturer's recommendations. We saw that all this equipment had been serviced as required by these recommendations.
- We saw resuscitation equipment readily available in each clinical area. There were systems to ensure equipment was checked daily to ensure it was ready for use. We saw from records that staff complied with these systems.

Medicines

- We observed that medicines were administered by appropriately trained staff whose competency had been checked. However, on Watman Ward the manager was unable to show us evidence that agency staff had the competencies to perform their roles in relation to administering intravenous drugs. The ward manager told us they relied on staff to be truthful about whether they had completed this training, and assumed that the manager responsible for booking agency nurses for shifts would check this; however, the manager concerned told us they would expect agency staff's competency in intravenous drug administration to be checked on the ward. We spoke with the temporary staffing office, who told us that no checks took place, although the agency confirmed that the staff supplied had undertaken relevant training.
- There was a ward-based pharmacy service. Patients' prescriptions were checked by a pharmacist to ensure their medicines treatments were safe, effective and met current guidance. We saw pharmacists' annotations on prescription charts, demonstrating such review. Prescriptions met legal requirements and were clear and legible. Clinical staff could access a pharmacist for advice, and patients and their families could also access medicines advice.
- We observed nurses administering medicines and found that, overall, Nursing and Midwifery Council (NMC) standards for medicines management were being adhered to. However, when we looked at a recent drug error on Watman Ward, we found that staff had not followed NMC standards: a patient had not been given their anticoagulant drug for three consecutive days; the patient had become unwell, alerting staff to the administration error; for three days, both nursing and pharmacy staff had failed to notice that nurses had not signed the prescription chart.
- We saw that management of controlled drugs met legal requirements. We checked order records and controlled drug registers and found these to be in order. We spot-checked some medicines and found that stock balances were correct. We saw there were arrangements for ward staff to check stock balances weekly, and saw records of this.
- We found that medicines were stored securely in locked cupboards and trolleys. We saw that keys to drug areas were stored in a key cupboard with access using a digital lock. Controlled drugs on Watman Ward were kept secure using a digital lock, and the code was shared among staff that required access to these medicines. Agency staff were also given the number required to access these medicines. The code for the digital lock was not changed, and staff were unaware of any policy that required them to routinely change it. This meant that there was potential for unauthorised access to these medicines.
- We found that the temperatures of medicine fridges were not consistently checked. We also noted that the ambient temperatures of rooms where medicines were stored were not monitored. We spoke to a ward-based pharmacist who told us they would expect room temperatures to be checked but there was no formal system for doing so. Ward staff we spoke with were not aware that room-temperature checks were required to ensure medicines remained in optimal condition.
- Although records on Watman Ward showed that nurses had checked the temperature of the fridge containing medicines, on two separate occasions the temperature had fallen below the minimal requirements. On both occasions, staff had failed to report a potential fault in the refrigerator to EME as required by the trust's policy. This meant that medicines were not consistently stored at the correct temperature.

Records

Medical care (including older people's care)

- 83% of staff working in medical care services had received training in information governance.
- Medical care services had integrated patients' records shared by doctors, nurses and other healthcare professionals. This meant that all professionals involved in a patient's care could see the patient's full record.
- We looked at patients' records and found they were comprehensive, up to date and reflected the care and treatment patients received. Patients' records were readily accessible to those who needed them.
- We found that medical records were not always stored securely and that unauthorised access was possible. Records were often stored in notes trolleys in ward areas to which the public had access. Although these trolleys could be locked they were not, and staff confirmed this was usual.
- We saw that patients were risk assessed in key safety areas using national validated tools. For example, we saw that the risk of falls was assessed and that the risk of pressure damage was assessed using the Waterlow score. We noted that when risks were identified, relevant care plans that included control measures were generated. We checked a sample of these control measures and found them to be in place. We saw that risk assessments were reviewed and repeated within appropriate and recommended timescales.
- We found that staff had attempted to resuscitate a patient who had been assessed as 'not for active resuscitation' (NFAR). This was because staff were unable to find the patient's health records when the patient died. The patient's health records had been missing for 24 hours, and staff had failed to recognise this or raise it as an issue. This indicated that nursing staff were not following Nursing and Midwifery Council (NMC) guidelines for record keeping or the NHS code of practice for records management. We noted that this particular ward was heavily dependent on the use of agency staff because of a very high vacancy rate.

Safeguarding

- Training in safeguarding children and adults formed part of the mandatory training programme. Of staff, 91.7% had completed some training in safeguarding adults and 90.5% in safeguarding children.
- Staff we spoke with were all aware of their responsibility to report potential abuse and knew how to do this. Staff knew the name of the trust's safeguarding matron and said they would not hesitate to contact the matron for advice and guidance. Clinical staff valued the support provided by the safeguarding matron.
- Staff gave us examples of the management of safeguarding concerns that demonstrated that processes were followed and that staff were engaged in the process.

Mandatory training

- In the directorate of speciality and elderly medicine, compliance with mandatory training was 83.4%. This narrowly missed the trust's target of 85%. In the directorate of cancer and haematology this target was achieved, with a rate of 85.2%.
- Staff were aware of the mandatory training they were required to undertake.
- Ward managers we spoke with demonstrated the systems they used locally to monitor attendance of their staff at mandatory training, to ensure training was completed or refreshed when necessary.

Assessing and responding to patient risk

- We found that patients' physiological parameters such as pulse and temperature were monitored in line with National Institute for Health and Care Excellence (NICE0 guidance CG50, Acutely ill patients in hospital.
- We saw that an early warning scoring system, the 'patient at risk' (PAR) took, was consistently used whenever observations were taken. Staff could talk authoritatively about the scoring system and were confident in its use.
- We watched observations being taken and noted that the technique used would ensure an accurate result.
- We looked at an example where the PAR score had indicated a risk of deterioration, and saw that appropriate actions in line with the trust's protocol had been instigated.
- When reporting concerns about deteriorating patients, staff used a situation–background–assessment–recommendation (SBAR) tool. We saw that copies of relevant SBAR documents were in ward areas. Staff could explain how they used the documents, with examples of when they had done so.
- Staff could access specialist advice in relation to acutely unwell or deteriorating patients between 8am and 8pm from a critical care outreach team. We saw this team

seeing new patients and reviewing patients for whom concerns had been escalated. Staff also told us that the outreach team was proactive and approached ward staff routinely to help them identify and manage patients at risk of deterioration. However, the service did not operate overnight; the site practitioner team carried out this function, but the skill levels of this staff group in relationship to critical care were not formally assessed or recognised.

Nursing staffing

- In the directorate of speciality and elderly medicine, the nursing vacancy rate for registered nurses was 1.7%, with approximately 20 whole-time equivalent (WTE) registered nurse vacancies. However, it was noted that there was in excess of 11.6 WTE unregistered nurse vacancies. The directorate's management team told us that recruitment was one of its major concerns and outlined plans for further overseas recruitment initiatives.
- In the directorate of cancer and haematology, vacancies for registered and unregistered nurses were at 6.2%.
- The numbers of staff planned and actually on duty were displayed at ward entrances in line with Department of Health guidance. We saw that the actual numbers did not fall below the agreed templates. Staff we spoke with told us that it was very unusual for staffing levels not to be maintained, and if it did occur it was because of last-minute changes such as late-notice staff sickness.
- We noted that the number of staff on duty exceeded the ratio of one registered nurse to seven patients, recommended by NICE. Often there was a ratio of 1:4, and registered nurses were supported by care support workers, who represented less than 40% of nursing staff on duty.
- Ward managers told us that nursing staff establishments were reviewed every six months. They felt that the directorate's management team and the board were supportive and were focused on ensuring adequate numbers of nursing staff to provide care. The ward manager on Mercer Ward described the process followed to increase the numbers of staff on night duty in response to a changing patient profile and an increased incidence of falls.
- The ward manager on Foster Clark Ward demonstrated the acuity and dependency tool that was used in medical care services to ensure that staff numbers were appropriate. We were told that if this tool indicated a need, then more staff were put in place. A member of staff commented, "It's nice that they listen and we have the back-up to ensure we don't have more than we can cope with."
- On Watman Ward, 21 of the 26 qualified nursing posts were vacant. This was because permanent staff had been redeployed during a consultation process six months earlier, because it was planned to close the ward; the decision to close the ward had then been reversed, leaving inadequate numbers of substantive staff on the ward. As a result, the ward relied on agency nurses for most of its workforce. The qualified nursing posts had been advertised at the time of our inspection. The lack of qualified nurses and the use of agency nurses meant that continuity of staff and their development was difficult to achieve in this ward area.
- At Maidstone Hospital, temporary nursing staff from both the trust's bank and external agencies represented 14.7% of the nursing workforce in the period February 2013 to August 2014. Staff told us that requests for temporary staff were usually filled.
- We saw arrangements for nursing staff to hand over the care of patients between shifts. These arrangements were supported by printed handover sheets. We looked at these sheets and found they contained relevant information on the specific needs and risks of patients that supported the delivery of safe care.

Medical staffing

- Overall, we found that numbers of doctors at appropriate grades were adequate to meet the needs of patients. We were told that each medical team cared for about 15–20 patients at a time.
- Within the directorate of speciality and elderly medicine, the vacancy rate for medical staff was 6.6%, and in the directorate of cancer and haematology it was 4.7%.
- The use of locum medical staff in medical care services at Maidstone Hospital represented 4% of staff during the period February 2013 to August 2014.
- Consultants represented 29% of the workforce in medical care services against the England average of 33%. Registrars represented 45% against an England average of 39%. This meant there were fewer consultants but more registrars in medical care services than the England average.
- Some junior doctors expressed concern about their workload during night-time hours. The hospital did not operate a 'Hospital@Night' programme, which meant

that specialty medical staff were responsible for their patients and there were no agreed cross hospital working arrangements for medical teams. The medical night cover consisted of an on-call consultant, a registrar and two junior doctors, one providing ward-based cover and the other based in the admissions unit. Junior doctors we spoke with felt the workload for the ward-based doctor was high and said they experienced difficulty completing all the tasks required. It was noted that there was no critical care outreach support overnight for them. Nurse site practitioners could provide some assistance, for example by screening and collating ward requests for the doctor. However, the doctors said the skills of this team were "variable". We were given examples of delays in treatment to patients caused by high workload, including a serious incident in which a patient with dangerous blood levels of potassium came to harm as a result of a delay in being medically reviewed.

- We found that newly admitted patients received a timely review by a consultant. Morning and evening post-take ward rounds took place.
- A consultant on-call system operated. Junior medical staff told us they could access advice from a consultant at any time, and that, when required, consultants medically reviewed patients. Junior doctors told us they had good support and back-up from senior doctors
- We found consultants did not review all patients every day, except where it was determined that not doing so would affect a patient's care pathway. However, the medical team reviewed patients daily during the week, and this was recorded in patients' notes. This meant that although patients were reviewed by a doctor, this was not necessarily a consultant; this had the potential to delay patients' progress through their treatment pathway.
- We found that the hospital was introducing measures to improve handover between medical teams. The trust had recently invested in an electronic system that enabled staff to access records on new patients. We were told that formal handovers between day and night medical staff in the assessment unit worked well. However, we were told that arrangements for communication from the outgoing night medical team were informal. The medical staff also maintained a 'sick list' of patients whose condition was giving cause for concern. This was a new initiative, and staff told us it was still being embedded into practice. For weekend teams, a spreadsheet was maintained containing names of patients who required review or needed attention such as investigations. We were told this worked well, although one doctor commented that "Sometimes patients aren't reviewed." These measures showed that there were a range of handover mechanisms between medical teams during and out of core hours. This had the potential to cause confusion, with a risk that patients might not be reviewed when required. A consultant told us, "The trust are aware some work needs to be done."
- The management team was aware of the risks that medical handover presented, and described arrangements as "haphazard".

Major incident awareness and training

- We found that staff were prepared for a major incident or an event that had an impact on business continuity. All staff we spoke with in medical care services were aware the trust had plans for major incidents and business continuity. All staff had a broad idea of their responsibilities in these situations and were clear about where they would find guidance if needed.
- On Lord North Ward, a staff nurse was able to show us where the 'grab bag' containing essential elements like a torch could be found in the event of an emergency.

Are medical care services effective?

Requires improvement

It was difficult for staff to access clinical guidance, and in some cases staff used guidance that was not current. However, we found that overall practice was compliant with current clinical guidance. Patients who had a stroke were not receiving the possible best care, as shown by the Sentinel Stroke National Audit Programme outcomes. Diabetic inpatients were receiving care of a standard that was below the national average in some areas.

Medical staff's competency in key skills was not assessed to ensure they could carry out procedures safely. However, nursing staff were subject to processes that confirmed their competency when they joined the trust.

Systems for authorising and communicating the outcome of urgent authorisation under Deprivation of Liberty Safeguards were not robust.

Medical care (including older people's care)

Arrangements were in place to ensure patients received adequate pain relief and adequate amounts to eat and drink. Patients could access the expertise of the full range of healthcare professionals, and there were arrangements to ensure the multidisciplinary team worked well together with access to the information they required to care for patients effectively. There was some access to the multidisciplinary team out of hours. Where diagnostic services were not available out of hours locally, there were agreements with other providers to ensure patients could access diagnostic services if needed.

Evidence-based care and treatment

- The medicine directorate's management team explained how new guidance from the Department of Health, National Institute for Health and Care Excellence (NICE) and learned societies was reviewed and implemented. New guidance issued was disseminated to directorates, where it was reviewed by appropriate staff. A report was produced that demonstrated where compliance was achieved and any necessary actions needed where it was not. These reports were discussed at specialty governance meetings and the directorate was required to report progress to the trust's standards committee. This meant there were arrangements in medical care services to ensure that practice remained in line with current guidance.
- On the whole, we found that staff were aware of NICE guidance that was relevant to their work, for example Falls: assessment and prevention of falls in older people (CG161), Intravenous fluid therapy in adults in hospital (CG174) or Chronic heart failure quality standard (QS9). Staff talked confidently about the guidance and how they worked to ensure their practice was compliant. For example, on Foster Clark Ward staff told us that guidelines for tracheostomy care were being reviewed. This was as a result of new national guidelines being introduced; the clinical team had identified that local guidelines needed to be matched to the latest guidance.
- On Watman Ward, we found that staff were not always following evidence-based practice guidelines. For example, in one incident, staff had failed to provide the patient with a sensory mat, despite the patient being assessed as at high risk of falls. When the patient had fallen, staff had failed to follow NICE guideline CG176 for adults who have sustained a head injury. The patient was not offered a computerised tomography (CT) head scan within an hour, and staff had not performed neurological observations.
- We reviewed policy documents, for example those concerned the management of sepsis, and found that the evidence base on which they were based was clearly stated. All local guidance that we reviewed carried a review date that was in the future.
- We found that the trust web-based system for accessing clinical guidelines needed improvement to make it fit for purpose. To access a guideline, the user had to search on key words, which required the user to be very specific in order for the search to produce results. There was no index or contents for each specialty.
- We asked the management team about clinical guidelines. We were shown examples of local guidelines used in endocrinology, and we saw these had recently been reviewed. We saw that the respiratory specialty had developed a chest drain checklist; the specialty lead told us, "Whilst the British Thoracic Society and European Respiratory Society produce such comprehensive guidelines, there is little point rewriting them unless there is significant local variation, which we do not exhibit." We were told that all other medical specialties used national guidelines, although these were not easy for ward medical staff to locate. For example, we asked to see guidelines on acute coronary syndrome, gastrointestinal bleed, asthma and neutropenic sepsis. Junior doctors and a consultant questioned could not find these, and there was no evidence that the guidelines existed in the hospital.
- We were unable to find any guidelines on several common medical emergency conditions. On coronary care, a folder of guidelines was produced. It was not comprehensive and did not cover many common areas for that specialty. There was a myocardial infarction guideline, but this was 10 years old and out of date. This meant that although guidance was available, its use was difficult in practice because it was not easily accessible or up to date. This presented a risk that staff might, therefore, not consult written guidance to provide care that was in line with current practice..

Pain relief

- Patients we spoke with said that staff asked them whether they were in pain and gave them painkillers

when they were required. One patient said, "When I am in pain, they give me tablets." Another said, "Pain control is good; whenever I have needed tablets, they have automatically given them to me."

- We saw that assessments of patients' pain were included in all routine sets of observations. We noted that as part of intentional rounding processes, staff ensured that patients were comfortable.
- We found that staff had access to specialised pain-assessment tools for people with dementia and those with a learning disability. Staff were able to explain how they would use these. This meant that there were systems to objectively assess people with poor cognition to enable appropriate pain relief to be given.

Nutrition and hydration

- We looked at patients' records that showed that patients were assessed for the risk of malnutrition using a recognised, validated tool – the malnutrition universal screening tool (MUST). We saw that screening was repeated as necessary.
- When nutritional screening demonstrated a risk, we saw that appropriate actions, such as the maintenance of food charts, the provision of dietary supplements or referral to the dietician, were taken. However, in November 2013 an audit of nutrition screening demonstrated that 63% of patients at Maidstone Hospital had a nutritional risk assessment carried out within 48 hours of admission. Only 31% of patients were reassessed after seven days in accordance with national guidelines. This showed that not all patients were appropriately screened for the risk of malnutrition at the time of the audit.
- We looked at the results of patient-led assessments of the care environment (PLACE) for Maidstone Hospital. A score of 78.48% was achieved for food. We looked at the detailed reports for medical care services and did not identify any concerns regarding food.
- Patients were positive about the quality of food provided. One patient said, "The food is very good," and another commented, "The food is OK."
- 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 there were medical problems that compromised patients' nutrition.
- Dietary supplements were given to people when prescribed. One relative on the stroke unit expressed concern at the time their family member had had to wait (13 days) for a feeding tube to be inserted when he had swallowing difficulties. They were told the delay was because of the limited number of doctors who were able to insert the tube.
- Audit data from the stroke unit showed there were arrangements to ensure that patients who had had a stroke were assessed promptly to ensure they had a safe swallow and were not denied food or fluid unnecessarily.
- We saw that food charts were generally well completed to enable dieticians and nurses to monitor the nutritional intake of people at risk of malnutrition. Fluid balance charts were used when required.
- We noted that patients were helped to eat and drink and were left with a drink within reach.
- Food that met people's special cultural and religious needs was available.
- There were facilities that enabled families and visitors to purchase food and drink.

Patient outcomes

- Mortality rates for medical care services were in line with national expectations. In the directorate of speciality and elderly medicine, the crude mortality rate since April 2014 was 3.5% against a maximum target of 5.5%.
- The standardised risk of readmission in medical care services overall at Maidstone Hospital was in line with national expectations at 100 for elective admissions and 98 for non-elective. This meant that patients in medical care services were no more likely to require unplanned readmission, suggesting the hospital's care and discharge arrangements were appropriate.
- In the Sentinel Stroke National Audit Programme for January to March 2014, stroke services at Maidstone Hospital achieved a performance rating of D on an A–E scale, where A is the highest. Areas of particular concern identified as part of the audit were compliance with discharge standards and access to speech and language therapy. However, an improvement was noted against the previous reporting period, where an overall E score was awarded.
- We spoke with a stroke clinical nurse specialist who was able to demonstrate some improvement in stroke metrics, although acknowledging, "There is a distance to go." For example, we were told that the hospital kept

beds available for stroke patient admissions, and that 46% of patients were admitted to a specialist stroke unit within four hours. Thrombolysis was now a 24-hour service facilitated by tele-medicine systems, and thrombolysis rates within one hour of presentation were better than the national average at 67%.

- We saw that the trust had a comprehensive action plan to improve its stroke services. We found that the progress of this plan was being monitored. The management team and staff working in stroke services were aware of this plan and were able to discuss its content and implementation with us.
- In the National Diabetes Inpatient Audit (NaDIA) for September 2013, Maidstone Hospital performed worse than the England average in nine of the 22 standards. These included items relating to foot risk assessments and staff knowledge and awareness of a patient's diabetes.
- In a national audit of care of patients with non-ST segment elevation infarction (a form of heart attack), as part of the Myocardial Ischaemia National Audit Project (MINAP), Maidstone Hospital performed better than the England average for patients who were seen by a cardiologist (99% against 94%) but did worse in the number of patients admitted to a cardiac ward (42% against an England average of 53%) and patients that were referred for angiography (65.6% against an England average of 73%).
- In the National Heart Failure Audit, Maidstone Hospital performed better than the England average in nine out of 11 areas. We looked at audit data in relation to the complex pacing of cardiac patients. The data indicated good practice and demonstrated a safe and effective service.
- We found that national and local audits resulted in action plans. We were shown examples of some action plans, for example the one as a result of the NaDIA. This showed that actions to improve compliance with guidance were identified and their implementation monitored.

Competent staff

- In the directorate of speciality and elderly medicine, 47.8% of staff had received an appraisal since April 2014. The figure for the directorate of cancer and haematology was 45.4%. These percentages related to the financial year to date and indicated that the directorates were on course to complete appraisals for staff by the year end. It is worth noting that in the last staff survey most staff said they had an appraisal in the previous year.
- In medical care services, 91.7% of new staff had attended the corporate induction programme. However, only 34% of new starters had had a local induction checklist completed.
- On Watman Ward , ward-based staff completed a two-week trust induction before starting work. This was followed by a two-week local induction on the ward, where the staff member would be supernumerary. Staff that we spoke with confirmed that they had received this induction.
- On Watman and Mercer Wards, we were shown competency-assessment booklets. We were told that nursing staff that were new to trust completed these. The booklets covered a wide range of clinical competencies that were to be demonstrated within the first six months of starting work. We noted that staff were completing these booklets.
- We found no arrangements to assess the competency of medical staff in key skills when they started work in the directorate of speciality and elderly medicine. The directorate's management team had not considered this when we raised the topic with them.
- On Foster Clark Ward, the ward manager explained there was a system for ensuring that at least two nurses who had competency in caring for patients receiving non-invasive ventilation were on duty. This ensured that this treatment could be safely managed on the ward at any time. We saw that this system was followed, and ward records showed the competency of those staff on duty.
- We found a system for orientating and inducting temporary staff to ward areas in medical care services. We were shown a standard checklist that was used, and noted that it had been completed for temporary staff who were working on the day of our inspection. We also saw archived copies of these forms that had been completed before our inspection. This meant there were arrangements to ensure temporary staff could work safely.

Multidisciplinary working

- Within medical care services, we identified a strong commitment to multidisciplinary working. Each ward

area had a multidisciplinary team (MDT) meeting on at least a weekly basis to plan the needs of patients with complex needs. We saw documentary evidence of a multidisciplinary approach to discharge planning.
- Ward teams had access to the full range of allied health professionals, and team members described good, collaborative working practices.
- Ward teams told us they had access to mental health services from a mental health trust. Psychiatric assessments were carried out as a result of referrals.
- In medical care services, the physiotherapy department responded to 76% of referrals, and 85% of those were responded to within 48 hours. The occupational therapy department responded to 97% of referrals, with 73% seen in 48 hours; speech and language therapy to 78% of referrals, with 88% seen within 48 hours; and dieticians responded to 94% referrals, with a 48-hour response rate of 77%.
- We also saw arrangements for a daily handover to the whole MDT in the form of a ward board round, and we saw these in progress. Therapy staff said they considered these a useful format for ensuring they had access to all the current, relevant information they required to provide care.

Seven-day services

- The management team described their approach to seven-day services as "a constant work in progress".
- New medical admissions were seen every day on one of the twice-daily post-take ward rounds.
- A consultant did not routinely see and review patients at weekends in all specialties. For example, there was a cardiology consultant ward round every day, but no routine elderly care ward round at weekends.
- Access to therapy and social care services was available seven days a week. However, the service at weekends was limited and focused on assessments that enabled patients to be discharged.
- Endoscopy services were available seven days a week, but not on a 24-hour basis. A four-hour service was provided on both Saturday and Sunday. If urgent endoscopy was required outside service hours, there were arrangements with another NHS trust to provide this service.
- No interventional radiology service was provided out of hours. However, we were told about arrangements with other NHS trusts for patients to be transferred if emergency interventional radiology was required.
- Ward doctors and staff told us they could access most diagnostic services seven days a week. Magnetic resonance imaging (MRI) scanning was cited as a service with more limited availability. This was not seen as an issue, because other types of imaging could be used. We were told there were no difficulties obtaining the results of diagnostic investigations performed out of hours.

Access to information

- Clinical staff told us they had access to current medical records and diagnostic results such as blood test 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.
- Ward staff explained the arrangements for ensuring that they received a handover for patients arriving on the ward from areas such as the A&E department that would enable their needs to be met and risks mitigated. For example, we saw that Mercer Ward had developed a checklist to complete when accepting referrals to the ward. We saw examples of these checklists being completed, and staff gave us examples of how the information might be used; for example, staff would place a patient at high risk of falls in a bed adjacent to the nursing station for better observation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) formed part of the mandatory training programme. Of staff in medical care services, 73.1% had completed this training, and 50.3% had completed training in consent to care and treatment. These percentages are lower than the trusts expected standard of 85%.
- Staff we spoke with were able to talk about their responsibilities under the MCA. They could name the safeguarding matron who led on matters relating to the MCA and gave examples of how they use their expertise.
- We saw evidence that, where required, formal best interests meetings were held to establish patients' capacity and determine best interests in line with the Department of Health code of practice for implementing the MCA.
- Staff understood the concept of deprivation of liberty and could give examples of where the safeguards had been applied or considered. We scrutinised the records of a patient whose liberty had been restricted. We saw

that urgent and standard applications had been made to the managing and supervisory bodies, and that these met legal requirements. However, there was no record that the managing body (i.e. a senior trust manager) had approved the urgent deprivation of liberty, and staff were unaware that an urgent application did not equate to approval. This meant that, potentially, the patient's liberty had been unlawfully restricted. We also noted that the supervising body had not responded to the standard authorisation referral; we were told there was a delay and backlog in applications. The urgent application was found to have expired, but there was no record of a further submission. We were told that the patient had regained capacity and that therefore deprivation of liberty had no longer been appropriate. There were no records indicating when capacity had been regained and when the deprivation of liberty was stopped. Therefore there was a lack of clarity regarding the appropriateness of this patient's deprivation of liberty, which could have resulted in unlawful restrictions.

- Patients told us that staff gained their permission before giving care and treatment, and we observed this happening. A patient said, "They always ask if you are OK with what they are going to do, explain it fully and reassure you." Another patient said, "The team tell you [about treatment]; you sign to agree. When the staff come to administer care, they ask permission to start."

Are medical care services caring?

Good

Patients and relatives spoke of care being delivered with kindness and of privacy and dignity being upheld. Patients and their relatives told us they felt supported emotionally by hospital staff. They also told us that they felt involved in their care and given adequate information about their care and treatment.

Compassionate care

- Overall, patients expressed a high level of satisfaction with the care and treatment provided.
- We observed that patients were treated with kindness and respect. Their privacy and dignity were maintained; for instance, we saw that care interventions were carried out behind closed doors or curtains, and staff asked permission before they entered.
- Overall, feedback from patients we spoke with was positive; they told us they felt well cared for. A patient told us, "They are very good here; always close the curtains and tell you what they are going to do." Another said, "It's been good care here; I need to be wheeled to the toilet, and they always come quickly. They shut the curtains; they always ask permission before giving me my injection."
- A patient told us, "There is always a chaperone in the room; they use blankets to cover my modesty and explain as to what is being done."
- Patients consistently told us that staff were approachable. A typical comment was, "Care is excellent. Staff are all friendly and attentive; all grades."
- The national Cancer Patient Experience Survey highlighted eight areas where the service was performing below national averages. These included provision of conflicting advice, opportunities to discuss worries and fears, and the provision of sufficient privacy. We asked patients attending the Kent Cancer Centre about these specific areas and were told that in all eight areas, staff had met patients' expectations.
- At Maidstone Hospital, the results for the Friends and Family test averaged 71 out of 100 in the period April 2013 to– July 2014; the England average is 71.
- We looked at the results of patient-led assessments of the care environment (PLACE). Maidstone Hospital had a score of 79.15% for privacy, dignity and well-being. The detailed reports for medical care services did not identify any concerns in this area.
- The trust's patient satisfaction survey asked, "Were you given enough privacy when discussing your condition or treatment?" In the directorate of speciality and elderly medicine, 97.5% of patients responded that they were given enough privacy; in the directorate of cancer and haematology, the result was 100%.

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

- Patients' relatives told us they were encouraged to participate in care when it was appropriate to do so. One relative told us, "She has not been eating foods, so the staff and I have been giving her lots of liquids. They have involved me totally in her care."
- Patients said they were kept up to date about their care and treatment. A patient reported, "The young doctor told me about my treatment and medication. They didn't rush, and my family could ask questions." Another patient commented, "My sisters and mum can ask questions, and they are answered clearly. My sister phones and speaks to the staff, and they answer her questions. The staff have told us we are welcome to speak to the consultant."
- The trust's patient satisfaction survey asks, "Were you involved as much as you wanted to be in decisions about your care and treatment?" In the directorate of speciality and elderly medicine, 87.5% of patients responded that they were involved as much as they wanted; in the directorate of cancer and haematology, the result was 100%.
- The trust's patient satisfaction survey asks, "Did the hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?" In the directorate of speciality and elderly medicine, 95.5% of patients responded that hospital staff did; in the directorate of cancer and haematology, the result was 90%.
- In the National Diabetes Inpatient Audit (NaDIA), 70.2% of patients reported that they felt able to take control of their diabetes care, a percentage that exceeds the England average of 54.7%
- As part of the trust's patient satisfaction survey, 72% of patients responded positively to the question, "Did a member of staff tell you about medicine side effects to watch for when you went home?" The performance target was 90%. However, staff told us that often patients completed the survey before their discharge medicines were available, and that discussions about side effects and medicines management were held in the discharge lounge once medicines were ready.

Emotional support

- The trust's patient satisfaction survey asks, "Did you find someone on the hospital staff to talk about your worries and fears?" In the directorate of speciality and elderly medicine, 93% of patients responded that they did, and in the directorate of cancer and haematology the result was 100%.
- Staff could refer patients to a mental health liaison service. We looked at a patient's notes and saw that a referral had been made when they expressed suicidal thoughts as a result of their condition. We noted that the response was almost immediate and that an appropriate mental health assessment had been performed.
- Patients told us that staff provided emotional support. One said, "The care is excellent; they have been so kind listening to you. My worries are in my private life. When I have called them they seem to have time, and when they say they will come back later they keep their promise. Nurses listened to me and it helped."
- 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 and their families in relation to their psychological needs.

Are medical care services responsive?

Requires improvement

There was insufficient capacity in the medical service to ensure that patients received the right care, in the right bed, first time. There were also insufficient single rooms to meet patients' needs. However, medical care services were meeting national targets in relation to access to care and treatment.

There were no arrangements to ensure that patients for whom English was not their first language were offered professional interpreting services when required. However, attention was being given to providing a dementia-friendly care ethos.

Medical services were responding to comments and complaints from people who use the services, and these were used as a vehicle for evaluating and improving the provision of care and treatment.

Service planning and delivery to meet the needs of local people

Medical care (including older people's care)

- At the listening event, members of the public commented that they were often taken to Maidstone Hospital because there was insufficient space at Tunbridge Wells Hospital. At our unannounced inspection, we noted medical admissions from GP's were being diverted from Tunbridge Wells hospital to Maidstone Hospital. The public felt that being required to travel to Maidstone Hospital because of capacity issues was not being responsive to their needs.
- We saw that the trust was promoting supported discharge arrangements for stroke patients so they could continue their rehabilitation at home.
- We found insufficient single rooms at Maidstone Hospital to meet people's needs. We were approached by a family member of a patient receiving end of life care who was upset at his position on an open ward. The nurse told us that a bed had been requested 48 hours previously but that a single room was not available in the hospital because these rooms were prioritised for infection control measures. On the same ward, a patient with a malodorous condition was also awaiting a single room, because others' reaction to their problem was compromising their dignity. We observed a stroke patient transferred from a specialist unit to a general ward because he required isolation and that was the only side room available. Although the patient's needs in managing their infection were addressed, there was a risk that the patient's care and treatment needs relating to stroke would not be.

Access and flow

- At Maidstone Hospital, the average number of medical patients in non-specialty beds was 145 per month. During the period April to July 2014, three patients were moved more than four times for non-clinical reasons. This indicated that patients did not always receive the right care, in the right place, the first time.
- We found that when demand for beds exceeded the available number, areas such as the cardiac catheter areas were used to provide additional capacity. Staff told us that this had resulted in patients having cardiac procedures cancelled because these beds were not available or could not be adequately decontaminated quickly enough for their procedures to go ahead safely. We found this had happened on seven occasions in April 2014, 17 occasions in July and two in October. This indicated that a lack of bed capacity was having a negative effect on bed availability for elective cardiac procedures.
- Overall bed occupancy exceeded the national benchmark of 85%. In the directorate of cancer and haematology it was 96.3%, and 95.5% in the directorate of speciality and elderly medicine. Staff we spoke with said bed shortages caused constant pressure. There was little flexibility to facilitate good bed management practices, which culminated in the impacts described above.
- The overall length of stay in medical care services was in line with England averages.
- All specialties within medical care services were meeting national standards for referral-to-treatment times, including all national cancer care waiting time standards.
- No patients were reported as waiting longer than six weeks for diagnostic tests in medical care services.
- In the directorate of speciality and elderly medicine, delayed transfers of care represented 6.2% of total admissions, exceeding the target of 3.5%. Staff and managers told us that most delays were attributable to waiting for care home places or other community-based services.
- Medical handover arrangements ensured that medical patients in non-medical beds were reviewed in a timely way.

Meeting people's individual needs

- Of staff in medical care services, 88.4% had attended equality and diversity training.
- We saw that patients with sensory impairments were identified through the use of a discrete magnetic sign to ensure staff could manage their communication. We saw that signage in public areas included braille information.
- People with dementia were identified by a discrete 'forget me not' sign so all staff would be aware of their special needs. We saw that 'This is me' documents produced by the Alzheimer's Society were used to ensure staff had access to a patient's biographical data to inform the patient's care plan. On Mercer Ward we saw that a separate activities room had been developed to cater for the needs of people with dementia.
- Ward managers we spoke with were unaware of any evaluation of their ward areas for dementia friendliness.

We noted some appropriate signage had been used, for example pictorial toilet signs. However, simple interventions as advocated by the University of Sterling publications, such as the use of coloured lavatory seat and fittings, the removal of highly polished floors, and distinctive way-finding features were absent. Some of these elements of a dementia-friendly environment were identified in the reports of the last patient-led assessments of the care environment (PLACE). We noted that the trust's action plan following the National Audit of Dementia Care in General Hospitals contained no reference to environment.

- We saw that bathrooms and lavatories were suitable for those with limited mobility. Supplies of mobility aids and lifting equipment such as hoists to enable staff to care for patients were adequate.
- Hospital mattresses were fit for purpose and provided protection from infection and pressure damage. Where the risk of pressure damage was particularly high, staff could access specialist dynamic mattresses to ensure patients' needs were met and patients were protected.
- Ward staff explained how they could access specialist equipment to treat bariatric patients.
- Staff told us that interpreting services could be accessed through the hospital switchboard. However, they told us that professional interpreters were not used, but instead members of staff who spoke another language. Staff thought that these staff had undergone checks to ensure they were competent to interpret, but could not give any details. This meant that patients whose first language was not English were not provided with independent translation services whose quality could be assured.
- We did not see any patient literature displayed in languages other than English.
- There was a hospital chaplaincy service and staff were aware of how to contact spiritual advisors from major world faiths in order to meet the spiritual needs of patients and their families.
- Medical care services reported no breaches of guidance on mixed-sex accommodation since April 2014. However, we saw that a man and a woman were sharing a bay on the coronary care unit. This unit is exempt from requirements to segregate sexes under the national guidance because of the specialist nature and intensity of care required. However, in this case segregation was warranted because neither patient's clinical condition required them to be cared for in a coronary care unit, but they remained there because there was a lack of beds elsewhere for them to move to. This was a breach of the guidance and should have been reported in line with national standards.

Learning from complaints and concerns

- In the directorate of speciality and elderly medicine, the directorate closed 85% of complaints by the agreed date.
- We observed that literature advising patients how to raise a concern or complaint was displayed in ward areas. Patients we spoke with knew how they could raise a concern. One said, "I would complain to the nurse in blue, but I have none."
- Complaints, their outcomes and lessons learned were discussed at ward level. Some areas such as Lord North Ward used staff newsletter formats, while other areas included these discussions as a standing agenda item at ward meetings. The management team reviewed complaints and their themes and trends as part of their governance meetings.

Are medical care services well-led?

Good

Ward-based staff demonstrated in their work that they understood the stated values of the trust and the local care visions they had developed. Governance arrangements in the directorates that provided medical care services were adequate, and performance was monitored and managed. All staff understood the major challenges facing the service.

Staff told us they felt supported to deliver high quality care. We saw that staff were positive about their work, spoke well of the organisation and were fully engaged with its work and development.

We saw examples of innovative care practice for patients with dementia on Mercer Ward. However, there were no arrangements to ensure that efficiency gains made as part of the national 'Productive Ward' initiative were sustained. Quality and safety issues were prioritised in the directorates, but this meant that cost improvement plans were not sustainable nor sufficiently impact-assessed in the directorate of speciality and elderly medicine.

Vision and strategy for this service

Medical care (including older people's care)

- The trust's vision and values were prominently displayed in medical care services, and staff we spoke with were aware of these.
- We found that ward areas had developed their own visions, which were in line with those of the organisation. Staff spoke passionately about these visions and told us how they tried to make them part of their work.
- We noted that staff were engaged with the broader issues of the trust and were aware of developments planned across the organisation. For instance, they could how the lessons learned from a Never Event in another directorate had relevance across services.

Governance, risk management and quality measurement

- We found that governance systems in the directorates were satisfactory. Management teams were aware of the key challenges in their directorates. Similarly, staff on the wards knew their directorate's areas for improvement, for instance in falls management or improving stroke care.
- A system of specialty governance meetings fed into meetings of the directorates. Meetings included a monthly half-day governance meeting, where items discussed included complaints, serious incidents, audit results, new guidance, performance and directorate board meetings. We looked at minutes of these meetings and established they represented a robust governance framework.
- The directorates produced a quality and safety report that was reported through trust structures such as the health and safety committee and standards committee to enable board-level challenge and assurance.
- We saw directorates' dashboards were maintained and that these provided a range of key management and quality metrics that could be benchmarked against agreed performance targets.
- Performance information was displayed in ward areas in the form of 'How we are doing' displays accessible to staff, patients and their families. Some ward managers displayed additional performance data. Staff we spoke with were aware of this data and took an interest in their team's performance.
- We saw that some events such as falls or Clostridium difficile infection were assigned incidence thresholds. When these thresholds were reached, the ward entered a period of focused activities and enhanced monitoring of key metrics relating to the issue. In this way, medical care services intervened early when safety themes were emerging.

Leadership of service

- Staff we spoke with said they felt supported by the directorate's management team and the board to deliver high quality care.
- Ward-based staff recognised the directorate's managers and board members and told us that middle and senior managers visited ward areas.

Culture within the service

- We observed that staff spoke positively about their work, colleagues and the organisation. Each person appreciated the contribution they made to the care of patients. A junior doctor told us, "I really, really like this hospital."
- We found that staff showed a keen interest in their work and that of others, and demonstrated a commitment to improving services.
- The staff sickness rate within the directorate of speciality and elderly medicine was 4.1%, exceeding the trust's target of 3.3%. The directorate of cancer and haematology achieved the target with sickness a rate of 2.7%.
- Staff turnover in the directorate of speciality and elderly medicine was 8.5% – better than the trust's target of 10.5%. In the directorate of cancer and haematology, turnover was 9.8%. These figures suggest a stable workforce.

Public and staff engagement

- Ward areas in medical care services operated a variety of models to ensure staff were kept informed of developments in their service. However, all staff we spoke felt that whichever system was used, it was effective and met their needs.
- Junior staff told us they felt supported by their line managers. Staff often used the phrase "listened to" to describe how they felt.
- The medical care services supported the trust's patient experience group and patient-led assessment of its performance.

Innovation, improvement and sustainability

Medical care (including older people's care)

- We discussed the medical directorates cost improvements plan. It became apparent that these programmes may not be sustainable because the management teams chose not to compromise aspects of safety and quality.
- In the directorate of cancer and haematology, we were given a clear account demonstrating how risk thresholds had been attached to a cost improvement plan. When those thresholds had been breached, the associated element of the programme was stopped.
- In the directorate of speciality and elderly medicine, the management team discussed how the cost improvement plan related to nursing staffing, but that providing a safe service that met people's needs was a priority, and when there was conflict the cost improvement plan became secondary. This had been confirmed with ward managers in our discussions relating to staffing. We examined the cost improvement plan submitted to us by the directorate. We noted that it contained financial information only and lacked any impact assessment or measures that might or would need to be taken to mitigate the cost improvement plan's influence on safety and quality.
- We saw evidence that ward teams had used the Department of Health's 'Productive Wards' programmes to promote efficient working practice in clinical areas. Although elements of the approach were evident, ward staff told us that the techniques and processes used as part of the programme had not been revisited for at least two years. This meant that medical care services could not be sure that efficiency and quality gains resulting from the Productive Ward programme were sustained.
- We judged arrangements and developments in care for people with dementia on Mercer Ward to be innovative practice. These included the development of a well-resourced activities room and the creation of a dedicated dementia support worker on the ward team. We saw that an article detailing the project and its outcomes had been published in a national journal.

Surgery

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

Information about the service

Maidstone Hospital provides a range of surgical services. Surgical procedures carried out in the last year were divided into 73% day case procedures, 23% elective surgery and 4% emergency cases. The hospital has a dedicated laparoscopic theatre linked to an international minimal access centre for surgery. This new facility is involved in the worldwide development of innovative techniques in keyhole surgery.

We visited all ward areas where surgical patients were being cared for, including the pre-admission unit and admissions lounge, short stay surgical unit, day surgery unit and discharge lounge to observe care and speak with staff and patients. We spent time observing clinical practice on the wards and in the operating theatres, tracked patient care from admission to discharge, and reviewed the medical records of 29 patients.

We spoke with staff of all grades, both individually and in groups. We also met senior staff and managers responsible for surgical services across the trust. In total, we spoke with over 60 members of staff involved in providing surgical services. 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.

During our previous inspection of Maidstone Hospital in February 2014, we found the trust was not meeting all the regulations in surgical services. Some of these related to how the trust monitored the quality of service provision. We issued a compliance action for this, and the trust submitted an action plan detailing how it was going to meet the regulatory requirements.

Surgery

Summary of findings

The quality of care in the surgical services at Maidstone Hospital requires improvement overall. There was very limited learning from incidents. What learning there was appeared to be very localised and reliant on local managers. Some medical records were incomplete, disorganised and not completed in accordance with the standards set by the Royal College of Surgeons. Evidence of water testing was provided following the onsite inspection. However, legionella testing had not been carried out as scheduled.

The main barrier to providing highly effective care was that the hospital had occupancy levels, at times, over 100%. The hospital could not accommodate all the surgical patients that were admitted, which meant that some patients due for elective surgery were, at times, not admitted and were sent home on the day of the operation. However, most people admitted for surgery received good care and had good outcomes.

Patients reported that they received very kind and attentive care from staff. Most patients and relatives we spoke with assured us that the staff, particularly the nursing staff, were always gentle and provided sufficient assistance.

The trust presented a clear vision, but this was not well understood by all staff. Although some consultants were very happy with the support they received from the trust, others clearly were deeply unhappy. A strong team of band 7 nurses were said to be supportive and approachable.

Are surgery services safe?

Requires improvement

There was very limited learning from incidents. What learning there was appeared to be very localised and reliant on the quality of local managers. There was very limited dissemination and no wish to drive improvements through incident and complaint analysis and action planning. The action plans we saw in response to quite serious complaints and incidents were insufficiently robust to be effective. It seemed as if the action plans had been created as an administrative task rather than as a tool for learning across the organisation. Root cause investigations into incidents was very nursing centric; consultants never led investigations, even where the incident was doctor led. We were told that consultants were involved in the process but never took ownership.

Falls prevention work at the hospital was at an early stage with a clear strategy that had yet to be embedded in practice. More people were falling and sustaining injuries than was expected when the trust was compared with other trusts nationally. There were also noticeable differences between wards, with a clear correlation between the use of high levels of agency nursing staff and the number of falls reported, such as seen on Pye Oliver Ward.

Most people admitted for surgery at Maidstone Hospital received good care and had good outcomes. However, the safety of surgical services had scope for significant development and improvement.

The hospital was visibly clean, with clear evidence that housekeeping arrangements and monitoring was good. Infection rates across the trust were falling consistently over time. However, not all staff adhered to the trust's hand hygiene policy. Trust-wide polices showed poor levels of compliance with hand hygiene, and we observed some poor practice.

The estates department did not know when water testing had taken place. This meant the water supplied for operating theatres had not been tested for pathogens and

posed a potential infection hazard to staff and patients. Evidence of water testing was provided following the onsite inspection. However, legionella testing had not been carried out as scheduled.

Despite the trust being criticised in a report by the Royal College of Surgeons in December 2013 for a lack of continuity and having no named consultant for patients because of the 'team approach' preferred by the trust, the situation persisted with patients being unaware of who their surgeon was and having responsibility for their care transferred between teams.

Record keeping was very poor, with loose documents spilling out of files, no systematic order to any filing that had taken place, and entries that did not comply with guidance from professional bodies.

Resuscitation services were well managed and ensured that equipment was available and ready for use across the trust. Staff participated in practice scenarios to ensure their skills were maintained. Adequate numbers of staff had completed advanced life support training, although the uptake of the mandatory basic life support training was low.

Staff had a good awareness of the trust's safeguarding policy and were able to give examples of where they had raised concerns. Most staff had completed the mandatory safeguarding training.

Incidents

- There were several incidents relating to retained maternity and gynaecology swabs and packs. We were shown that the World Health Organization's surgical safety checklist had been amended in the light of these incidents to prevent recurrence. The action plan provided by the trust confirmed that the surgical safety checklist had been amended in June 2014. However, we also saw a recent incident report that related to a nerve block given to treat the wrong leg of a patient. This should be had been classified as a 'Never Event' and was not. We spoke with a senior nurse with responsibility for oversight of surgical services and were told that they were unaware of the incident.
- Records relating to the investigation of an incident where a patient sustained a fractured hip and a pressure wound after falling did not show a comprehensive analysis of the reasons for the incident or a robust action plan. The action plan provided to us was inadequate; it had no target date for completion of the suggested actions and insufficient detail to enable improvements in service delivery to be made. There was no evidence of learning from this incident. We shared the action plan with the director of nursing, who agreed it was inadequate and there was no further information that demonstrated a more comprehensive response.
- From talking with staff and looking at the dissemination of learning from incidents, it was clear that any learning and action following incidents was usually a local response. Staff had a good awareness of how and when to report incidents, but there was a limited response and it appeared that the directorate leaders filtered and dealt with some reports.
- We saw a poster which contained details promoting a third party incident reporting system. We spoke with staff who told us some anaesthetists used an incident reporting system by a commercial survey provider that was not part of the trust's incident reporting system. This commercial survey related more to the working hours and circumstances surrounding the incident than any details about the patients. This raised concerns that two parallel systems were in use and that information that should be used to improve the service was not being shared fully with all trust personnel.
- We saw and heard evidence of better learning from incidents within the theatre teams. Details of any action required following reported incidents and key messages were disseminated across both sites and all theatre staff. This happened because of strong local leadership in the theatres, but there was still limited learning outside the theatres.

Safety thermometer

- The level of pressure damage to the skin experienced by patients at the trust had fallen from a high in September/October 2013 to none reported in quarter 1 of 2014/15. The NHS QUEST group of hospitals had recognised this and had requested to do a case study on the trust's sustained improvement.
- A similar pattern could be seen with high levels of falls reported in July 2013 and a subsequent reduction in incidence over several months. The level appeared to have increased in June and July 2014. The level of falls across the trust was above the national average for all acute trusts in England, and the overall annual level for

2013/14 was significantly higher than in 2012/13 (46 reported incidents against 36 the previous year). The highest level of falls recorded correlated with high levels of agency nurse staffing.

- The minutes of a meeting of the quality and safety committee dated July 2014 showed an increase in complaints about basic nursing care and reported concern about avoidable pressure ulcers and the level of falls sustained across the trust. The minutes showed that nursing key performance indicators were met 50% of the time against a target of 90%. This level of underperformance by nursing staff meant that patients were placed at risk of harm through inappropriate care planning and delivery.
- The Safety Thermometer showed the percentage of harm-free care for the current year (2014/2015) at an average of 96.9%, with a range of 90.3% in April rising to 97.3% in June.
- The crude mortality figures for trauma and orthopaedics showed rates above the planned level for patients presenting with fractured neck of femur. However, supporting evidence showed that the trust was providing treatment for an older cohort with significant co-morbidities. Patients aged over 90 years of age made up 29% of these admissions, compared with 21.5% nationally. Similarly, 9.9% of patients with fractured neck of femur were admitted from a nursing home, compared with 7.4% nationally. These variations were sufficient to mitigate concerns about the crude mortality figure.
- The Safety Thermometer information was visible across the hospital and prominently displayed on wards.

Cleanliness, infection control and hygiene

- The hospital generally appeared clean. Public areas and individual rooms were maintained to an appropriate hygiene level. All clinical staff were observed to be following the 'bare below the elbows' policy.
- Adequate supplies of hand gel and hand wash were available in all areas of the hospital. People we spoke with reported that staff washed their hands before providing care. Hand washing audit reports demonstrated poor compliance with the trust's hand hygiene guidance. However, in the operating theatre, local audits were completed and showed good compliance with the hand hygiene policy.
- The theatre manager was the link person for infection prevention and control (IPC) and had sight of housekeeping and cleaning audits carried out in the theatres. There was, however, no input from the IPC team in relation to environmental audits.
- In the operating theatre, we observed good IPC practice. There were clear records of effective, regular cleaning taking place. A system of marking cleaned equipment with a green sticker was in use. Theatre and equipment cleaning was audited and any shortfalls addressed in a timely manner.
- In the operating theatre we observed good IPC practice. The theatre manager was the link person for IPC and had sight of housekeeping and cleaning audits carried out in the theatres. There was, however, no input from the IPC team in relation to environmental audits.
- The trust reported that its targeted action to improve the incidence of Clostridium difficile had been effective, with a lower number of C. difficile infections diagnosed than in the previous year. The number of reported cases, at 35, was below the maximum for 2013/2014 of 42.
- Methicillin-resistant Staphylococcus aureus (MRSA) screening remained below the planned level, with 96% of patients admitted for elective surgery being screened, against a target of 100%. Screening for non-elective surgery had improved to 97% against a target of 100%.
- The surgical site infection (SSI) rate for trauma and orthopaedics was above the clinical commissioning group's target, with a rate of 126.15 per 10,000 compared with a target of 88.2. Overall, the incidence of SSI for trauma and orthopaedic patients had fallen from the previous year's level. This may have been, in part, because the surgical teams could not meet the recommendation to warm patients before their operations, because of a lack of available beds.
- The data provided by the trust relating to SSIs following total hip replacement showed that the rate after total hip replacement was significantly above the national benchmark for the period from October 2013 to December 2013: the trust's rate was 2.2% compared with a national benchmark figure of 0.5%. This rate had fallen and levelled out for the first two quarters of 2014 but remained above the national rate.
- We were shown evidence that the surgical directorate had set up a task group chaired by the trauma and orthopaedics clinical director with representation from anaesthetic staff , microbiology staff, theatre staff and ward staff. An action plan had been created to reduce

the level of SSI further. A root cause analysis was completed on each SSI and the findings shared with the individual consultant and clinical director. Wider dissemination of the findings might prove more effective.
- The SSI rate following breast surgery had only recently been collected. The figure given was that 1% of patients developed a postoperative infection.
- Evidence of water testing was provided following the onsite inspection. However, legionella testing had not been carried out as scheduled. Legionella testing was due in March 2014, but had been rescheduled for October/November 2014, with no specific date given.

Environment and equipment

- Adult resuscitation services across the hospital were well managed. The resuscitation officer was clear about the provision and had a firm grasp of the service they led. Equipment was checked in accordance with the trust's protocols and any identified shortfalls were rectified in a timely manner. Staff knew where resuscitation equipment was kept and were aware of their responsibilities in relation to resuscitation.
- Fire door and exit regulations were not always followed. For example, we observed fire doors that were wedged open with pieces of card torn from a box, and fire doors blocked with medical equipment and boxes of supplies. We also saw fire exit routes blocked with trolleys.
- The operating theatre environment was cramped, with limited storage space and lots of equipment in the corridor.
- The safety testing of portable electrical appliances and equipment was not up to date.

Medicines

- Nursing staff checked the controlled drugs registers on the wards and in the theatres during each shift change. The temperature of the drugs fridge in the theatre was monitored daily.
- During our previous inspection, concerns had been raised about drug cupboards being left unlocked and drugs being prepared in advance of use. Minutes of the operating department's clinical governance meeting dated October 2014 showed that full discussion and consideration had been given to the practice of leaving the theatre drug cupboard unlocked while a list was in progress. A risk assessment had been undertaken, and it was felt that patient safety might be compromised if anaesthetists did not have immediate access to emergency drugs.
- The operating theatre had a dedicated pharmacist, and medicines were delivered twice weekly.

Records

- We reviewed 29 sets of notes from across the trust. Some related to patients that had already been discharged, and some belonged to current patients. We found records that were disorganised with some documents not fixed into the files. In one set of medical notes we could not find notes of the operation although it was clear the patient had been to theatre.
- The format of notes was chaotic with multidisciplinary surgical care pathways used for recording all care and intervention by staff. These records were also duplication of information in some cases, and trying to track the care a patient had received was very difficult.
- Not all records were completed in accordance with the standards set by the royal colleges. In general, junior doctors made the best records, with their entries being legible, dated, signed and having a clarity that was missing from the entries made by many other staff. Entries by specialist staff such as clinical nurse specialists were also formatted and recorded correctly. Many other entries we saw were not signed or dated, not written in black ink, were illegible with numerous abbreviations and acronyms and with no clear evaluation or plan of care.
- We saw a note in one record where staff were uncertain about a person's resuscitation status, because as the 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) form they thought was in the notes was missing (as opposed to being cancelled).
- Several nursing records that we looked at on the wards were inaccurate and incomplete. Some frail, elderly postoperative patients had no pressure damage risk assessment records. One person had no next of kin recorded; we asked staff to find the persons next of kin details for us but they were unable to do so. The records did not show that this frail, elderly patient did not want anybody contacted if their condition deteriorated. While records completed by staff in the admissions lounge were more complete, poor record keeping was highlighted as a concern on the trust's risk register.

- Patients records' were kept in a key-coded secure cupboard in the admissions lounge until the patient arrived for surgery. This ensured patients' notes were available before patients' arrival but stored safely. However, several patients' records that we saw were temporary notes, which risked important information not being reviewed.

Safeguarding

- Staff we spoke with had a sound understanding of their role and responsibilities in relation to safeguarding vulnerable adults. Staff on the surgical wards were also able to demonstrate their knowledge and how they adhered to safeguarding policies in practice. However, an entry in a patient's medical record showed that a concern had been raised by a patient that their daughter was not acting in their best interests. This statement was recorded, but no action appeared to have been taken by either the junior doctor who wrote it or by other staff who saw the entry.
- Across the surgical directorate, most staff had completed level 1 safeguarding adults training, with rates reported as above the target of 85%.
- In the operating theatres, staff were made aware at team meetings of their responsibilities in safeguarding adults and children.
- Safeguarding champions, who had completed level 3 training, were identified within clinical areas.
- All staff were given a safeguarding information leaflet with the name of the safeguarding champions on it.

Mandatory training

- We asked for details of the mandatory training completed by staff but were told that wards did not keep records. A ward manager was unclear who had completed any training. The trust later gave us ward-level training records; these showed that the majority of staff had completed most mandatory training in areas such as infection prevention, information governance and control and patient handling. The completion rates for other areas of mandatory training were not as good, with low levels of uptake of training in consent, blood transfusions and venous thromboembolism – all of which are key to the provision of safe surgical services. Sepsis training has been mandatory every two years since 2010, but the level of training completion on surgical wards was low.
- The trust's risk register had an entry opened in August 2014 that showed an internal audit had highlighted a failure to meet statutory and mandatory training targets.

Duty of Candour

- Junior doctors we spoke with were unaware of their statutory duty of candour (duty of candour is a new legislative requirement of health and social care providers to ensure that those providers are open, honest and transparent when things go wrong). The trust recognised the introduction of the duty of candour as an issue on its risk register, and a plan was in place to heighten staff awareness.

Assessing and responding to patient risk

- A clinical audit report of non-gynaecological patients admitted to the gynaecology ward stated, "The review of postoperative vital signs and monitoring demonstrated a presumption by staff of a trust policy on the topic that does not exist, along with varied perspectives and practices surrounding the care of patients as they return to the ward. Such inconsistent practice could lead to the deterioration of a patient following surgery that could be avoided with appropriate monitoring."
- Theatres were following National Institute for Health and Care Excellence (NICE) clinical guidelines on venous thromboembolism assessment and prophylaxis (CG92), infection prevention and control (CG139) and pressure damage prevention (CG29).
- In the operating theatres, we observed that patients had completed risk assessments, including for venous thromboembolism (blood clots in the deep veins of the limbs). Patients were fitted with anti-embolism stockings and boots that provided intermittent pressure to the calves, with a consequent improvement in venous return and reduced risk of clot formation.
- Warming blankets were being used in the operating theatre to maintain a patient's body temperature and reduce the risk of postoperative infection.
- Staff in theatres used the World Health Organization's surgical safety checklist with adapted versions for maternity cases, ear, nose and throat surgery and cataract surgery. The theatre manager carried out spot checks to ensure compliance with the safety-checking process. Use of the checklist across the trust had been

variable, and an action plan was created to address this dated September 2014. The target date for completion of trust-wide dissemination of learning was November 2014.

Nursing staffing

- The operating theatres used a baseline tool developed by the Association of Perioperative Practitioners and created a roster of staff in accordance with this guidance. From the rotas, we could see that staffing levels were safe, with vacancies being covered by agency staff.
- Information was publicly available on the trust's website showing planned and actual ward staffing levels, as part of the national safe staffing initiative.
- The short stay surgical unit had a planned establishment of three registered nurses and two clinical support workers during the day, and two registered nurses with one clinical support worker during the night. Registered nurses working on the unit told us that the planned staffing levels were not always met, but that in their opinion the staffing levels were safe.
- The discharge lounge had a planned staffing level of one registered nurse from 8am to 6pm supported by one clinical support worker from 10am to 6pm and one clinical support worker from 8am to 4pm. We were told there had been an additional registered nurse between Tuesday and Thursday, but when they left they had not been replaced,tThe registered nurse on duty did not get breaks, as they could not leave the unit despite not being paid for this time. We were told the registered nursing staff on the unit felt quite isolated from the rest of the hospital. They said although they could technically attend the sisters' meeting, they frequently did not because no staff were available to cover their absence.

Surgical staffing

- Patients were usually only seen by their consultant general surgeon once a week. In between this time, the consultant telephoned the junior doctors for updates on the clinical condition of their patients. The quality and frequency of registrar reviews was variable. This often left junior doctors overworked and regularly having to work outside their contracted hours.
- Proportionately fewer consultant surgeons were working at Maidstone Hospital, and more junior doctors when compared with the national averages for all trusts in England.
- Consultants' cross site working and commitments at a neighbouring trust limited their time to see patients. Team job plans made it difficult to know the exact whereabouts of some surgeons – as was commented on by the Royal College of Surgeons (RCS) in its report about upper gastrointestinal surgery in December 2013. Some patients never met a consultant surgeon during their stay.
- Several consultant surgeons talked to us about patients being handed from one team to another with a resultant lack of continuity of care. The job plans for surgeons in some specialties were team plans created since a review of upper gastrointestinal surgery by the RCS at Maidstone Hospital, reported in December 2013. The report criticised the effectiveness of team working and lack of continuity of care. In a response to phase 2 of the NHS Future Forum, the RCS made clear the expectation that each patient should be admitted under the care of a named consultant. The RCS made clear the expectation that a patient's named consultant would see them before surgery, would operate on them and then review them postoperatively. This was not happening at Maidstone Hospital where the team approach to patient care was used.
- We saw one surgical patient who had been transferred from the intensive care unit to a medical ward as an outlier. The patient did not have a named consultant and did not appear to have been reviewed by a consultant between 29 September and 8 October 2014.This patient had undergone major surgery and had been treated for sepsis. We also saw the records of two urology patients who had not seen a consultant during their admission.
- One patient told us, "I don't really know who my consultant is, but I have seen several different doctors. I get a new one each day. The same junior doctor has been around three days running though."
- There was no formal hospital at night or clinical outreach team at night. We found that at night, shifts could be very busy with only one junior doctor covering the wards. When we visited a ward at night, the junior doctor who should have finished at 4pm was still working at 9pm.

Surgery

Are surgery services effective?

Requires improvement

Most surgical patients had positive outcomes and experiences, but there remained scope for further improvement and development.

The main barrier to providing highly effective care was that the hospital's occupancy levels were at times over 100%. The hospital could not accommodate all the surgical patients that were admitted, which meant some patients due for elective surgery were at times not admitted and were sent home on the day of the operation. Others waited in the accident and emergency department or the recovery area for a bed on a ward – sometimes for long periods. The lack of beds had an impact on the trauma and orthopaedic team's ability to comply with the trust's fast-track policy for patients with fractured neck of femur. The lack of protected elective beds meant that surgeons could not admit patients to beds before their operations, and could not pre-warm patients as part of the enhanced recovery programme.

Monitoring and challenge of individual consultant's performance was not well developed; team outcomes were reported, but governance processes did not provide robust assurance about the quality of individual practitioners' work. Individual attendance at multidisciplinary meetings was monitored but there was no evidence that inconsistencies in attendance were discussed with individuals.

Assessment of risk for individual patients was not always completed and was not always used to inform care delivery. Staff reported good support for their learning, and many told us about higher level courses they had completed that increased their knowledge and skills. Advanced practitioners were working in the surgical assessment unit, which improved the flow of patients and helped nurse-led discharge.

Breast care services were effective with all the surgeons being trained to provide oncoplastic surgery. This improved the choice for patients and reduced the need for patients to transfer to other hospitals for reconstructive work.

The practice of theatre staff was good, and there was clear evidence of plans to improve patient care. However, waiting and changing facilities did not meet the needs of pre-operative patients and required improvement.

Evidence-based care and treatment

- At the time of the inspection, the policies relating to care in the operating theatre were being revised to be in line with current guidance from professional bodies. Protocols for checks of the anaesthetic machine were in line with Association of Anaesthetists' guidance. The swab count protocol for the trust had recently been revised in line with Association of Perioperative Practitioners' guidance.
- Local audits were being undertaken and the results shared among colleagues within the surgical directorate. There was not much evidence of wider sharing of results, and action plans that we saw were insufficiently robust to effect significant change.
- The trust's breast care service provided care and treatment in line with national guidance from NICE (QS12). Breast-conserving surgery was the preferred option, when clinically appropriate, but patients' preferences were considered and incorporated into the treatment plan.

Pain relief

- Patients on the wards we visited said their pain was well managed and they were offered analgesia frequently. We saw some evidence in the nursing notes that pain levels had been assessed and analgesia offered, but this was not routinely recorded. Pain-assessment tools were incorporated into the surgical pathways, but these were not always completed by ward staff.
- We saw significant input from the chronic and acute pain teams. It was clear from recordings in patients' notes that medical and nursing staff sought the teams' advice routinely. We were also told that the pain team provided support to theatre staff and that link nurses attended pain team meetings. Two full-time clinical nurse specialists (CNSs) provided pain advice across both hospital sites.
- The breast care CNS led a breast pain clinic with 20-minute appointments for women with benign breast pain. This allowed them to fully explain the underlying causes of breast pain and order imaging if necessary.

Nutrition and hydration

- Not all patients had been screened to determine their level of risk of malnutrition. Some assessments were partially completed and a body mass index (BMI) had been calculated but this had not been used to inform the risk assessment. The Parliamentary and Health Service Ombudsman commented on poorly completed nutritional risk screening and management of hydration when it wrote to the trust in September 2013.
- Some patients were required to fast for excessively long periods because of the pre-operative admission arrangements. Patients were admitted to the admissions lounge but were advised to fast from 3am. They were advised to have a of drink water on waking but then nothing further pre-operatively. The hospital ran 'all day' lists, and we were told that patients went to theatre up until 4.30pm. This meant that some went for over ten hours without fluids. Nursing staff told us they contacted the anaesthetist if they "were worried", but that because the list was subject to changes and the order could be changed they could not risk people drinking.
- We observed that postoperatively, people were encouraged to drink plenty of fluids on the wards. Water was provided and within patients' reach; hot drinks were also provided throughout the day.
- Patients' views on the food were mixed. Some felt it was, "Quite nice, better than it used to be," and others told us they didn't eat it or that it was "too bland with a lack of fresh vegetables". However, most patients felt the meals were reasonable and that sufficient options were available. We heard positive comments about snack boxes provided for day surgery and short stay patients.

Patient outcomes

- Mortality rates for general surgery were below the national average.
- The standardised relative risk readmission data provided by hospital episode statistics (HES) for 2013/14 showed that in general, readmission rates were similar to or better than the national benchmark, but there was a degree of variation; notably, elective urology and non-elective surgery had higher readmission rates. No explanation was provided for this level of variation.
- Performance in the National Bowel Cancer Audit showed that the trust was generally performing in line with expectations. The notable exceptions were in ensuring patients having major surgery had all their data recorded, where the trust scored only 46% compared with the benchmark of 79%, and computerised tomography (CT) scans being reported, where the trust scored 63.5% compared with the benchmark of 89.1%. Improvements on the previous year's results were demonstrated by increased multidisciplinary team involvement (trust's score of 99% compared with a benchmark of 97.8%) and the involvement of a CNS (trust's score 99.4% compared with a benchmark of 87.7%).

Competent staff

- Staff education was valued by the trust, and staff said they were encouraged to gain additional qualifications that supported their work. One clinical support worker talked to us about being supported to attain National Vocational Qualifications and said that they were going to university to undertake their nurse training next year. The clinical support worker said the managers had been very encouraging and had accommodated shift changes to make the extra training manageable.
- Most staff reported having annual appraisals. The data provided by the trust supported this, although, because it was collated from April through to March each year, it looked as if the levels for 2014/2015 were lower than they actually were.
- In theatres, a professional development nurse worked across both hospital sites. Staff felt the nurse provided good support and gave them information about sponsorship for courses.

Multidisciplinary working

- We saw evidence of collaborative working with specialist tertiary centres. All upper gastrointestinal malignancy were referred to London following concerns that the Royal College of Surgeons raised about the safety of the service in December 2013. Urology patients who needed dialysis were treated at a neighbouring trust.
- Surgeons' attendance at multidisciplinary team (MDT) meetings was generally good. We were provided with a record of attendance at all tumour group MDT meetings across the trust. For a nine-week period between 1 April 2014 and 1 June 2014, the record showed that all head and neck surgeons attended the MDT meetings regularly. Lower gastrointestinal surgeons' attendance was more variable. Some weeks no member of the surgical team attended the lower gastrointestinal MDT meetings. Similarly, urology consultants' attendance

was also variable, with four surgeons attending some weeks and no representation at other times. Records demonstrated that one urologist attended MDT meetings twice as frequently as colleagues did.

Seven-day services

- Emergency surgery was not provided at Maidstone Hospital. Patients arriving at the accident and emergency department with acute surgical conditions were transferred to the Tunbridge Wells Hospital site. Where it was clear that a patient might need emergency surgery, the ambulance usually took them straight to Tunbridge Wells Hospital. An on-call theatre team was available when a patient's condition was too unstable to transfer them before surgery.
- The hospital had a seven-day therapeutic endoscopy service for managing patients with upper gastrointestinal bleeding. A consultant anaesthetist and a staff-grade anaesthetist were available on call for the theatres at all times.
- The pharmacy department provided a daily service from Monday to Saturday. Outside usual working hours, a pharmacist was on call, if necessary.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to online training on the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards. Staff had been given hand-outs to support their understanding of this legislation. At the time of the inspection, 65% of theatre staff had completed the training, but this figure was calculated from April to March, so the level was not a concern.
- The trust's risk register showed an entry opened in spring 2014 following an audit of compliance with the MCA 2005, carried out across both hospital sites. The results of the audit showed that practitioners were not implementing MCA policy into their practice. Tools for assessment were not being used. Medical records reviewed during our inspection showed that capacity assessments were not being routinely carried out and record keeping in relation to best interests decisions and the involvement of family members was generally poor.
- Guidance and a flow chart were in place to support staff where patients declined treatment with blood components: a simple decision-making algorithm considered whether the patient had written and signed an advanced directive to refuse treatment.
- Consent forms we saw were generally well completed. Patients assured us they had been given full explanations about the risks and benefits of surgery, and said they had the opportunity to ask questions. Consent was checked several times on the day of surgery as part of the World Health Organization (WHO) surgical safety checklist process. Audits of the WHO checklist showed improving levels of use across the trust.
- Very low levels of nursing staff in the surgical directorate had completed mandatory training on consent, with only 17.5% of nurses having done the training. A higher proportion of medical staff had completed the training, but the rate of 76.4% was still below the trust's target of 85%.
- Breast care CNSs talked to us about best interests decision making in relation to people with learning difficulties or early dementia presenting with breast symptoms.

Are surgery services caring?

Good

Patients reported that they received very kind and attentive care from staff. Most patients and relatives we spoke with assured us that the staff, particularly the nursing staff, were always gentle and provided sufficient assistance, but this sentiment was not universal.

One person told us they had already made a formal complaint to the trust about the care they had received and the lack of compassion or empathy from the nursing staff. Another relative told us, "It's not ideal, but I suppose they do their best."

The Family and Friends test for the hospital overall scored above the national average, but there were areas of inconsistency with some surgical wards scoring very poorly at times.

Compassionate care

- We observed staff being kind and attentive to patients. Patients reported mainly very kind and compassionate staff, but some mentioned less positive experiences. A patient in the admissions lounge said, "We got the impression the doctor was not listening to us. They could not even be bothered to make eye contact and just stared at their computer screen. They were dismissive and did not answer our questions. Everyone else was lovely, mind."
- Comments made by patients on the short-stay surgical unit were very positive. We saw numerous thank you cards from patients. One said, "Thank you so much for the calming words and care. It was wonderful. I do get in a state sometimes. Thank you for putting up with me."
- We noted that call bells were answered reasonably promptly and patients reported this was usually the case.
- On the surgical wards, the responses to the Friends and Family test were inconsistent. The hospital did not address these inconsistencies; senior staff repeatedly assured us that the hospital scored well on the Friends and Family test, which it did overall.
- As well at the national Friends and Family test, the trust also carried out its own patient satisfaction survey.
- The breast care nurse specialist talked to us about their role and a 'funding pot' they had to support patients diagnosed with breast cancer. They explained that if a woman turned up for a prosthesis fitting appointment with an unsuitable bra and couldn't afford a new one, they gave her money to buy one. Similarly, if a patient arrived for an appointment by public transport and became distressed, they paid for a taxi to take the patient home if they could not afford it.

Understanding and involvement of patients and those close to them

- Patients we spoke with felt that surgical teams had given very good explanations of the treatment and care plans. When we asked patients to tell us what the plans were, they were less clear. We saw on a ward round that the consultant orthopaedic surgeon gave time for patient questions and answered them in a way that patients understood.
- Most people were content with the level of communication and information they received from clinical staff. We heard from three people who felt confused by conflicting information they had been given and who were unclear about the plan for their treatment and discharge. One relative spoke with us about the constant changes to their parent's plan of care. They said, "One doctor says one thing and then a different one tells you something completely different the next day."
- Leaflets on all wards that we visited provided additional information to support what staff told patients.
- One patient told us, "Some care is very good and some rather poor. I wanted help and one nurse ignored me. Another took my temperature and said it was high; they flung the window open and took my blanket off me. I said I was cold and debated with them, but they said they were the trained nurse. Considering I had pneumonia, I thought they were wrong."

Emotional support

- Clinical nurse specialists (CNSs) worked closely with the wider multidisciplinary teams to ensure optimal support for patients and their families.
- At the breast care centre, we spoke with three CNSs who talked in detail about the emotional support and care they provided for patients attending the breast clinic. A group of volunteers visited patients undergoing surgery and breast cancer treatment, to offer emotional support. The volunteers were all people who had personal experience of breast surgery and cancer treatment.

Are surgery services responsive?

Requires improvement

Lack of capacity to cope with the number of patients being admitted led to significant shortfalls in the responsiveness of the service. Patients' operations were cancelled after they had arrived at the hospital for their surgery, and delays were frequent. At times patients were cared for overnight in recovery. Bed occupancy was at a level that exceeded the Royal College of Surgeons (RCS) recommendation. An over-cautious attitude to discharging well, relatively young patients also caused pressure on beds.

Patients admitted through the admissions lounge were pre-assessed to ensure they were able to cope with the environment and that staff were able to meet their needs. One patient we spoke with described the admission process as, "very smooth".

Surgery

Translation services were inadequate and failed to meet the needs of people with limited ability to understand or speak English. Staff told us they used relatives and sign language to communicate. This was insufficient to ensure that patients understood what was being discussed and were able to give informed consent.

We saw very limited and localised learning from complaints. There were delays in responding to complainants and a tendency to give a dismissive response.

Access and flow

- The trust had introduced an additional urology operating list to reduce the backlog of patients waiting more than 18 weeks from referral to treatment. It had also introduced a list on Saturday mornings to reduce waiting lists.
- As of July 2014, 91.2% of patients who were referred for inpatient treatment were being managed witin the national 18 week target. 95.9% of patients referred for non-admitted treatments were also being managed within the 18 week target.
- The trust said bed occupancy was over 90%. Data we hold suggests that for quarter 3 of 2013/14, the level was 95.6% and for quarter 1 of 2014/15 it was 93.9%. NHS England statistics show the national bed occupancy for general and acute hospital beds averaged 89.5% for quarter 4 and 88.1% for quarter 1 in 2014/15. The trust was running at above the national average bed occupancy levels, and this had a significant impact on flow of patients and on patients' outcomes. Several consultant surgeons told us the trust had, in practice, occupancy levels above 100%, which resulted in patients' operations being cancelled after they had arrived at the hospital. One consultant described the situation as, "patients having to bunny hop between beds and hospital sites".
- A number of doctors and nurses told us that patients were sometimes operated on when no bed was available for them postoperatively. We heard that patients were kept for excessively long periods in the recovery area when there was no space on the wards. This was an inappropriate place to care for patients after the immediate postoperative period, because there was no ready access to lavatories, catering facilities and single-sex accommodation. It also meant that either too many patients were being cared for in a limited space or that other operations were delayed until there was more capacity in recovery.
- Because of a lack of available beds, many patients at the trust were accommodated on wards other the specialty they were admitted to. We saw 22 patients on one surgical ward, of whom six were medical outliers. Although medical outliers were mainly on surgical wards, surgical outliers were also on medical wards. This had an impact on the quality of care these patients received. A clinical audit report looked at the care of non-gynaecological patients admitted to the gynaecology ward. It stated, "There was a considerable lack of evidence to demonstrate the nursing care they [the patients] were receiving. Many did not have nursing assessments carried out, nor individualised risk assessments, nor appropriately completed care plans." It concluded that, "Outliers on the ward are not managed as effectively as gynaecology patients and are therefore at risk of developing unnecessary issues and complications throughout their admission."
- On one surgical ward we saw 22 patients of whom six were medical outliers. Meanwhile, surgical outliers were being cared for on medical wards. Bed occupancy was such that a woman was being cared for on a male ward, albeit in a single room.
- One relative said, "My husband is in the hospital now – he was transferred to another ward on Friday night after midnight, which is totally unacceptable. He's being barrier-nursed and was moved from a room with its own bathroom to a tiny side room and told he had to use a commode." The patient's dignity and privacy were not maintained, because he was asked what he wanted for supper while using the commode. We were concerned about the reported levels of movement between wards and around the hospital and the risk this posed to effective infection prevention and control. We noted that a total of 361 bed moves had taken place across the trust during 2013/2014 although the data was not sufficiently specific to identify the times of day when patients were moved. However, we could see from patients' records that it was very common to move patients, and that this occurred at night.

Surgery

- The length of stay for patients at Maidstone Hospital was in line with or longer than the benchmark figure. Non-elective trauma and orthopaedic surgical patients had significantly longer stays in hospital than the national benchmark
- There were no dedicated beds for people admitted for elective surgery. Beds intended for elective orthopaedic patients were taken by medical and surgical outliers, which resulted in patients' operations being cancelled. Numerous staff members told us that this happened "quite often".
- Staff told us that the reason for many beds being unavailable and for the excessive lengths of stay for patients was mainly that the local authority was slow to arrange the necessary care packages. Although this may be true for many patients, there were also clear examples of inappropriate admissions for procedures that most GPs could have treated, delays in discharging well, younger patients, and patients being told to stay in their beds and not go home between two operations because they would "lose" their space. We saw one patient who was admitted to a bed to have a cyst removed from a finger under local anaesthetic; the patient was middle aged and otherwise well. This bed-holding culture contributed towards high occupancy rates and a lack of beds when they were most needed. It is not acceptable to hold patients in recovery when people who are well are occupying the bed they need for fear another bed may not be made available later.
- The lack of bed capacity caused backlogs in other areas of the hospital and had a negative impact on patients' care. The short stay surgical unit would not take postoperative patients from recovery unless an electronic discharge notification had been completed. This necessitated junior doctors going to recovery to complete the form. When the junior doctors were busy elsewhere (as they often were), patients were kept in recovery for most of the day, blocking space and causing delays to patients awaiting surgery.
- Data provided by NHS England relating to cancelled operations was not clear. It showed that the trust had reported no operations being cancelled where the patient had not been treated within 28 days for the period April 2011 to June 2014. Alongside this information was data presented as a percentage rather than absolute figures that showed that between 3% and 6% of patients had their operations cancelled and were not treated within 28 days over the same period.
- Managers told us that no patients were admitted to the short stay surgical unit overnight, but nursing staff confirmed that internal transfer of patients took place, with patients being moved to the short stay surgical unit from wards.
- Women having breast surgery were admitted to either the day surgery unit for wide local excision or sentinel node biopsies or to the short stay surgical unit for an overnight stay when they had undergone mastectomy or axillary clearance. There were rarely delays or problems with the flow of these patients.
- The hospital had a newly refurbished discharge lounge for people awaiting transport or medicines to take home. Staff told us there were clear criteria for admission to the lounge and that site managers would respect the discharge lounge nurse's assessment of a patient's suitability. Where pressure on beds meant that patients were transferred to the lounge whose needs could not be fully met there, measures were put in pace to mitigate the risks. We heard about a person who was quadriplegic who was due to be admitted to the lounge, but the nurse in charge refused because of a lack of staff to provide safe care. The site manager transferred the patient but then remained to assist in the patient's care. Frequently, also, staff were encouraged, because of pressure on beds, to accept patients for whom discharge notifications had not been completed. These patients were technically in the discharge lounge, having not actually been discharged. The discharge lounge was open from 8am to 6pm from Monday to Friday, and 10am to 4pm on Saturday and Sunday.

Meeting people's individual needs

- We were told that the trust had a strong focus on preventing falls. Patients assessed as being at increased risk of falling were provided with wristbands to alert staff. We were also told the ward staff used pressure mats to warn them when a person prone to falling tried to move unassisted. We were also told about very low beds to reduce the risk of falls and the height from which a person might fall. We asked to see these in use

on an orthopaedic ward, but were told there were no patients with them. We did see the wristbands and noticed the non-slip socks that had been provided for patients at risk of falling.

- Patients were admitted to the new admissions lounge (which had only been open for three weeks) immediately before surgery. The lounge had separate bays for men and women, reasonably comfortable chairs and private consultation rooms. One person had written on the NHS Choices website, "My partner had a circumcision today. Initially, we were both disappointed at the lack of consultation rooms in the admissions lounge area, and despite having had a consultation in a bay where everyone could hear about an intimate procedure, the staff, in particular the nursing staff's attitudes, more than compensated for the lack of privacy."
- The new admissions lounge had overcome problems around privacy and confidentiality**.** People were quite happy with the area and preferred being called at home to come in shortly before their operations rather than wait at the hospital from 7am, as happened at Tunbridge Wells Hospital. They would have liked Wi-Fi or at least a television. The bays were fairly stark and uninviting. We were also told that relatives could not usually remain with the person having an operation once they were waiting in a bay; some people waited quite a while. There was a notice to this effect, and the reason given was that people were changed into theatre gowns and sat around in dressing gowns at this point. However, most people were very nervous immediately before surgery, and the presence of a friend or relative might have been reassuring.
- The short stay surgical unit had four bays, two for women and two for men. No breaches of single-sex accommodation occurred, but privacy for patients was limited because the toilets and showers were outside the bays. The bays were wide open to the corridor with no curtain or door across them.
- The trust's risk register had an entry opened in August 2014 that showed a lack of easy-read information across key areas of the trust. Written information was not provided in a way that was accessible for people with learning difficulties.
- The availability of translation services was limited. Staff we spoke with were uncertain about the arrangements and told us that they relied on relatives and other members of staff who spoke languages other than English. One senior nurse told us. "We usually manage to get by with simple instructions and sign language. We do not have many people needing interpreting, so it's not really a problem." This meant that the few patients who did have a limited understanding of English might not fully understand any discussions about their care and treatment. It would also have been difficult for them properly to give informed consent. The exception was the breast care service, which provided patients with leaflets and DVDs in other languages.
- A complaint received by the trust in September 2014 showed that a patient felt vulnerable and isolated because of a language barrier.
- The rate of completion of equality and diversity training was below the trust's target of 85%. Across the surgical directorate, 79% of nursing staff and 80% of medical staff had completed the training.
- Some patients complained about the lack of wireless internet access. They said they felt, "cut off from the outside world".
- Leaflets on all wards that we visited provided additional information to support what staff had told patients.
- They hospital linked with many volunteers, who worked in groups to provide an embroidered cushion for every patient having surgery. The cushions were heart shaped and had kind words on them. The heart shape also meant it was very useful for making the patient's underarm more comfortable. The volunteers also made canvas bags for patients to carry their wound drains in after surgery, removing the need to use carrier bags or hospital property bags.

Learning from complaints and concerns

- During the period August 2013 to July 2014, the Parliamentary and Health Service Ombudsman received 75 complaints against the trust. The ombudsman accepted 12 of these complaints for investigation and made formal recommendations to the trust because of concerns identified in its handling of complaints. Concerns included delays in responding to complaints and poorly managed local resolution meetings. We found that delays in responding to complaints continued.
- We looked at the reports of investigations carried out into three complaints against the surgical services of the trust. One complainant made repeated contact asking for a response from the trust, but kept getting a standard, inadequate reply saying that the investigation

was ongoing and a response would be sent as soon as possible. We also noted an investigation into a complaint from another trust that was insufficiently robust and left many unanswered questions. We saw the action plan resulting from this complaint; three vague actions had no start or completion dates and there was no evidence to support progression or completion. We gave the director of nursing the opportunity to provide us with a more comprehensive response but none was forthcoming.

Are surgery services well-led?

Requires improvement

The trust presented a clear vision, but this was not understood by all staff. Many staff told us that posters and other supporting documents to make the vision more visible were introduced only very recently. When asked, some staff were unable to tell us what PRIDE (the trust's vision statement) meant.

The trust's governance processes had been strengthened a little since our inspection of Maidstone Hospital in February 2014, but still needed further work to make them sufficiently rigorous to provide assurance that the service was as safe, effective and responsive as possible. The executive team lacked an understanding of service delivery and quality.

Some consultants were very happy with the configuration of surgery services, the support they received from the trust and their work environment. Others were deeply unhappy, felt they were not listened to and that their concerns about the safety of patients were dismissed. Following our previous inspection of Maidstone Hospital on February 2014, changes had been made to the clinical leadership of the surgical directorate. Some staff raised concerns that they considered the clinical leadership at both a local and trust wide level to be ineffective with anecdotal comments made that the anaesthetic consultant team were favoured over the surgical team. Some surgeons described the medical director as issuing instructions rather than engaging with staff.

A strong team of band 7 nurses were said to be supportive and approachable. The band 7 nurses were clearly visible on the wards and departments and knew their staff well. We saw some very good examples of local leadership in the surgical assessment unit and in theatres.

External relationships appeared good. We received positive comments from a number of stakeholders about surgery services' open culture and commitment to improvement.

Vision and strategy for this service

- Staff were wearing badges and we saw posters relating to the trust's new vision. PRIDE – Patient First, Respect, Innovation, Delivery, and Excellence – was the message being passed out from the executive team across the trust. Many staff were unaware of the message; others had only heard of it very recently. More work was needed to get the message fully embedded.
- The trust was developing its five-year strategy with a public consultation accessible on the trust's website.
- Many staff had accepted the reconfiguration of surgical services across the trust, but a significant number, particularly doctors, had not; they felt disempowered and disconnected from the trust and the services' leadership.

Governance, risk management and quality measurement

- In the operating theatres there were theatre governance meetings every two months. Minutes were provided for the October 2014 meeting which demonstrated that the operating department gave due consideration to the monitoring of practice and risks. Action plans were created where shortfalls were identified. However, we were told that the surgical directorate held monthly meetings, but we were not given any evidence of outputs from these meetings.
- We were given the results of spot-check audits of use of the World Health Organization (WHO) surgical safety checklist across all theatres at the hospital. Band 7 nurses carried out the audits and recorded use of the checklist rather than undertaking a qualitative review of how the checklist was being completed. In October 2013 the level of compliance was variable across the eight theatres, with three scoring 92% use. The audit showed improvement over time, with the most recent results for

August 2014 showing the lowest use being 98% and three theatres scoring 100%. This demonstrated that the band 7 nurses were committed to improving patient safety through sound governance.

- The upper gastrointestinal surgery service at Maidstone Hospital, which was criticised in the RCS report of December 2013, was discontinued at the trust. All surgery for upper gastrointestinal malignancy was transferred to London. We asked for assurance that these surgeons were performing safely when undertaking surgery for benign conditions. The trust gave us a spreadsheet that showed the 30-day mortality, length of stay and readmission rates for benign upper gastrointestinal surgery. The spreadsheet gave very little information, although we noted that the 30-day mortality rate for hernia repair had doubled between 2012/13 and 2013/14. The numbers involved were very small, with groups of 417 and 398 patients respectively. There was no analysis of this information and no information to determine whether the deaths were related to surgery or other causes.
- Comparative data held on individual surgeons was difficult to evaluate because most surgeons worked in teams as opposed to holding individual accountability for their patients. The trust's website had a link to the NHS Choices website, but no specific details of individual performance were available. We were provided with the data the trust used for monitoring the performance of upper gastrointestinal surgeons, but this was not broken down into individual surgeons' performance, despite serious concerns having been raised previously about their performance.
- Following criticism in our report of the Maidstone Hospital inspection in February 2014 of the very limited time given to the quality and safety committee, a 'deep dive' review was held after each meeting of the quality and safety committee, that focused on a particular aspect of the trust's work where there were concerns. The first 'deep dive' looked back at the RCS report into upper gastrointestinal surgery. Although the increased focus on areas of concern was welcome, the minutes of the meeting showed that the time was spent going over old ground rather than looking at ways to improve the service and at the learning that should have come from the report. We were therefore not assured that robust and timely action was being taken to resolve long standing cultural issues within the surgical directorate.

We also judged that whilst changes had been made to the exisiting governance system, these changes were also insufficiently robust to ensure risks were sufficiently managed and resolved.

Leadership of service

- We saw several examples of strong local leadership from individual managers. The operating theatre manager provided good leadership, was aware of the improvements they felt could be made to theatre practice and was working through a clear strategic plan.
- Some surgeons we spoke with voiced concerns about the effectiveness of their clinical leadership. They described the medical director issuing instructions rather than engaging with them.
- The clinical lead for surgery had only been in the post for two months, which was an insufficient time for us to assess their impact. Previously, the post had been managed by a consultant surgeon for four hours a week, but the current post-holder was full time and had additional administrative support.
- We visited one ward where the ward manager had gone to a focus group, and spent 25 minutes trying to find the person in charge of the ward. It remained unclear who had been in charge of the ward during the time that the ward manager was away.

Culture within the service

- Groups of staff we met were entirely positive about their work and the trust. They told us the trust had changed and was now more receptive to the staff's opinions. However, we heard a different story when we met staff individually and in smaller groups. A significant number of staff of all grades, from a band 6 nurse to consultant surgeons, told us they felt they voices were not heard. One person said, "They are listening, or at least pretending to listen, but they are not hearing."
- The trust's representatives told us that the trust was an open and transparent organisation that engaged well with staff. However, two years ago a group of consultant surgeons had written to the chief executive officer to raise concerns about the safety of surgical services provided across two hospital sites and asking for a fuller appraisal of options. In a meeting between the trust's board and the group of surgeons, we were told that promises had been made to involve the surgeons in changes and to consider wider options for reconfiguration, as they had asked. The surgeons told us

that subsequently they were told, "It's not going to happen." The record of the meeting supported the surgeons' view that they had been promised involvement and a wider consideration of their concerns. Surgeons we spoke with felt their concerns and ideas had been placed in the "too difficult" category and simply laid to one side.

- The report following a review of upper gastrointestinal surgery at Maidstone Hospital in December 2013 pointed out that various staff had identified problems within the specialty "years ahead" of a number of deaths forcing the trust to respond. Numerous staff had raised concerns about poor outcomes and inappropriate behaviours, that had been dismissed at the time. This should have given the trust a clear message about listening to its staff. There appeared to be a similar dismissal of the consultant surgeons' ongoing concerns. We were told that some consultants had raised their concerns with the medical director two weeks before the inspection but had been "brushed aside". Some consultants we spoke with voiced concerns that the two-hospital-site working and team job planning hid a lack of consultant input.
- We also heard from a ward manager who had raised concerns numerous times about patients being cared for in inappropriate environments, being held for excessively long periods in recovery, and even being cared for in a bed in the reception area of the ward or in the corridor. We did not see and could not corroborate this during the visit, but heard similar anecdotes when we met a group of nurses.

Public and staff engagement

- Staff in the operating theatres were very positive about the level of support they received locally.
- Other staff told us they felt that engagement from the senior executives was "tokenistic" and that their voices were not being heard. There was a common perception that decisions were made before consultation took place.

Innovation, improvement and sustainability

- The trust had developed a wristband system with a numerical code that matched the number on the pathology form for a blood sample taken in the pre-assessment clinic that was tested for blood group and saved in case a blood transfusion became necessary during the operation. The patient was given the wristband to take home with the number sticker fixed to it; they were meant to bring it back when they arrived for surgery. This system had been developed in response to an incident several years ago. Unfortunately, the system appeared to create more problems than it solved. We spoke with one person who had forgotten their bracelet and whose spouse had to return home to collect it – an additional round trip of 40 miles. A senior biomedical scientist explained the three options if this happened: the patient or their partner went home to collect the wristband; the operation was cancelled; or the patient went to the pathology laboratory for a repeat blood test. A deviation policy was in place that relied on the consultant in charge filling out a form to override the red-number system, but which used the name, date of birth and hospital number as verification of identity. The red-number system was superfluous and not used by other trusts across the country. It created additional work and resulted in delays to patients' treatment.

Critical care

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

Information about the service

The intensive care unit (ICU) at Maidstone Hospital offers care to level 2 and level 3 critically ill patients who require either organ support or closer monitoring in the immediate postoperative period. The unit has a sister ICU at Tunbridge Wells Hospital, 15 miles away; the ICUs share, for example, the unit's matron and consultants.

The unit admits around 500 patients a year and cares for patients in an age range from 18 years upwards. The unit has 14 beds, with nine currently commissioned for use. The unit is staffed to provide level 3 care for up to seven patients, that is for patients who are critically ill and require one-to-one nursing support, for example patients requiring mechanical ventilation. The unit has two side rooms where patients who required isolation can be cared for. The outreach team provides support for the deteriorating patients on the wards, but this is a daytime service only.

The ICU has consultant cover 24 hours a day, seven days a week. A junior doctor is always present in the ICU. However, the consultants on call at night and weekends are consultant anaesthetists and not always specialised in intensive care. At weekends and at night, the on-call ICU consultant is shared between the trust's two ICUs at Maidstone and Tunbridge Wells Hospitals.

As part of our inspection, we spoke with 28 staff and five patients and relatives. We spoke with a range of staff including nursing staff, junior and senior doctors, a physiotherapist and managers. We observed the care and treatment that patients were receiving and viewed all of or part of 10 care records. We sought feedback from staff and patients at our focus groups and listening events.

Critical care

Summary of findings

Significant improvements were required to ensure the safety of patients in critical care. No apparent admission guidelines were in use to show the benefits of, and criteria for, admission to the intensive care unit (ICU). Improvements were required to ensure that all incidents were reported through the same trust-wide system and were acted on promptly.

Although the ICU was obtaining mostly good-quality outcomes, there was some lack of compliance with national guidelines. For example, at weekends there was only one ICU consultant-led ward round per day, and the consultants were often more than 30 minutes' away because they were shared between the trust's two ICUs.

Governance systems were inadequate; for example, at mortality and morbidity meetings, not all deaths were discussed, and there was no record of the meetings that had taken place. Improvements were also required to the leadership of the ICU to ensure that national best practice guidelines were followed, for example the core standards for intensive care units, 2013.

We found infection control and medicines management systems to be safe. Staff cared for patients in a compassionate manner with dignity and respect. Patients and their relatives were very satisfied with the care provided. However, patients who were ready to be discharged to a ward environment were often delayed for up to a week because of a lack of ward beds, breaching same-sex accommodation, and in many instances were discharged home directly from the ICU. Facilities for patients waiting to be discharged were inadequate, for example there were no separate male/female toilet or bathroom facilities; the nearest bathroom for patients to use was on a nearby ward.

Are critical care services safe?

Requires improvement

Not all deaths were discussed at mortality and morbidity meetings, which was contrary to best practice. There was also a lack of clarity regarding actions and lessons that arose from these mortality and morbidity meetings.

While medicines were accurately dispensed and recorded, medicine incidents were under-reported in the intensive care unit (ICU). The unit did not comply with the requirements for modern critical care units in terms of space, air flow, layout and storage.

Nurse staffing on the unit was adequate. However, the model of consultant cover on the unit conflicted with the core standards of the Intensive Care Society. For example, the general anaesthetists, who covered one of the trust's two ICUs out of hours, had no daytime direct clinical care commitments within the ICU.

The unit and equipment were generally very clean, tidy and well organised. There was good compliance with the trust's policies in relation to infection control, and security of the unit was good. Resuscitation equipment was available and checked by staff. Risk assessments and care plans were well completed. Staff had been trained to recognise vulnerable patients and respond in order to safeguard them.

Incidents

- The intensive care unit (ICU) had reported no Never Events (serious, largely preventable patient safety incidents that should not occur if healthcare providers implement the available preventative measures) in the year 2013/14.
- From the incidents we reviewed, staff were open and honest about incidents they reported. We reviewed the ICU incident reports from 1 April 2014 to October 2014. Different categories of incidents were reported, with no particular identifiable trend. Staff reported when they made an error, such as giving a low dose of medicine; this was an infrequent occurrence. We reviewed one incident investigation undertaken by the manager of the ICU. The incident had been thoroughly investigated, with all the relevant parties involved. Action plans and lessons learned were shared with staff. The staff we

spoke with were aware of the incident and changes to practice to ensure the incident did not reoccur. However, when we reviewed incidents for the past six months, we found that many had not been investigated or closed since July 2014.

- A senior member of staff told us that medicine incidents were under-reported in the ICU and throughout the hospital. Evidence of this was gained through an audit the staff member collected as part of a project. Following this audit, the hospital was required to report to the local clinical commissioning group (CCG) on at least 50 medicine-related incidents a month.
- Generic anaesthetic department clinical governance meetings reviewed mortality and morbidity. No other members of the ICU multidisciplinary team (MDT) attended these meetings, and no minutes were made. Consultants told us that not all deaths were discussed at these meetings, which was contrary to best practice. There was lack of clarity regarding actions and lessons that arose from these meetings. With no record or action plan from the meetings, we were unable to determine who was accountable for any actions or learning, or whether there had been any shared learning within the entire ICU MDT and whether anything had improved as a result.
- There was a trust-wide electronic incident reporting system. However, consultant anaesthetists and intensivists had developed one for their own use, through an external survey company. This system was widely and openly advertised within the operating department in the hospital. This meant that the trust could not have an overview of all incidents and potentially there was no robust mechanism for escalating serious incidents. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons so that similar incidents were not repeated.

Safety thermometer

- Safety Thermometer data for the ICU showed low risks and no specific concerns. There had been only one new unit-acquired pressure ulcer in the last 12 months. There were no falls with harm. No patient harms were reported in 11 of the 12 months from October 2013.
- The unit had high scores when audited for completion of safety data. In the month ending September 2014, for example, 10 records were audited and the ICU scored 100% for completion of risk assessments, action plans, fluid balance charts, care plans and consent. The unit had scored 100% for three of the six audits in the year so far.

Cleanliness, infection control and hygiene

- The unit and equipment were generally very clean, tidy and well organised. Although purpose-built, the ICU, over the years, had taken over adjacent areas in order to increase its size. This affected the layout, which was irregular. The unit did not comply with the requirements for modern critical care units in terms of space, air flow, layout and storage. Space for storage was limited, but nursing and cleaning staff ensured that areas were kept clean and well organised.
- Cleaning of the unit was checked. The unit was audited almost weekly for cleanliness, because cleanliness was seen to be an area of high risk because of the vulnerability of the patients. The audit scores were high, 98%, which demonstrated that the unit was being cleaned effectively.
- Compliance with the trust's policies on infection control was good. Staff practised 'bare below the elbows'. All staff uniforms appeared clean and in good condition. When appropriate to do so, staff wore gloves, aprons and masks. We did not observe any procedures where eyewear was used; however, it was available. There was good adherence to disposal of personal protective equipment when caring for patients in isolation. We observed good hand-washing techniques. Hand-wash sinks were supplied with hot water, soap and paper hand towels. There was hand-sanitising gel at the entrance to the ward, and we observed staff and visitors using this when they arrived in and left the unit. Hand-sanitising gel was also available at patients' bedsides, in side rooms and in other clinical areas and rooms such as the dirty utility room (sluice).
- The main area comprised a bay with six beds. Floor tape marked an area around each bed space. We observed staff sanitising their hands and putting on gloves and aprons before entering each bed space. The aprons were colour-coded according to each bed space. We observed staff taking off the aprons and sanitising their hands again before leaving the bed space.
- Infection rates for the unit, as reported through the Intensive Care National Audit and Research Centre (ICNARC), were low, as in most similar critical care units in England.

Critical care

Environment and equipment

- Security of the unit was good. The ICU was locked and visitors were required to use an intercom to identify themselves upon arrival, and be met by staff. Staff entered the unit by means of a swipe card that was unique to each member of staff
- There was enough equipment for the services provided to patients in most situations. There were enough ventilators for seven patients, and two transfer ventilators were used to transport ventilated patients having investigations in other parts of the hospital. Transport ventilators could also be used on a temporary basis until the patient could be transferred to another facility, or a fixed ventilator rented.
- Resuscitation equipment was available and checked by staff. We reviewed the checklist, and saw that checks were completed twice daily.

Medicines

- Medicines were managed safely. Controlled drugs were stored in a locked unit and the keys held by the nurse in charge at all times. The other medicines were in lockable cupboards within a clean utility area. Medicines requiring refrigerated storage were appropriately stored. We saw that the temperature of the refrigerator was checked each day. There was an awareness of what action to take if the fridge temperature was outside safe parameters.
- Medicines were accurately dispensed and recorded. We reviewed a sample of the controlled drugs and found the registers to be an accurate report of the stocks held. The entries were made as required, in that the administration was related to the patient and was signed appropriately. New stocks were checked and signed for and any destruction of medicines was recorded.
- We checked a sample of different medicines in the general cabinets and found them all to be in date. The expiry dates and batch numbers of the medicines matched the boxes they were stored in.
- The unit had support from the pharmacy team and had a 0.5 whole-time equivalent (WTE) pharmacist. Furthermore, the pharmacists did not attend ward rounds. This was contrary to the core standards for intensive care units (2013).
- Medicines were safely administered, and the patients' records we reviewed showed that medicines were given when they needed to be. Any gaps in administration shown on the charts were appropriately explained and recorded.

Records

- The patients' notes and all associated clinical work such as medicine administration were recorded on paper records
- Patients' records were maintained safely. We reviewed six sets of nursing notes and found them to be up to date and well completed. Risk assessments and care plans were well completed. Care plans included the malnutrition universal screening tool (MUST) score, a pressure ulcer risk assessment tool, use of anti-embolism stockings, moving and handling risks, falls prevention and bedrail assessment.
- The doctor's notes were kept separately by the patient's bedside. Duty doctors completed a daily handwritten pro forma. Four sets of medical notes were reviewed; they were found to be up to date, well completed and organised.
- We observed that it was not easy to use the notes for an overall summary of the patient's stay in the ICU.
- Bedside notes and charts were up to date and clear. Vital signs were well documented, along with cardiac and respiratory indicators. Neuropathic indicators such as pain and pupil reaction were well documented. Prescription drug charts were clear and complete. The trust's generic drug chart was used for patients, with additional ICU-specific drugs recorded on the patients' bedside observation charts. Medicines were appropriately signed for, and if discontinued were signed and dated at the date of discontinuation and crossed through.

Safeguarding

- Staff had been trained to recognise vulnerable patients and to respond in order to safeguard them. Records showed that 94% of staff had been trained in safeguarding vulnerable adults. Mandatory training in safeguarding was delivered every three years and staff were up to date with their knowledge. We spoke with four staff regarding their role in ensuring patients were safeguarded from abuse; all were clear about their responsibility to report abuse, as well as how to escalate concerns both internally and externally.

Critical care

Mandatory training

- We saw from the trust's records that most training for staff in mandatory subjects was up to date. Staff said they were responsible for ensuring that they completed their training. Much training was through e-learning; the matron or line matron checked that staff were routinely completing their eLearning modules in line with trust policies. In some subjects, such as infection control, all staff were up to date with their annual training.

Assessing and responding to patient risk

- The hospital used an early warning scoring system called the patient at risk (PAR) score, which had been in use for a number of years. The PAR score calculated certain indicators of whether a patient was deteriorating clinically, and if so, whether further or new intervention was required. The score included simple physiological observations of the patient's respiratory rate, oxygen saturation, temperature, blood pressure, pulse rate, urine output and level of consciousness. A higher score triggered further intervention from a senior nurse or doctor to ensure that any changes in a patient's status were managed immediately.
- Patients were monitored using recognised observational tools and monitors. The frequency of observations depended on the acuity of the patient. Alarms were set on monitoring equipment to alert staff to any change to the patient's vital signs observation such as heart rate, blood pressure or blood oxygen levels; these alarms assisted staff in being able to assess patients, and where necessary ensure appropriate escalation of the patient to appropriate clinical teams for further intervention.
- Patients were monitored for different indicators. For example, each patient could be monitored for the level of carbon dioxide in their respiratory gases; this was always used for patients during intubation, ventilation and weaning, as well as during transfers and the insertion of tracheostomies (for monitoring the end-tidal carbon dioxide to ensure the tube was in the correct place).
- An outreach team provided support for the management of deteriorating patients on the wards. This service was available seven days a week from 7.30am to 8.30pm. The hours of this service had recently increased from 8.30am to 6.30pm, five days a week. However, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommended in 2011 that outreach teams in hospitals should be available 24 hours a day, seven days a week. Staff we spoke with were complimentary about the service offered by the outreach team, particularly because the team visited each ward every day to assess and offer advice to the staff on any patient causing concern. We spoke with one of the outreach nurses who described a good relationship with the staff in ICU and on the wards. However, in order to facilitate extended hours, the service had been reduced from two nurses on duty for outreach, to one. Some staff were critical that the service had been reduced in this manner, which was thought to have reduced the effectiveness of the service. A senior nurse told us that the number of nurses was reduced to mitigate the extra cost of providing a service for longer hours.

Nursing staffing

- The ICU followed the staffing standards from the core standards of the Intensive Care Society and the guidance on the staffing of critical care units from the British Association of Critical Care Nurses. There was one nurse for each patient needing intensive care (level 3) and one nurse for each two patients needing high dependency care (level 2). In addition, the nurse in charge was supernumerary.
- The staffing rota was planned and staff worked on a rotational basis on days and nights. The nurse manager informed us that staff shortfalls were covered mostly by the unit's own staff or internal bank staff. We were shown a diary in which permanent staff stated their availability for extra shifts, should there be a shortage of staff.
- There were four nurse vacancies for which staff were currently being recruited.
- Occasionally, agency staff with ICU experience were used. We saw a graph that demonstrated that use of temporary staff was rare. The unit was usually provided with agency staff who were known to the trust and was given evidence and assurance that the staff were qualified and had current registration with the Nursing and Midwifery Council.
- New agency staff were given a brief induction to the unit. They were required to sign to confirm they were qualified to care for level 2 or 3 patients, that they were aware of the trust's policies and they had current skills to administer drugs through intravenous lines. In

addition, the nurse in charge told us that in the rare event of a member of staff being unknown to them, that member of staff was allocated a less dependent patient and was supervised by an experienced nurse in the next bed space and by the nurse in charge.

- When shifts changed, the handover between nursing staff was good. At the start of each new shift, a formal handover session to the nurse coming on duty took place in the patient's bed space for half an hour.
- Most nurses worked the trust-standard 12.5-hour long shifts, unless a different flexible arrangement was agreed.
- A ward clerk worked from Monday to Friday, and was able to free the nurse in charge from non-clinical duties and book temporary staff when they were needed. In addition, a healthcare support worker worked from Monday to Friday and assisted the nursing staff with clinical duties. The healthcare support worker was responsible for checking equipment and had been trained to do so; they were also responsible for some other non-clinical tasks. The ward manager, band 7, was on the roster for a clinical shift every two weeks, which gave them sufficient time for other duties such as supervision.
- There was a mix of senior and junior members of staff. However, the unit did not have 50% of nurses with a formal critical care qualification – the percentage was 46%. The critical care matron, band 8b, was not on the roster for clinical duties, because of not having a critical care background; several staff members of different grades mentioned this to us. Best practice guidance from the Intensive Care Society and the British Association of Critical Care Nurses states that the lead nurse for critical care units should have a critical care qualification. The band 8b lead nurse was an experienced matron but also had responsibility for several other areas, including the operating theatres and decontamination services, across the trust's two hospital sites.
- We were shown both recent and historic information regarding dependency scores (which show how many level 2 or level 3 patients are cared for in the unit). We saw links between the dependency levels of patients, staffing levels and the number of patients being admitted.

Medical staffing

- Consultants led and delivered care in the ITU. A total of 12 ICU consultants worked in rotation and were responsible for providing senior cover across the trust's two critical care units at Maidstone and Tunbridge Wells Hospitals. In addition, a number of junior doctors provided care to patients who were under the jurisdiction of the consultant. In daytime hours, the consultant covering ICU did not have other clinical commitments other than in the critical care unit at Maidstone Hospital.
- The consultant led two ward rounds each day, from Monday to Friday. Other relevant staff, including junior doctors, nurses and allied healthcare professionals, gave input to the morning ward round.
- Guidance from the Intensive Care Society and the British Association of Critical Care Nurses states that the consultants' work patterns should deliver continuity of care. However, each consultant only worked one day at a time, covering the ICU from Monday to Friday between 8am and 5pm. It is usual in critical care units that the consultant works four to five days in a row to provide continuity of care. We spoke with a consultant and five nurses, who agreed this working pattern was not ideal. The junior doctors were not critical of this method of working. However, several of junior doctors recounted incidents where plans to wean patient from ventilators were altered on a daily basis according to the individual consultant's preferences. One consultant we spoke with agreed that this was not an ideal situation and told us, "We have tried to get two days in a row working if we can, but it's a bit ad hoc." Junior doctors and trainees supported the consultants to cover the unit on a daily basis; one consultant told us, "It's a fresh pair of eyes. Continuity of the juniors and trainees helps."
- At night and at weekends, not all the consultants were intensivists (doctors specialising in critical care medicine), but instead were general anaesthetists. The trust had consultants on call out of hours – a general anaesthetist and an intensivist. Each consultant was on call for one of the trust's two hospitals, covering not just the ICU but also theatres, A&E and all other anaesthetic emergencies. This model of care was in conflict with the core standards of the Intensive Care Society, which recommend that consultants on call for the ICU have daytime direct clinical care commitments within the ICU. The general anaesthetists, who cover one of the trust's two ICUs out of hours, do not have such

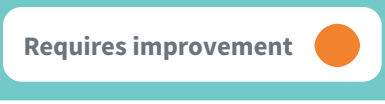
experience. Additionally, The core standards of the Intensive Care Society state that consultants on call for ICUs must not be responsible for providing other services, aside from their commitment to the ICU. One consultant told us, "It's not a perfect on-call system. I think a different on-call model will emerge."

- At weekends, only one intensive care consultant was responsible for providing senior cover across the trust's two critical care units at Maidstone and Tunbridge Wells Hospitals, while also being the anaesthetic consultant for one of the trust's two hospitals. This meant that only one consultant-led ward round was held daily on each unit, rather than the two recommended in the core standards of the Intensive Care Society and by the British Association of Critical Care Nurses. Furthermore, the standards recommend that the consultant on call should be available within 30 minutes. This was not always the case. Although the distance between the two units was 15 miles, the journey could take considerably longer than this, depending on traffic. We saw the minutes of a staff meeting dated December 2013 and September 2014, where concern was expressed regarding lack of consultant cover at weekends.
- Staff told us that, depending on which unit the consultant started their ward round on, the other unit might not have a consultant-led ward round until later in the day, at times, as late as 4pm. This meant, for example, that patients who were ready to be weaned from a ventilator might have this delayed until the following day because it is not good practice to start weaning late in the day.
- The core standards of the Intensive Care Society and the British Association of Critical Care Nurses recommend that a ratio of one consultant to 14 patients should not be exceeded. When the ICUs at both Maidstone and Tunbridge Wells Hospitals were busy; this ratio was, at times, exceeded.
- The lead consultant told us there were plans to recruit more intensive care consultants, and estimated that 15–20 more would be needed to cover the units at both sites. One new consultant was due to start employment in February 2015. The lead consultant thought that the trust had plans to recruit a further two consultants early 2015, but these plans appeared imprecise.
- Handovers between consultants were undertaken twice a day. However, these did not always take place at the patient's bedside; they were often done by telephone or email.
- Before the trust merged the two sites at Maidstone Hospital and Tunbridge Wells Hospital (formerly Pembury Hospital) two years ago, the consultants worked solely at one site or the other. However, since then there had been cross-site working. We received some information before our inspection about antagonism between the two groups of consultants; one consultant had said, "I don't want to set foot on the other site." One consultant we spoke with told us there had been antagonism, however said, "Life has moved on, the falling out has mostly resolved." However, not all the ICU consultants had regular daytime commitments in both of ICUs that they cover out of hours. All consultants had a base ICU where they provided most of their daytime cover.

Major incident awareness and training

- A hospital-wide major incident plan included the response required from the ICU and anaesthetic department. The policy referred staff to an action card that would be used in the event of a major incident. There was a large folder which was easily accessible and included prompt action cards for staff including the nurse in charge. We spoke with three members of staff who understood what a major incident was and what their role was in responding to it.

Are critical care services effective?



There was a lack of clinical guidelines, and the ICU did not always follow recognised guidance for the care and treatment of critically ill patients. However, patients were assessed regularly for pain, nutrition and hydration. The ICU took part in some clinical audit work in order to determine whether patient care was effective when compared nationally.

Multidisciplinary work with a range of professionals who provided support to the ICU was not as comprehensive as guidelines recommend. The hospital did support a critical care outreach team, although only during daytime, seven days a week.

The ICU contributed to data collected for the Intensive Care National Audit and Research Centre (ICNARC). This enabled

the service to be judged on important clinical indicators against other comparable units and the national picture. The service compared well with other units in terms of outcomes, including low mortality rates.

Nursing and medical staff received appraisals to assess their competency and discuss professional development.

Out of hours the hospital was led by the clinical site manager with input from medical and surgical teams and involvement from the ICU junior doctor. Arrangements for out-of-hours support from other services such as physiotherapy, imaging and pharmacy were suitable.

Evidence-based care and treatment

- Recognised clinical guidance was not always followed:
- NICE guideline CG83, Rehabilitation after critical illness (2009) – research shows that up to 70% of patients admitted to a critical care unit have some of degree of post-traumatic stress following their discharge. There was no post-discharge follow-up of patients in the ICU to recognise and treat post-traumatic stress.
- NICE guideline CG50, Acutely unwell patients in hospital: recognition of, and response to, acute illness in adults in hospital (2007) – part of this guideline states that patients should not be transferred from the ICU at night. However, data that we saw demonstrated that eight patients (4%) had been transferred to another ward between 10pm and 7am. This was because of pressure on beds; for example, if a patient required admission to the ICU either from another ward or A&E, that patient was given priority.
- There was no post-discharge follow-up for patients who had been in the ICU. (The Intensive Care Society's core standards for 2013 and NICE guidance CG83, Rehabilitation after critical illness (2009) recommend post-discharge follow-up.)
- The ICU participated in organ-donation work and had a specialist nurse and lead consultant for organ donation. The trust was part of the national organ donation programme and followed NICE guideline CG135, Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation (2011). The organ donation rates for the ICU were, however, very low.
- There was a lack of clinical guidelines; for example, although there was a protocol for weaning patients from a ventilator, it was not readily available and there was little awareness of its presence, and therefore it was not used routinely.

Pain relief

- Pain relief was well managed. Pain scores were documented in patients' records using recognised techniques and measures. Nursing staff said, and we observed, that patients who were awake were regularly checked for pain. Pain was also managed by prophylaxis, which was to anticipate pain and provide relief in advance.
- The trust employed an acute pain clinical nurse specialist (CNS) who worked across both sites, at Maidstone Hospital and Tunbridge Wells Hospital. The CNS reported having a good relationship with ICU staff. The CNS was aware of any patients having major surgery and visited them postoperatively to ensure their pain relief was effective. The CNS reviewed all patients who had epidurals inserted to control their pain, and left a list of these patients for the weekend on-call anaesthetist, in order that regular reviews continued.
- The pain team, which included members from the acute and chronic pain teams, undertook a number of audits to ensure their practice improved in line with Royal College of Anaesthetists' guidelines.

Facilities

- Some staff we spoke with who work across both sites, at Maidstone Hospital and Tunbridge Wells Hospital, reported time wasted when working across the two sites that could have been used to benefit patients. Staff reported that although the sites were only 15 miles apart, the journey could take upto an hour because of frequent delays caused by heavy traffic.

Nutrition and hydration

- The ICU used the malnutrition universal screening tool (MUST) to assess the nutritional needs of patients. Nutrition and hydration were managed effectively. Fluid intake and output were measured, recorded and analysed. The method of nutritional intake was recorded and evaluated each day. Energy drinks and food supplements were used for patients who needed

them. ICU staff followed a protocol for hydration and nutrition for ventilated patients, and enteral tube nutrition was initiated. Support from a dietician was available from Monday to Friday.

Patient outcomes

- Quality indicators for patient outcomes were good. The data the ICU provided to the Intensive Care National Audit and Research Centre (ICNARC) showed that, when compared with similar units, rates for patients readmitted to the ICU were low. The rate of readmission within 48 hours of patients being discharged was 0.4%. This indicated that patients were being discharged from the ICU when it was clinically effective to do so. For patients being transferred to other units for clinical reasons, such as needing more specialist treatment (for example, patients with an acquired brain injury), the ICU's rate was similar to that of other comparable units.
- The ICU had low mortality rates when compared with similar units. However, most admissions to the ICU followed routine elective surgery; there were very few emergency medical or surgical admissions, because most of these went to the sister unit at Tunbridge Wells Hospital. Deaths were rare: 13 in 2013.

Competent staff

- The induction for new staff was comprehensive and included both a trust-wide induction and local indication. There was one local induction programme designed for permanent staff and students and another for flexible workers such as bank and agency staff. The ICU had developed an induction competency pack for band 5 nurses (the most junior qualified nurses).
- Staff we spoke with reported they had regular appraisals with their line manager, where they discussed their performance and career aspirations. All staff said they found the appraisal process useful.
- Staff were given the opportunity for specialist training. However, only 46% of nursing staff had a post-registration critical care qualification. The core standards for intensive care units recommend that 50% of nursing staff should have this critical care qualification. Two nursing staff were undertaking critical care courses at the local college. All ICU staff were trained in adult and child intermediate life support. All band 6 and 7 nurses had completed advanced life support training.
- The ICU had developed a course for nurses, 'Foundations of nursing the critically ill'. This was accredited by the University of Greenwich – 30 credits at level 6. Several staff were undertaking this course.

Medical staff

- Some junior medical staff were undertaking a rotation programme and, as part of this, had protected study days.

Multidisciplinary working

- A multidisciplinary team (MDT) supported patients and staff in the ICU. For example, a dedicated critical care pharmacist provided advice and support to clinical staff in the ICU. However, all the multidisciplinary team did not attend the doctors' ward rounds.
- An MDT meeting every weekday was led by the consultant and attended by the ICU junior doctors, lead nurse and microbiologist, but not the pharmacist. 'Parent' teams were invited to attend the MDT meeting; during our inspection we saw a consultant surgeon attend the meeting and discuss a patient with the ICU team.
- Speech and language therapists visited the ICU when required. They were not formally part of the MDT.
- The ICU had an outreach team, as recommended by the Faculty of Intensive Care Medicine and by Intensive Care Society core standards. The outreach team was a team of senior nurses within the hospital that provided advice and guidance for staff caring for patients in other wards who might be showing signs of deterioration. Members of the team also visited patients who had been discharged from critical care back onto a general ward. The team worked during the day, seven days a week. At night, the service was provided by the site manager, who although a band 7 nurse, did not have specific training, for example ALERT, to recognise deteriorating patients. (ALERT is a multi-professional course to train staff to recognise deteriorating patients and act appropriately to treat the acutely unwell patient).
- Physiotherapists were attached to the ICU and joined ward rounds to discuss, for example, weaning plans for patients receiving respiratory support via a ventilator and mobilisation and rehabilitation for patients. Physiotherapists were also available at weekends and out of hours on an on-call basis.

Seven-day services

Critical care

- A consultant was on call to the service out of hours. However, consultants were not necessarily specialists in intensive care medicine, but were general anaesthetists and had other commitments within the hospital as well as covering the ICUs at both Maidstone Hospital and Tunbridge Wells Hospital.
- Consultants worked in rotation and were responsible for ensuring the ICU had adequate clinical cover from junior doctors at all times when a consultant was not on duty on the ICU.
- Most services – including physiotherapists, radiographers, radiologists and the pharmacy service – were available out of hours: they were available at night and weekends.
- There was consultant cover for patients in the ICU during the day, from 8am to 5pm, and an on-call service out of hours.

Consent and Mental Capacity Act

- Patients gave consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient or in an emergency. Staff we spoke with said they understood and acted in accordance with the Mental Capacity Act 2005 if it was decided to deprive a patient of their liberty temporarily. Staff had received training in all aspects of the Mental Capacity Act 2005, including provisions for depriving someone of their liberty in their best interests.
- Care and treatment for patients who could not give valid informed consent was given in their best interests. The clinical teams delivered general day-to-day care such as giving medicines, nutrition and hydration, attending to personal care and performing tests, and made treatment decisions. If more serious decisions were needed, staff held best interests meetings with those people who could speak about the patient to hear all the views and opinions on future decisions. The assessment form for mental capacity and best interests was thorough and was completed by the patient's consultant.

Are critical care services caring?

Good

Comments from patients, relatives and carers about the care patients had received were overwhelmingly positive.

Patients were cared for by dedicated, kind and caring staff. We saw and overheard sensitive and considerate interactions between staff and their patients. Patients were treated with privacy and dignity. Patients and their relatives were involved in decisions about care and treatment and, where able, gave informed consent.

Compassionate care

- Staff practised and understood the principles of delivering compassionate care to patients receiving intensive care. This included supporting patients who were confused or anxious. Staff said they would talk to a patient and tell them their name, smile, be relaxed and try and help the patient relax.
- We observed the care of a patient who was confused and anxious following a period on a ventilator, and saw that the nurse was kind and considerate of their needs, re-orientating the patient and reassuring them when they seemed anxious. The nurse told the patient, "I have just spoken to [name of patient's spouse]. [Name] will be here at 3pm. It's 9.30am now. I told [Name] that you're doing very well in the hospital and feeling a bit better today."
- All the patients we met told us their care had been good. Relatives we spoke with said staff had met them soon after they had arrived for the first time, and had given updates on each subsequent visit. All visitors we met said they had been given time with the nurses and doctors to ask questions, and this had been done in a private room if appropriate.
- We observed care being delivered where patients' privacy and dignity was preserved. Nurses and healthcare assistants talked to patients and their relatives with kindness and compassion Where care was need to be delivered in private, curtains were drawn. 'No entry' signs on curtains were clearly visible when curtains were closed; curtains were clipped together to prevent other staff or visitors entering without first considering a patient's privacy.
- Compassionate care was given to patients receiving intensive care. This included supporting patients who were unconscious. Staff said they would talk to a patient and tell them their name, the date and time of day. They would then tell them what they were going to do when delivering care, and why. They would explain, for example, when medicines were given, when staff changed at handover, or if the patient was being moved to another department for a test.

Critical care

Understanding and involvement of patients and those close to them

- Patients felt included and involved in decisions when they were able to be. The patients we met told us they had been asked for their consent for any treatment and for their opinions about any decisions to be made. Patients and relatives told us staff had explained the advantages and disadvantages of any proposed treatment options, including the risks and benefits.
- Patients' confidentiality was maintained as well as it could be in an open unit where information about patients could be heard; however, curtains were drawn around patients in the open six-bedded bay during the ward round.
- Patients' nursing and communication notes were stored at the bedside where a nurse was in attendance. Medical notes were stored securely behind the nurses' station.

Emotional support

- The ICU had a ward clerk who worked on weekdays. The ward clerk greeted patients and their relatives and was warm, friendly and approachable.
- The ICU used 'patient diaries'. Staff used these to record progress and for friends and family to record their visits or significant events. The system for starting the diaries was not well developed; for example, we saw one patient whose dairy had started two days previously although they had been in the ICU for a week. Staff we spoke with were unsure what happened to the dairies once a patient was discharged from the ICU.
- When there was a death on the ICU, staff told us that sessions were held to enable debriefing and support. Non-clinical staff, for example the ward clerk, were included in these sessions. However, no counselling was in place for bereaved relatives.

Are critical care services responsive?

Inadequate

The ICU was not able to respond at all times to the need to admit or discharge patients at the most appropriate time.

Patients were admitted to the ICU inappropriately pre-operatively and kept in the ICU when they were fit to be discharged. There were no washing facilities for patients who had been declared fit to be transferred back to a ward.

The ICU did not meet modern standards for critical care in terms of space and facilities. Although the ICU had a quiet room for relatives to have discussions in private, the main waiting area for relatives was opposite one of the main entrances to the ICU through which patients left and entered. Furthermore, the relatives' area was used for daily multidisciplinary team (MDT) meetings, therefore relatives had to sit elsewhere during MDT meetings.

The ICU was able to meet the individual needs of patients and provided personalised nursing care. However, medical care was fragmented and inconsistent. There were no resources for meeting the needs of people who did not have English as their first language. Complaints from patients were infrequent, but these were responded to appropriately. However, there was no evidence that details were shared with staff to improve future care and treatment.

Service planning and delivery to meet the needs of local people

- As with many district general hospitals, at Maidstone District Hospital the ICU was not able to meet some clinical needs, such as for some patients with brain injuries. Certain categories of patient who needed specialist services would therefore be transferred to appropriate units, the nearest being in south east London.
- The hospital did not have a separate high dependency unit, and therefore at busy times relied upon care on wards, transfers to Tunbridge Wells Hospital, caring for patients in the postoperative recovery room, or discharging patients to wards at inappropriate times.
- The environment in the ICU did not conform with modern building standards. Although the ICU had a quiet room for relatives to have discussions in private, the main waiting area for relatives was opposite one of the main entrances to the ICU through which patients left and entered. Furthermore, the relatives' area was used for daily MDT meetings, therefore relatives had to sit elsewhere. There were two rooms where relatives could stay overnight if, for example, their loved one was very unwell or was unstable.

- Facilities for people with motor or sensory disabilities were limited, and there was no toilet with disabled access on the ICU.
- Bed spaces were small and did not meet the size recommended by the Department of Health Building Note 04-02. This was not included in the trust's risk register.
- The hospital had the ability temporarily to increase its capacity to care for critically ill patients during a major incident such as a pandemic flu crisis or serious public incident. The hospital was able to make up to 14 beds available for critical care; however, there was a reliance on temporary staff to do this.
- When new patients were admitted, they were not always seen by a consultant in intensive care medicine as recommended by the core standards for intensive care units. This was particularly the case during the evening or at the weekend.

Meeting people's individual needs

- Equality and diversity of patients were considered, although there was no specific resource in one place for staff to access. Staff were able to describe the areas of equality and diversity they had experience of supporting. They were knowledgeable about the strands of equality and diversity and what made each person an individual. Staff would respect different cultures and religious needs by, for example, providing only male or female staff if this was important to the patient. Staff told us all patients were treated and cared for as individuals and adjustments were made to ensure that outcomes for patients were as good as they could be.
- No translation services were available. However, the local population was not ethnically diverse. If patients did not speak English, a family member or a member of staff would provide translation, which was not ideal.
- Staff had access to a network of support for patients' spiritual needs, both within the hospital and from the local community. The chaplaincy based at the hospital visited the wards regularly, and specific visits could be arranged.

Access and flow

- Bed occupancy was around the national average at just over 80%, with a small increase over the winter of 2013/14, which was not unexpected.
- The discharge of patients from the ICU was often not done at the optimal time. Studies have shown that discharge at night can:

-increase the risk of mortality

-disorientate and cause stress to patients

-be detrimental to the handover of the patient.

- Between April and September 2014, eight patients (4% of admissions) were transferred from the ICU for non-clinical reasons, for example if another patient was admitted as an emergency and required an ICU bed.
- A very high number of patients were discharged more than four hours after they were fully ready for discharge (around 82%). Patients were often delayed from leaving the ICU by several days. The week before our inspection, staff reported that two patients who had been ready for discharge had stayed on the ICU for a week. In the past, when a patient's discharge was delayed by more than 24 hours it was logged as an incident. This then highlighted a continuing problem to senior managers and the board. However, since January 2014, when there were 46 such incidents, a member of the senior management team had asked staff not to continue to record any such incidents. The reason given for this was that, unlike for the four-hour waiting times in A&E and 18-week referral to treatment times for surgery, there were no financial penalties to the trust for breaching these best practice guidelines. Senior staff told us they continued to escalate delays to the matron during the daily bed meetings, but the practice continued. Conversely, staff told us that if a patient required urgent admission from A&E, a bed was always found for the ICU patient awaiting discharge and they were quickly transferred to a ward.
- The facilities on the ICU for patients who were ready for discharge to a ward were inadequate. There was one toilet, which, if there was more than one patient using it, breached directives on the provision of single-sex accommodation. Although senior staff told us this was escalated to the matron and discussed at daily bed meetings, it was unclear whether this was reported as a breach of providing single-sex accommodation, because we were unable to speak to the matron. There was no shower or bath for patients' use. However, staff said they took patients who required a shower to the ward next door.

- During our inspection, a very elderly patient was admitted for routine pre-operative tests such as blood tests before their planned surgery. Staff told us this was because there was no space in the surgical admissions unit. This meant that an elderly person was admitted to an unsuitable environment, before surgery, opposite a patient requiring level 3 care who was being ventilated. This was an inappropriate use of an ICU bed.

Learning from complaints and concerns

- The ICU received few complaints or concerns. Informal concerns or complaints were dealt with by staff on duty; the matron then either took responsibility for addressing these or was informed about how they had been managed. Formal complaints were redirected to the hospital's Patient Advice and Liaison Service (PALS), which acknowledged the complaint in writing before passing it to the relevant person in the ICU to respond to fully.
- Outcomes and actions from complaints were disseminated to staff informally. Staff told us they were aware if a complaint had been raised. However, Outcomes and actions were not disseminated by any other means or during staff meetings, which were too infrequent for information to be given in a timely manner.

Are critical care services well-led?

Inadequate

There was no statement of vision which was specific to critical care services.

Financial and quality governance systems were not wholly integrated; budgetary constraints had led to delays in the development of services such as the nursing outreach programme.

Governance arrangements were unclear which lead to existing arrangements being inefficient and ineffective. This led to delays in the review of critical care procedures and ensuring best practice guidance being implemented.

Minutes were not taken of some meetings, and the nursing and medical teams did not work together to ensure continuous improvement. The daily change of the consultant lead for each patient was perceived as a barrier to continuity of care.

There was no effective system for identifying, capturing and managing issues and risks at a local level. The was a lack of robust evidence to demonstrate that issues which affected or had cause to potentially affect the clinical effectiveness of the service were being resolved. Furthermore, there was a lack of clarity about who was responsible for change management and departmental development.

However, the critical care team was well motivated and supported at local level. The local nursing leadership staff were well respected because of their clinical skills and knowledge.

Vision and strategy for this service

- The outreach service increased its hours of cover from five days a week to seven at the end of September 2014 to help support the needs of the hospital.
- Plans to increase the outreach service to 24 hours, to comply with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines, were on hold because of current budgetary constraints.
- There were plans to increase the number of consultant intensivists, with one starting work in February 2015. However, firm plans to employ more consultant intensivists were inexplicit with no clear business case or confirmed funding in place to facilitate such an expansion of the consultant workforce.

Governance, risk management and quality measurement

- A trust-wide risk register was in use. We noted that, at service level, there was no risk register in place. Although there was an entry regarding delayed discharge of patients trust-wide, there was no entry specific to ICU and patients being kept in an unsuitable physical and psychological environment.
- Whilst there was evidence that clinical governance meetings were held monthly, we found that these meetings were anaesthetic-based sessions and senior nursing staff or other vital members of the ICU multidisciplinary team did not attend. Minutes of these meetings were not distributed to the entire ICU team.
- In the main, nursing and medical teams did not work together to ensure continuous improvement.
- We were shown minutes from clinical governance half-day meetings dated 14 May 2014 and 12 June 2014, which briefly outlined sessions held, led by doctors on topics such as guidelines on patient-controlled

analgesia, re-audit of sepsis guidelines, gynaecology readmissions and re-audit of ICU admissions compared with Intensive Care National Audit and Research Centre (ICNARC) data. However, there was no record of attendees' discussions or reviews of action plans. The meeting on14 May 2014 stated that the action points from the previous meeting were not available. There was little ICU-specific data.

- We were shown minutes of clinical governance meetings dated 17 September 2014 and 9 October 2014, from the anaesthesia service. The meeting dated 17 September stated that no minutes were available from the previous meeting, and gave no date when the previous meeting had been held. However, both meetings described issues arising from general anaesthetics and paediatrics. There was nothing specific to ICU.
- There were weekly key performance indicator meetings. We were told that these were attended by a senior nurse or nominated representative. Staff performance was discussed, as were safety thermometer results, trends and any actions taken. We were told that staff sickness, absence, training, staffing issues and incidents were discussed; however, no minutes were available for us to see. There was no evidence to support any improvements made or of who was accountable for change and development.
- A data coordinator was in post who collected data and submitted it to ICNARC. Senior staff were aware of the latest ICNARC data results, which were shared at a joint consultant/senior nurse meeting. However, it was reported that consultants attendance at this meeting was poor. We were not shown any minutes from these meetings.
- Clinical governance was inefficient, and therefore reviews of critical care procedures and ensuring best practice were slow. For example, we saw a draft protocol for catastrophic brain injury that had been discussed at a meeting in February 2013. However, by October 2014 the draft document had only just been written and had not been approved for use.

Leadership of service

- A band 8 matron, senior clinical nurse and consultant clinical lead led the ICU.
- Nursing staff at all levels said they thought the matron had a very large remit over both Maidstone Hospital and Tunbridge Wells Hospital, 15 miles away. The matron's responsibilities covered both ICUs, the operating departments and decontamination. All staff were aware that the matron, although an experienced clinical manager, was not experienced in critical care and therefore did not have a full understanding of the issues in an ICU.
- The band 7 clinical lead and band 6 charge nurses were all respected by the nursing staff because of their experience and knowledge. However, some band 7 nurses were delivering appraisals for nurses of the same grade. It is usual for appraisals to be carried out by someone senior to the appraisee.
- There was some criticism of lack of cohesion between some medical staff. In addition, the daily change of consultant lead caused staff to often feel frustrated that treatment plans devised one day were not followed through to the next because the consultant for that day had a different view. Staff perceived this as a barrier to continuity of care, with for example when weaning patients from ventilators. One member of staff told us, "You just have to get on with it. Eventually you get used to what each individual consultant wants. It is frustrating though when plans change, sometimes it seems, for the sake of it."

Culture within the service

- There was a strong culture of teamwork and commitment from the nursing staff in the ICU. All the staff we spoke with said the strength of the ICU was as a friendly and cohesive team. Patients and relatives also commented on the positive nature of the staff they met.
- Action to deal with issues of poor performance among staff was appropriate. The ward manager said staff would enter a capability pathway if they did not complete their mandatory training or there were other performance issues. There were human resource procedures to be followed and support available for disciplinary matters that needed to be escalated to senior management.
- Consultants did not appear to work cohesively either among themselves or with the nursing management team. For example, one consultant had never all met all his colleagues.
- There was very little engagement between the various health professionals to support a governance framework.

Critical care

- There was no evidence that multidisciplinary team meetings took place to discuss incidents, mortality and to develop clinical guidelines.
- Band 6 and 7 nursing staff team leaders were well supported and well respected by their own teams. All staff we met were committed to high quality, compassionate and safe care and treatment.
- Staff told us their values, and patients were at the centre of their descriptions. Staff also said how they valued their teams and the work they did.

Public and staff engagement

- Because of the nature of critical care, the general public was not involved with how the service was run, but patients and their relatives were asked to comment on patients' care. There was no analysis of feedback, or any trend analysis to drive improvements in practice.
- We were shown a document, Terms of Reference for Critical Care Users Forum, which had been approved on 12 August 2014. Meetings were to be held quarterly. However, there were no records of the meetings being held in August 2014 held.
- The relatives and patients we spoke with were all complimentary about the service.
- Most nursing staff told us they had a voice and their opinions were valued. There was a degree of flexible working, which staff appreciated.

Innovation, improvement and sustainability

- Two clinical practice facilitators, between them, worked as one whole-time equivalent (WTE). The rest of their hours were spent working clinically to maintain their skills. The clinical practice facilitators were committed to ensuring that nursing staff had a thorough induction to the ICU and that their clinical education continued throughout their employment there. They ran a series of individual and group sessions to improve skills and confidence.
- There were no current plans to improve or develop the service. For instance, patients' notes and all associated clinical work, such as medicine administration, were recorded on paper records, with no plans to upgrade these to more secure, efficient electronic records.
- The team working in critical care had strong shared values, but there were no longer-term objectives for the team to work towards. There was no evidence that the team were working towards improving their service through means such as ensuring compliance with national standards, for example, core service standards for intensive care, NICE guidelines and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines, some of which have been outstanding since 2009 and are the basis for achieving clinical excellence for all ICUs.

Maternity and gynaecology

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

Information about the service

The Maidstone Birth Centre (MBC) was opened in 2011; it is a purpose-built midwifery-led unit for women who have been assessed as having a low-risk pregnancy. The birthing centre is part of the maternity and gynaecology services of Maidstone and Tunbridge Wells NHS Trust. The facilities at the birth centre include two birthing rooms and four postnatal bedrooms.

From October 2013 to September 2014, 404 babies were born at the centre. Any women or babies with complications are transferred; 144 women started their labour at the centre but were transferred to the maternity unit at Tunbridge Wells Hospital.

Maternity and gynaecology services at Maidstone Hospital include antenatal clinics, specialist early pregnancy service, the antenatal day unit (ADU) and gynaecological oncology.

Summary of findings

Systems were in place to ensure that safety was a priority for both maternity and gynaecology services. Women who wanted to give birth at the Maidstone Birth Centre (MBC) were assessed to ensure they were suitable for a low-risk-environment birth. Women and their babies were treated in a well-equipped environment. National evidenced-based best practice, professional standards and expert guidance were routinely used to ensure that mothers' needs were assessed and care was delivered that was safe and effective.

Feedback from people who used the maternity service was positive about how staff treated them.

Staff were engaged with innovative practices; they were involved in making changes that had a direct impact on and improved women's experiences.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

Systems were in place to ensure that safety was a priority. Women and their babies were treated in a well-equipped environment. Staffing numbers were reviewed to ensure that service needs could be met. Risks were effectively assessed and managed, there was a process for reporting incidents, and any areas of learning were shared with staff.

Incidents

- The Strategic Executive information System (STEIS) records serious incidents and Never Events. There had been no Never Events reported during 2013/2014. Since the birth centre opened, one serious incident had been reported. The trust completed a serious incident review; the woman and her family were met and a full apology was given. As a result of the incident, the birth centre developed a quiz using scenarios for staff to learn and test their knowledge of trust guidance and policies.
- An electronic incident reporting system was in place to report near misses or adverse events. Maternity incidents were entered onto the system and graded according to their severity. Staff we spoke with understood the reporting process. Weekly risks meetings were held; a dedicated risk manager/clinical governance lead for maternity and gynaecology followed up and fed back about incidents. The weekly risk meetings were open to all staff who wanted to attend.
- We saw evidence that learning from incidents was shared with staff. During the inspection we visited different departments and saw folders of care assurance reading evidence (CARE) within the departments. The folders contained information that included but was not limited to feedback from risk and governance meetings.

Safety thermometer

- On the Maidstone Birth Centre (MBC), Safety Thermometer information in the form of 'How we are doing' boards was displayed in the entrance foyer. Information on display included anticipated and actual staffing numbers.
- The MBC had a designated lead midwife who coordinated venous thromboembolism risk assessments and monitored that they had been completed, on a weekly basis.

Cleanliness, infection control and hygiene

- The Safety Thermometer boards gave evidence of cleanliness audits. Results for weekly cleanliness audits completed between 1 and 22 September 2014 for both the delivery suite and postnatal ward averaged from 97.9% to 99.79%.
- In 2013, the MBC was audited using the National Childbirth Trust (NCT) toolkit, whose purpose was to evaluate the environment and facilities. In each of the areas audited, the MBC achieved the highest score available. The overall score had increased since the previous audit in 2012.
- All women were screened at 34 weeks, while completing their booking/risk assessment for having their baby at the MBC, for both Clostridium difficile and MRSA. There were clear policy guidelines on MRSA management.
- There was a designated band 7 lead midwife for infection control, who was responsible for ensuring that policies and practice were monitored. The lead attended the infection control meetings and gave feedback to staff. Minutes from the meeting were put onto the shared drive for all staff to access.
- Staff were observed adhering to the trust's policies for being bare above the elbows. There were policies for the safe use of birthing pools including an emergency evacuation policy, cleaning policy and water safety guidelines. Swabs were taken at water outlets, descaling was completed and shower heads were replaced every three months.

Environment and equipment

- The environment in the maternity service was secure. All areas were accessed through secure doors using an intercom system.
- The resuscitation equipment was checked daily in the places we visited and a record was kept of these checks. This included the adult resuscitation and emergency trolley, as well as the neonatal resuscitaires.
- The assisted delivery unit (ADU) was able to provide cardiotocography monitoring for two women behind curtained-off areas. Staff did not report any concerns with the available equipment.

- On the day of the inspection, the medicines fridge on the MBC had developed a fault; it was reported to pharmacy, who had arranged to replace the fridge on the same day.
- During the inspection we observed a door missing from the sluice. This meant that the area where urine specimens were tested was not closed off; young children in the antenatal clinic would be able to access the area. We spoke with a senior member of staff to raise concern that the sluice room had no door; we were told this would be reviewed.

Medicines

- Temperatures of the medicines fridge were checked and recorded daily. Because of a fault with the medicines fridge on the MBC, all the stock had been destroyed appropriately. We were told the pharmacy would provide replacement stock.
- Controlled drugs were appropriately stored. Midwives were aware of and followed Nursing and Midwifery Council (NMC) guidelines on the administration of controlled drugs.
- Arrangements in place for the safe storage of medicines in clinical areas were mostly appropriate. However, when we checked on the ADU, in an unlocked cupboard we found 22 ampules of Chlorprep Sepp 0.67ml that had expired between May and July 2014. We spoke with staff, who disposed of the expired ampules.

Records

- All women were given a 'red book', also known as the child health record, which provided information on the health of their baby, including neonatal examination and new birth hearing screening.
- Women who attended the Emergency Gynaecology Assessment Unit (EGAU), which was part of the early pregnancy service, had paper records that ensured that any relevant information could be shared with the multidisciplinary team.

Safeguarding

- Systems were in place to identify and protect vulnerable people from abuse.
- Staff received safeguarding training in line with the trust's mandatory training policy. All midwives received level 3 child protection training.
- Staff could contact a lead midwife for safeguarding for advice or support.
- Staff were able to tell us about safeguarding procedures. The trust's abduction policy was available on the intranet.

Mandatory training

- All staff were required to complete the trust's mandatory and statutory training.
- 100% of medical, dental, nursing and midwifery staff working in gynaecological oncology services had completed health, safety and risk training in 2013/2014.
- 60% of nursing and midwifery staff working in gynaecology services had completed health, safety and risk training in 2013/2014.
- 94% of nursing and midwifery staff working in Midwife led services had completed health, safety and risk training in 2013/2014.
- 100% of medical, dental, nursing and midwifery staff working in gynaecological oncology services had completed quality and diversity training in 2013/2014.
- 80% of nursing and midwifery staff working in gynaecology services had completed equality and diversity training in 2013/2014.
- 97% of nursing and midwifery staff working in midwife led services had completed equality and diversity training in 2013/2014.
- 85% of medical, dental, nursing and midwifery staff working in gynaecological oncology 85% of nurses and midwives working in gynaecology services and 85% of nursing and midwife staff working in midwifery led services had completed fire safety awareness training in 2013/2014.
- 100% of medical and dental staff and 66.7% of nursing and midwifery staff working in gynaecological oncology services, 60% of nursing and midwifery staff working in gynaecology services and 72% of nursing and midwifery staff working in midwife led services had completed training in information governance during 2013/2014.

Assessing and responding to patient risk

- On the MBC, there were clear assessment criteria to ensure that women who gave birth at the centre fulfilled a 'normal low risk' criteria. Staff said that detailed assessments were completed when women booked into the service and then again at 34 weeks' gestation; social and medical assessments were included.
- The MBC had a system known as 'silver star' bookings. Women who did not meet the 'normal low risk' criteria

but wanted to give birth at MBC were reviewed and risk assessed by a multidisciplinary team (MDT). The MDT consisted of a consultant, a birth unit midwife, a risk lead midwife and the consultant midwife.
- In the antenatal clinic at the initial booking, women discussed with the midwife different options for giving birth. If women fulfilled low risk criteria, they were able to have midwifery-led care for their pregnancy. If women were considered to be in a higher risk group, after a scan at 20 weeks, they would be seen by a consultant and management options would be discussed with them.
- The emergency gynaecology assessment unit (EGAU) was a nurse-led service with no midwives. The early pregnancy service had strict parameters and would see women who had been referred between six and 14 weeks, in the first trimester. GPs knew the referral parameters of the EGAU, and if the risk was deemed too high, such women would be referred to EGAU at Tunbridge Wells Hospital.

Midwifery staffing

- A consultant midwife and two birth centre managers provided day-to-day line management to staff working in the birthing centre.
- On a daily basis, two midwives (band 6 and 7) were on duty at all times, plus one maternity care assistant. If a midwife was required to transfer a woman to the Tunbridge Wells maternity unit, a community midwife would be called in to cover.
- The maternity dashboard showed that the midwife to birth ratio was 1:32, which was lower (worse) than the nationally recommended ratio of 1:28. The head of midwifery said that the service had a ratio of 1:27 using King's Fund data (2011).
- Women received one-to-one care during established labour. Midwives told us they never cared for more than one woman during labour.
- Community midwives worked from the birth centre as well, and their caseloads were of different sizes.
- The MBC did not use agency midwives, and only used bank midwives who had been risk assessed for the birth centre.
- Screening coordinating midwives oversaw the foetal anomaly screening programme, and worked closely with the specialist foetal medicine consultant.
- Clinical nurse specialists (CNS) within the gynaecological oncology team worked closely with support groups and had also piloted a CNS-led clinic.

Medical staffing

- There were consultant-led clinics; one consultant specialised in screening foetal abnormalities and there were three consultants for the gynae-oncology team.

Major incident awareness and training

- The maternity service reported that the unit had not closed in the past year (May 2013 to August 2014); this was recorded on the dashboard.
- Both doctors and midwives had undertaken a specialist training programme called Practical Obstetric Multi-professional Training (PROMPT). On a monthly basis, interdisciplinary obstetric simulation training was undertaken involving all staff grades including obstetricians, anaesthetists and two to three midwives. Scenarios were used from obstetric emergency incidents.

Are maternity and gynaecology services effective?

Good

National evidenced-based best practice, professional standards and expert guidance were routinely used to ensure that mothers' needs were assessed and care was delivered that was safe and effective.

Care and treatment was based on nationally recommended guidance, which included that from the National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG). Women had access to comprehensive antenatal assessments that reflected their choice based on clinical need.

Evidence-based care and treatment

- The maternity service was managed in accordance with the principles in Safer Childbirth (Royal College of Obstetricians and Gynaecologists (RCOG), 2007). Policies referred to guidance from the RCOG and the National Institute for Health and Care Excellence (NICE).
- Specialist midwifery screening coordinators carried out audits, which were submitted to the United Kingdom National Screening Committee

- All clinical guidelines and protocols were available to staff on Q-Pulse, the trust's intranet. Staff signed to say that they had read policies and protocols.
- During November 2013, a retrospective audit was undertaken on the MBC to look at the documentation of two specific standards. The first was that an initial plan of care was documented in clinical notes once labour had started. The other standard was that there was a plan of care if there was a deviation from the norm. The results of the audit showed that both standards were being met, were evidenced-based and in line with NICE and the trust's guidelines.

Pain relief

- Women in labour had a range of choices for pain relief including, but not limited to the use of water (birthing pools) and aromatherapy as examples.
- On the MBC, the use of sterile water injections for the relief of back pain in labour was being trialled. The pilot had been running for two months; women who had undergone the treatment were being audited. Detailed information leaflets had been produced and were accessible to women. Midwives had received extra training in the technique.

Nutrition and hydration

- The MBC had a fully equipped kitchen with refreshments available. Families could bring in their own food for women.

Patient outcomes

- Women, who chose to deliver their babies at the MBC, had a detailed risk assessment completed. Those selected to deliver at the birth centre were low risk and expected to have 'normal deliveries'. If complications arose that required the women to have medical intervention, they were transferred to the consultant-led unit at Tunbridge Wells Hospital.
- From October 2013 to September 2014, 404 babies were born at the centre. Any women or babies with complications were transferred. One hundred and forty-four women started their labour at the centre but were transferred to the maternity unit at Tunbridge Wells Hospital.
- Intrapartum transfer rates were 36.2% for women having their first baby and 8.3% for those women who had previously given birth. These transfer rates were in line with the findings from the Birthplace Cohort Study by the National Perinatal Epidemiology Unit (2011).
- During 2013, 74% of women breast fed their babies within 48 hours. The service had achieved level 1 of the UNICEF UK Baby Friendly initiative, which aims to encourage breast feeding.
- Data collected before the inspection showed no maternal outliers.
- The complication rates for patients from gynaecological oncology were lower compared with those from the surgical directorate.
- We were told there were delays in cancer referral pathways from the diagnostic to the therapeutic stages, which affected the ability to meet cancer treatment targets.

Competent staff

- Supervisors of midwifery had completed 96.6% of annual reviews of midwifery. The Nursing and Midwifery Council (NMC) target was 100%.
- Records showed that the appraisal rate in maternity services was 57.6% against a target of 90%.
- Staff we spoke with understood the appraisal and mandatory training processes.

Multidisciplinary working

- Staff that we spoke with in the different areas we visited during the inspection described a positive working environment with close working relationships between departments and teams.
- Within the gynaecological oncology team there was good multidisciplinary team (MDT) working between the medical, nursing and allied health professionals aligned to the service. Also, links to support groups and charities were well established.
- Community support workers (band 3) worked with a team of 10 midwives and offered support specifically around new-born screening, breast-feeding support and parental education. Community midwives told us that they valued the community support workers' input and believed that the service would have benefited from an increase in staff numbers.
- We were told that communication with outside agencies such as children's social services can sometimes be problematic.

- Community midwives liaised with health visitor colleagues at 24 weeks of a woman's pregnancy.
- The MBC was part of the regional birth centres for the South East Coast. Regional meetings were held three-monthly to ensure all information and outcomes within the centres was comparable.

Seven-day services

- The Antenatal Day Unit was open from 8am to 5pm from Monday to Friday. Outside these times women had to travel to the triage unit at Tunbridge Wells Hospital.

Access to information

- Discharge summaries were sent electronically to GPs and community midwifery teams.
- Women who used the service had hand-held notes that contained information that could be accessed by staff at appointments or clinic visits.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Midwives had mental health capacity training. This was provided on alternate years within the trust's mandatory training programme, and was also available as an e-learning module.
- Support and advice were available from the trust's adult safeguarding lead. Staff were able to describe to us when they had to seek advice for women with substance misuse problems.

Are maternity and gynaecology services caring?

Good

Feedback from people who used the maternity service was positive about how staff treated them. All staff involved women who used the service as partners in their own care and in making decisions, with support where needed. Staff told us that providing a positive experience for women and their families was their priority.

Compassionate care

- The Friends and Family test for maternity services showed results that were better than or in line with average Friends and Family test results, although response rates were low.
- The Maidstone Birth Centre (MBC) used a maternity in-service questionnaire, which staff gave out to women once a week to gain a snapshot to monitor how the service was doing. The results from the questionnaire were displayed on the dashboard on the unit. Results from the maternity questionnaire from January 2014 to August 2014 showed an overall care satisfaction rate of 97%.
- The 2013 Care Quality Commission (CQC) Survey of Women's Experiences of Maternity Care reported that the trust performed in line with the England average for the maternity survey. The trust performed better than others in the maternity survey in relation to cleanliness. However, the trust performed worse in the maternity survey in relation to staff introducing themselves.
- On the MBC there was a comments book that women and their partners wrote in. We saw positive comments about the support, involvement and care they had received at the centre.

Understanding and involvement of patients and those close to them

- Written information was available throughout different areas of the maternity service that we visited during the inspection.
- Pregnant women and their partners could view a virtual tour of the maternity unit on the trust's website; the normal birth pathway was incorporated as well. It was also possible to ring the delivery suite and arrange a tour of the facilities and meet the staff.
- Three women we spoke with using different parts of the service were pleased with care but had also had to wait on occasions to be seen. Another woman told us that they had confidence in the staff's competence and had felt supported by the multi-disciplinary team.

Emotional support

- Community midwives provided a postnatal drop-in service; this was popular with mothers who had given birth before and community midwives found that it gave them more time to support women who needed more input.

Are maternity and gynaecology services responsive?

Maternity and gynaecology

Good

Women who wanted to give birth at the MBC were assessed to ensure they were suitable for a low-risk-environment birth. Women who fell outside the risk assessment criteria had the opportunity to be reviewed by a system known as 'silver star'.

The service used feedback from women and their families to further develop service planning.

Service planning and delivery to meet the needs of local people

- The maternity service was proactive in supporting women's choices and promoting 'normal birth'. There was a normal birth newsletter.
- Feedback from women who used the service was used to inform the service's strategy for development.

Access and flow

- Women were able to access the maternity services at the trust when they needed to. They could access the Maidstone Birth Centre (MBC) through their GP or midwife. There was an electronic booking system in the antenatal clinic, which also sent out appointment letters.
- There were clear parameters for women being referred to the early pregnancy service, with clear pathway guidance if they presented outside six to 14 weeks.
- If mothers required referral to another clinician or another part of the service such as the assisted delivery unit this was arranged.
- Before discharge, mothers were informed of community contacts such as community midwives.
- At the entrance to the Emergency Gynaecology Assessment Unit (EGAU), a staff board showed who was on duty. There was also a waiting times board so that women could see how long they would have to wait to be seen.

Meeting people's individual needs

- Women who wanted to give birth at the MBC had a comprehensive risk assessment to ensure they were safe to do so. Any woman who did not fulfil the risk assessment criteria would be reviewed through a process known as 'silver star' bookings. This allowed women who did not meet the 'normal low risk' criteria but wanted to give birth at MBC to be reviewed and risk assessed by a multidisciplinary team.
- Silver star discussions took place at a designated monthly meeting to assess low to medium risk women. Personal feedback was given that was recorded in a safer birth plan; this was a record which contains details of women's birth and management plans.
- Women's choices were respected; management plans were developed in partnership with the woman with due regard given to any underlying medical condition or other clinical need. If any complications developed during labour, there was an escalation plan in place to transfer women rapidly to the delivery suite at Tunbridge Wells Hospital by ambulance.
- Maternity care workers and midwives supported women with breast feeding, and community midwives provided a drop-in postnatal clinic.
- Community midwives ran an 'early bird' booking clinic. Women could be seen in the first trimester of their pregnancy, up to 12 weeks and 6 days. This enabled them to be signposted to the MBC.
- On the trust's website a comprehensive leaflet called Choice for Place of Birth at Maidstone and Tunbridge Wells NHS Trust was available. The leaflet gave detailed information to help parents choose their preferred birth option.

Learning from complaints and concerns

- Information was displayed in the maternity and gynaecology departments on how women and their partners could give feedback about the service they had received and how they could make a complaint.
- Complaints were coordinated by a governance lead for women's and children's health services. Themes were included in the risk management newsletter on a monthly basis.

Maternity and gynaecology

Are maternity and gynaecology services well-led?

Good

Staff had a clear awareness of the vision and values for maternity services at Maidstone Hospital. Staff were engaged with providing a high level of care to women and their families. A proactive approach was taken to seek a range of feedback from women who used the service.

There was an identifiable risk and governance structure. Staff were engaged with innovative practices and were involved in making changes that had a direct impact on and improved people's experiences.

Vision and strategy for this service

- At the Maidstone Birth Centre (MBC), staff were aware of the vision and values for their unit. They took pride in the service they delivered and the quality of the care they provided to women and their families.
- Clear strategies were in place to develop 'normal' births and increase the rate of water births.

Governance, risk management and quality measurement

- There was a specialist midwife, who was also the risk manager and governance lead, whose responsibilities included conducting audits, conducting root cause analyses following incidents, and monitoring any identified risks.
- Senior staff had a good understanding of the risks that could affect the safety and effectiveness of the service. Risks were recorded on the trust's risk register and monitored at monthly risk meetings.

Leadership of service

- The consultant midwife was passionate about the service that was provided to women and their families. They felt that there was a good relationship between the trust's board and the service. The chief executive visited the MBC regularly.
- The supervisor to midwives ratio was 1:15, as recommended by the local supervisory authority to allow for periods of absence and attrition. From January 2015, three new midwifery supervisors will bring the ratio down to 1:12 (one supervisor to 12 midwives).
- Within the gynaecological oncology team there was an identified lead of service; this was a rotational post, with different individuals assuming the responsibilities of the role for a specific length of time.
- The nursing manager was accessible and engaged with staff.
- Staff described the maternity team as "supportive" and felt that issues could be raised and discussed.

Culture within the service

- All staff felt they had a role to play in providing quality care to women and their families.
- Within the gynaecological oncology team, some staff told us they perceived a division between Maidstone Hospital and Tunbridge Wells Hospital.
- Community midwives were proud of the service they offered to women, whom they said were at the heart of everything they did. They felt proud of being able to work at the birth centre.

Public and staff engagement

- A maternity questionnaire was given to all mothers once a week, to obtain a snapshot of how well the service was performing. As a result of feedback, changes were made to improve women's awareness that food was available at all times, including during the night.
- Other sources used to obtain feedback included the Friends and Family test and the Care Quality Commission (CQC) maternity services questionnaire 2013. The maternity service also developed a 'You said – We did' action plan for inpatient maternity services.

Innovation, improvement and sustainability

- We were told that the service strived to improve women's experiences.
- Kangaroo care (skin-to-skin contact), was encouraged, and the benefits were improving outcomes for mothers and babies, and helping to improve breast feeding rates.
- Intradermal injections of sterile water were used for the relief of back pain in labour.
- The MBC had developed, designed and produced the Maidstone birth couch, which was used by women in labour.
- Following an exchange trip between Maidstone and Tunbridge Wells and a hospital in Sweden in 2012 and 2013, the Swedish twinning project was developed; this

has allowed for shared learning to be disseminated on an international basis, including consideration being given to the driving factors behind Sweden's low caesarean section rates.

Services for children and young people

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

Information about the service

The Riverbank Unit hosts a six-bed day case surgical unit, six-bed assessment area and a children's outpatient department at Maidstone Hospital. The service hosts a range of surgical services including orthopaedics, ophthalmology, general surgery, and ear, nose and throat surgery. The unit is staffed by a range of nursing and medical professionals that rotate between Maidstone and Tunbridge Wells Hospitals. The service does not have the facilities to provide overnight accommodation and is open from 8am to 7pm, Monday to Friday, only. Children requiring overnight care are transferred to Hedgehog Ward, which is in Tunbridge Wells Hospital.

During 2013/14, the Riverbank unit managed 2,425 ambulatory visits.

During our inspection, we spoke with four members of staff. We also spoke with two children and their families who were present in the outpatient department at the time of the inspection.

Summary of findings

The children's and young persons' service at Maidstone Hospital requires improvement to ensure that children receive appropriate, evidence-based and effective care. We found that nursing staff provided compassionate and empathic care both to children and their families. The environment in which children were cared for was appropriate; however, there was insufficient evidence to determine whether regular cleaning audits were carried out to ensure the unit was being appropriately cleaned. There were some inconsistencies with the frequency with which medical and electrical devices were serviced. Also, although we found that medicines were stored appropriately on the ward, we had concerns about the chain of custody of controlled drugs, and this was attributed to the informal nature with which keys to the controlled drug cupboard were stored at night and over the weekends, when the Riverbank Unit was closed.

The directorate used a combination of National Institute for Health and Care Excellence (NICE) and royal colleges' guidelines to determine the treatment it provided. However, there were discrepancies with the pre-operative management of children undergoing surgery with regards to nil-by-mouth guidance.

We could not fully determine the overall effectiveness of the service; this was because of the limited evidence and audit activity that was undertaken by the children's directorate that was specifically related to the Riverbank Unit. From the information that was collated, it was identified that the department was not always

Services for children and young people

performing in line with national standards; this was especially true for the management of children with diabetes. The children's directorate lacked a formal vision or strategy, and some staff were unaware of the trust's values. The overall leadership of the Riverbank Unit was poor. There was little in the way of consistent management oversight of the unit. There was limited evidence to demonstrate that incident reporting was an embedded practice within the unit, with only eight incidents being reported over a six-month period. Although the directorate's senior management team was aware of issues such as contractual issues with third party transport providers, these had not been listed as issues that posed operational risks to the effectiveness of the service.

Are services for children and young people safe?

Requires improvement

Although the trust had a system in place for managing incidents, we were concerned that the threshold among staff for reporting incidents was exceptionally high. We found occasions where incidents had occurred but had not been reported through the correct process.

Equipment and the environment were visibly clean. Medicines were stored appropriately; however there was a standardised practice among nursing staff of applying prescription-only topical anaesthetics to children without a valid prescription being in place. Furthermore, we had concerns that the chain of responsibility for the safe storage of controlled drugs might have been compromised because of the informal security of drugs keys when the Riverbank Unit was closed.

The number of eligible staff trained in level 3 safeguarding children was lower than the trust's standard of 85%.

Children admitted to the ward or within the assessment area were monitored; however, we could not find any evidence that observations were recorded on a Paediatric Early Warning Score (PEWS) system. Furthermore, we were not assured that the PEWS system in place had been appropriately validated or that it was supported by robust escalation criteria to ensure a timely response when a child's score triggered the tool.

During the inspection we found that nursing and medical staffing levels were, in the main, appropriate. However, there were concerns that staffing ratios may not have been based on any formal dependency or occupancy tool, and so it was difficult to ascertain whether the historic nursing ratios were set suitably to ensure the needs of children were always met.

Incidents

- A total of 80 incidents attributed to children's services were reported on the trust's electronic incident reporting system between 1 April 2014 and 19 October 2014. Because of the way the data was provided, it was difficult for us to identify the locations that some incidents referred to, and so the quoted number

includes incidents that occurred within the children's and young person's service at Tunbridge Wells Hospital. We were able to identify seven incidents that were directly attributed to the Riverbank Unit at Maidstone Hospital. Six of the seven incidents were listed as of no to minor harm and were attributed to issues relating to the transport of patients from the Riverbank Unit to Tunbridge Wells Hospital.

- During our inspection, we spoke with four members of staff. Each staff member was able to describe the incident reporting system; some referred to the system as Datix. Each staff member was able to describe the process for reporting incidents, although a common theme among staff was that the process of incident reporting was time consuming.
- Processes were in place for the investigation and analysis of reported incidents. In most cases, there was evidence that investigations occurred and that lessons learned were generated. However, there was no apparent process for disseminating those lessons learned in order that all staff were engaged with the risk management strategy.
- We asked staff whether they received feedback from incidents. Almost every staff member reported that they would receive individual feedback if they had been involved in an incident. Some staff reported that they were informed of incidents at their monthly team meetings, while others reported receiving emails from the band 6 nursing team who were responsible for investigating incidents.
- We were told that there had been an increase in the number of 'sharps' injuries that had occurred on the Riverbank Unit. We found that there was a limited supply of small, portable sharps bins that staff could take to the bedside of a child who required cannulation or blood sampling. Although wall-mounted sharps bins were located in the treatment room, staff told us that when this room was occupied, blood sampling could be and was carried out at the bedside. This meant staff were required to transfer unsheathed used needles from the bedside, across the ward and back to the treatment room. This is against national standards, which recommend that sharps such as needles are discarded into an appropriate container immediately after use. We were told that the issue of a lack of portable sharps bins had been raised with the relevant individuals. We noted that one small portable container was available on the unit, but had not yet been constructed. We asked to see the action plan that had been implemented following the increase in incidents; we were provided with the health and safety annual board report and strategy programme for 2014/15. Although trust-wide initiatives were listed to address the increase in sharps incidents, no specific actions were associated with a targeted reduction of sharps injuries (needle-stick injuries) on the Riverbank Unit.
- It was also difficult to determine the number of sharps incidents that had occurred on Riverbank Unit. Although the member of staff responsible for reviewing incidents informed us that there had been an increase in sharps-related incidents, no such incidents were reported between April and October 2014 for the whole of the children's directorate. We were therefore concerned that there may have been under-reporting of incidents
- Monthly paediatric directorate meetings were used as a forum to discuss clinical issues, complaints and child protection issues.

Cleanliness, infection control and hygiene

- During our observations of the immediate environment in which children and babies received treatment and care, we found all areas to be visibly clean.
- Where cleaning took place, domestic staff used colour-coded equipment for different parts of the ward. Domestic staff reported that they had access to policies and visual guides, including the 'Clean to dirty' protocol, which provided clear visual instructions to staff on how to safely clean areas such as toilets.
- We observed that staff complied with the trust's policies for infection prevention and control. This included wearing the correct personal protective equipment such as gloves and aprons.
- Although cleaning audits appeared to have been conducted for children's services at Tunbridge Wells Hospital, specifically on Hedgehog Ward and the neonatal unit at Tunbridge Wells Hospital, no audit data was available for the Riverbank Unit. Furthermore, where cleaning audits had been carried out in other clinical areas, results of audits had been displayed. Results from cleaning audits were not displayed throughout the ward area on the Riverbank Unit. Additionally, between April and July 2014, attendance of an infection control ward-based link nurse for Riverbank Unit at bi-monthly infection control link sessions had been listed as 'N/A'. Attendance of a Riverbank Unit

nurse representative was last reported as being at an infection control conference in July 2013. We could therefore not be assured that a robust infection control governance framework was in place on the Riverbank Unit.
- There had been no reported cases of Clostridium difficile or MRSA bacteramia's between April 2013 and July 2014 for children's services.
- Audits for both hand hygiene and saving lives high-impact interventions demonstrated 100% compliance between April and July 2014.

Environment and equipment

- The department had a range of equipment, which was seen to be visibly clean. We noted that staff used reusable blood pressure cuffs; because no children were present on the day of our inspection, we could not observe whether staff appropriately decontaminated the cuffs between each use.
- The bed spaces in the Riverbank Unit were visibly clean.
- Consumable equipment was found to be in date.
- Staff were aware of who to contact or alert if they identified broken equipment or environmental issues that needed attention.
- We saw evidence that regular checks of resuscitation trolleys were carried out.
- We noted that some equipment had service labels attached showing that service dates had lapsed. This included, as an example, a portable blood pressure monitor which, according to the service sticker attached the device, had last been tested on 10 May 2010. A portable pulse oximetry meter had last been serviced on 22 November 2011, while the power cable was scheduled for a portable appliance test (PAT) on 16 October 2013.

Medicines

- There were processes for ensuring that medicines were kept in cabinets and fridges on the ward. Medicines fridges were found to be locked. Fridge temperatures were routinely being recorded to ensure that medicines were stored in line with the manufacturer's recommendations.
- Controlled drugs were stored according to legal requirements. Staff were observed to be carrying out routine stock checks of controlled drugs. However, because of the operating times of the Riverbank Unit, the drug keys were left with the hospital switchboard operator overnight and at weekends. This therefore meant that the chain of responsibility for controlled drugs was potentially breached when the unit was closed.
- We found that some medicines such as local topical anaesthetic creams were not always prescribed before being applied to children and young people who required venous cannulation and blood sampling. Although the trust provided us with a copy of a patient group direction for the administration of a range of medicines, including topical anaesthetic and analgesics such as Paracetamol and ibuprofen, the staff who had applied the topical anaesthetics informed us that they had not completed any training about patient group directions, nor had they received authorisation to use the direction in line with the trust's policies.
- We saw evidence that staff working in the paediatric outpatient department received training on patient group directions every two years, which enabled them to administer vaccines such as the BCG vaccine.
- Staff had access to national formularies such as the British National Formulary for Children and a local electronic formulary detailing the preferred antibiotics for specific infections including but not limited to respiratory tract infections and urinary tract infections.
- The unit had access to a main pharmacy department. Staff had access to an experienced paediatric pharmacist based at Tunbridge Wells Hospital.

Records

- The pre-operative checklists we reviewed for children who had gone to theatre were completed following the trust's policy for pre-operative management.
- Risk assessments had been completed and there were evaluation records of whether patients' health and emotional needs had been met.
- During our inspection, we noted that records were kept securely.
- We found evidence that the department used the World Health Organization (WHO) 'five steps to safer surgery' checklist.

Consent

- Because no children were undergoing surgical procedures at the time of our inspection, we were unable to determine the action staff took to seek informed consent from parents and children about surgical procedures.

- We observed staff seeking verbal consent from parents/ carers when they wanted to physically examine a child. Staff we talked with showed that they understood the Fraser guidelines and explained that the consent process actively encouraged the involvement of young people in decisions relating to their proposed treatment (Fraser guidelines refer to guidelines set out by lord Fraser in his judgement of the Gillick case in the House of Lords, which apply to specifically to contraceptive advice and treatment for young people aged under 16 years)..
- We also noted a process for seeking consent from those with parental responsibility before staff administered vaccines such as BCG vaccinations.

Safeguarding

- Staff had a good understanding of their roles and responsibilities when reporting safeguarding concerns.
- A policy relating to safeguarding children and young people was available and accessible and had been reviewed in October 2013 and ratified by the hospital's quality and safety committee in November 2013. The policy was cross referenced with national policies, procedures and guidance including information from the Kent and Medway Safeguarding Children Procedures (2007), Royal College of Paediatrics and Child Health, Safeguarding Children and Young People (2010) and the Department of Health's Working Together to Safeguard Children (2013).
- The trust also provided us with a copy of the Kent and Medway Safeguarding Children Procedures, reference RWF-OWP-APP113; this document was dated September 2007. In line with national recommendations, amendments are made to this document every six months; the most recent took place in October 2014. Therefore, the version held by the trust is likely to be out of date and should be updated to ensure staff have access to the most recent guidance.
- The hospital had a named nurse and named executive for safeguarding children.
- There were systems for referring children and adolescents to the local Child and Adolescent Mental Health Service (CAMHS).
- The areas within children's services were supported by a safeguarding nurse, who was further supported by two part-time nurses.
- Of staff 83%, 84% and 63% had completed training in level 1, 2 or 3 safeguarding children, respectively.

Mandatory training

- Compliance with mandatory training by staff in the children and young person's directorate was below the expected 85%. Data provided by the trust demonstrated that 75% of staff working in the directorate were up to date with their mandatory training.

Assessing and responding to patient risk

- For children attending the ambulatory unit, observations were recorded on a generic observation chart. Although the trust had access to a Paediatric Early Warning Score (PEWS) system, we did not see any evidence of its use at Maidstone Hospital.
- Staff told us that they would rely on their knowledge and experience to recognise a deteriorating or acutely unwell child. Nursing staff could seek additional support and clinical guidance from either a consultant paediatrician or an experienced junior doctor, who were available on the unit between 9am and 6pm and 10am and 7pm respectively.
- Staff had access to protocols issued by the South Thames Retrieval Service (STRS). These guidelines were designed to support staff to stabilise acutely unwell children before they were retrieved by STRS or other retrieval services.
- Staff also had access to advanced paediatric life support algorithms and emergency resuscitation equipment.
- When children were identified as requiring hospitalisation, processes were in place for starting first-line treatments before children were transferred to the children's ward at Tunbridge Wells Hospital.

Nursing staffing

- Nurses were on a roster to rotate between the inpatient service at Tunbridge Wells Hospital and the Riverbank Unit at Maidstone Hospital. The nursing establishment was therefore combined accordingly. Information provided by the trust indicated that, as of July 2014, the establishment for the children's directorate was 99.7 whole-time equivalent (WTE) posts, with an overall vacancy rate of 5.2 WTEs (5%). We found that the department was spending more money than had been budgeted on temporary staff to ensure that shifts were appropriately covered.
- Although the overall vacancy rate was low, the directorate's management team considered that nurse

recruitment could be problematic because of the trust's proximity and easy access links to London hospitals, where nursing salaries with generally higher because of London weighting payments.

- We found that the nurse in charge of the clinical area did not have supernumerary status; that is, the nurse in charge was required to take charge of patients while also being responsible for managing the shift. Royal College of Nursing guidance, Defining staffing levels for children and young people's services (2013), suggests that, "The shift supervisor in each clinical area will be supernumerary to ensure effective management, training and supervision of staff."
- During the inspection, no children were undergoing surgery. The surgical unit was therefore closed. Three staff were on the roster to work on the day of the inspection. We were told that by its very nature, the Riverbank unit could vary in how busy it was; staff reported that at times (such as during the inspection) there were no patients, and on other occasions the unit might be full with six patients plus one patient being managed in the treatment room or high dependency area. In addition, activity on the surgical side varied. We noted that the nursing establishment increased on some days to four staff; this occurred when surgical patients were present. We were given examples by staff of when one nurse would be allocated to care for six surgical patients while being supported by a nursery nurse, while two other nurses cared for patients on the ambulatory unit. The trust had a policy in which a registered nurse was required to collect children from theatre. This therefore meant that during a surgical list, the nurse responsible for the surgical patients was required to leave the unit to collect children, leaving a nursery nurse to monitor a range of pre-operative and postoperative children. Although staff assured us that the nursery nurse would be supervised by the nurses working on the ambulatory unit, we could not be fully assured that the unit was always staffed to a satisfactory level.
- It was also not possible for us to determine how staffing levels had been calculated. Because the unit was quiet during our inspection, we could not fully corroborate whether staffing was, in fact, an issue or whether it was simply a potential risk.

Medical staffing

- The unit was supported by a consultant paediatrician between 9am and 6pm. Additional support was provided through an on-call service, and consultant paediatricians could also be contacted at the Tunbridge Wells Hospital if support or advice were required.
- Further medical support was provided by junior doctors who had a range of experience within paediatrics.
- It was noted, however, that although the service had access to appropriately trained paediatric anaesthetists during those times when a paediatric theatre list was underway, outside those times, no formal system was in place for ensuring that an anaesthetist with paediatric skills was always available postoperatively to provide support, advice and treatment in an emergency.

Major incident awareness and training

- There was a hospital-wide major incident plan, which included intensive care and anaesthetic response. The policy referred staff to an action card that would be used in the event of a major incident. There was a large folder, easily accessible with the nurse in charge's action card. We spoke with two members of staff who were clear about what a major incident was and their role is responding to it.

Are services for children and young people effective?

Requires improvement 

An extremely limited range of data was available for us to determine the overall effectiveness of the children's service at Maidstone Hospital. Policies and guidelines were in place that were consistent with national best practice and based on recommendations by organisations such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH). We did, however, identify a number of guidelines that were around 12 years old and were no longer relevant. We were informed that up-to-date guidelines were accessible on the trust's intranet.

There was some disparity regarding the arrangements for the management of pre-operative children who were required to be 'nil-by-mouth'.

Services for children and young people

Staff followed specific care pathways and used pain assessment tools to ensure that patients received appropriate care and treatment and effective pain relief. They ensured that patients' nutritional and hydration needs were closely monitored and maintained.

A senior nurse carried out appraisals for nursing staff, identified training and development needs and maintained records of staff training. However, staff were not routinely offered clinical supervision sessions in line with the trust's policy.

Although multidisciplinary working was an embedded concept across the delivery of general paediatrics, relationships between the adult surgical team and the general paediatricians was poor. There was a lack of engagement and input from the adult surgical team; communication was poor about the management of patients admitted under the auspices of the general surgical or urology team.

Evidence-based care and treatment

- Children's services used a range of guidelines that had been produced by the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH) to define the treatment provided.
- There were pathways and protocols for the management and care of various medical and surgical conditions; however, there was an inconsistent approach to the way postoperative urology and general surgical patients were managed (we discuss this further in the section 'Multidisciplinary working' below).
- There were processes for ensuring that clinical services complied with national standards. However, we found that a range of pathways dating as far back as 2002 were still available in paper format on the Riverbank Unit. Although staff reported that they would refer to the intranet for clinical guidelines and pathways, we were not fully assured that this would always be the case. There was a need for the historical pathways to be replaced and updated with the most recent versions.

Pain relief

- Nursing and medical staff had access to a range of oral medicines and local anaesthetic to ensure pain control was effective during procedures for children and young people.
- The department used an evidence-based pain-scoring tool to assess the impact of pain when this was needed.

Patient outcomes

- There was no evidence of absence looked but not there to identify how the department gained assurance that the clinical interventions it performed resulted in positive patient outcomes.
- Because of the design of and resources applied to Riverbank Unit, the service was able to meet the standards set by RCPCH, in that all children attending the unit were seen by a middle grade doctor or consultant within four hours, daily consultant-led handovers occurred, consultant paediatricians were available on the unit every day, and specialist paediatricians were available by telephone for support and guidance.

National Paediatric Diabetes Audit

- NICE quality standard 6 for diabetes in adults recommends that patients with diabetes agree to maintain a personalised HbA1c target of between 6.5% and 7.5% and receive an ongoing review of treatment to minimise hypoglycaemia. This guidance is also considered as part of the National Paediatric Diabetes Audit. Data from the 2011/12 audit showed that the target HbA1C rates for Maidstone Hospital were worse than the national average. For example, the percentage of patients who were managed with an HbA1c target of less than 7.5% was 10.3% of the total caseload, as compared with a national average of 17.4%. The trust had acknowledged this and had reported that its performance in this area had improved on previous years and additional work was being undertaken to further improve the management of children with diabetes.

Competent staff

- The paediatric database reported that, as of July 2014, 83% of nursing staff had participated in an appraisal. The staff told us that they considered the appraisal system to be beneficial to their personal and professional development.
- Although staff reported that they received annual appraisals, there was a consistent theme that staff were

not provided with any clinical supervision. We asked three staff whether they had ever engaged in or signed a 'clinical supervision contract'; we were informed that they had not.
- Of staff, 75% had completed basic life support training in the previous 12 months.
- Two of the 11 consultants had attended training in European paediatric life support during the preceding four years.
- Of nurses working within the children's directorate, 28 had completed an advanced paediatric life support course in the previous four years.

Multidisciplinary working

- There was limited evidence to demonstrate integrated, multidisciplinary working between those staff who worked on the Riverbank Unit and those in other specialties such as surgical services at Maidstone Hospital.
- Concerns were raised that engagement with a number of surgical teams was poor. This was especially noted for the general and urology specialties. Efforts had been made to resolve the poor communication among some surgical specialties, including the paediatric team facilitating a multidisciplinary surgical care pathway meeting; however, this meeting had not been repeated because healthcare professionals were unable to decide a suitable date and time to meet. Staff reported that the poor communication among some specialties led to inconsistent postoperative management of patients; for example, nursing staff had been required to manage patients undergoing circumcisions differently depending on the practices of the individual surgeon.
- Staff were, however, complimentary about their engagement with the orthopaedic surgical team; this was likely to be attributable to the fact that two orthopaedic surgeons specialised in the management of childhood orthopaedic abnormalities, and so were orientated to caring for children on a regular basis.

Are services for children and young people caring?

Good

Children, young people and their parents told us felt they were fully informed and involved in decisions relating to the patient's treatment and care.

Because of historic practices, however, children attending theatre were not offered consistent emotional support from a familiar healthcare professional. Ward staff routinely escorted children to the main theatre reception area, where the care of the child and their accompanying parent was then handed to an unfamiliar theatre practitioner. Following the induction of anaesthesia, parents/carers of children were required to return to the ward unaccompanied, or were asked to wait in the theatre reception area; this practice falls outside the recommendations of national guidelines, which encourage familiar staff to support parents/carers once they have left the anaesthetic area.

Compassionate care

- Throughout our inspection, we observed that staff provide compassionate and sensitive care that met the needs of the child, young person and parents/carers.
- We observed members of staff engage with children and young people in a way that we considered to be friendly and approachable.
- We observed staff interact with children; interactions were age appropriate. Staff were observed to use age-appropriate language with children.
- Procedures and the equipment used during these procedures were explained in a comprehensive way for patients and their parents/carers, to increase understanding. The level of anxiety that patients and their parents/carers visibly demonstrated upon arrival in the hospital environment was subsequently reduced, in this way. One parent stated, "I felt reassured straight away by nursing staff upon our arrival. They explained what to expect during my child's surgery and then demonstrated to my child what would happen by using a teddy bear as the patient. We both found this very helpful."

Patient understanding and involvement

Services for children and young people

- Children's and young people's services did not participate in the Friends and Family test but we had evidence of a feedback form, 'How was your stay in hospital?' The form was clearly designed with children in mind and appeared easy to complete. Put comments in….
- Parents and carers whose children were using services at Maidstone Hospital during our inspection told us that they had not been asked for feedback or comments following their child's treatment as an inpatient. We did, however, note that comment cards were clearly available within the outpatients department.
- Children and their parents/carers were included in discussions surrounding the children's treatment and ongoing care. One parent said that they felt comfortable in asking the staff questions and confident that they would receive an appropriate answer.

Emotional support

- The process of escorting a child to theatre pre-operatively was poor, and children and families were not provided with the assurance that they would receive continuous support from the same healthcare professional during the pre-operative stage. Although children were admitted by a children's nurse or a healthcare assistant to the ward, when the child was called to the operating department, the child and a family member/carer were transferred to the care of a theatre practitioner. The ward nurse then returned to the ward, leaving the parent/family member/carer to find their own way back to the ward, without the emotional support of a children's nurse or other suitably skilled staff member. Guidance from the Royal College of Nursing, Transferring children to and from theatre, recommends that, "the parent/carer is supported following handover". Furthermore, the presence of a children's nurse or other staff member with whom the parent/carer and child are familiar, helps to ensure that the child has an advocate who is able to support the child during induction of anaesthesia as well as being able to offer distraction therapies in order to reassure the child and family.

Are services for children and young people responsive?

Requires improvement

The directorate had identified issues with clinical letters being dispatched to health professionals such as GPs within a defined timescale. The trust had acknowledged this and had introduced additional resources to address the issue.

We found that although most children being admitted for elective surgery were offered pre-assessment appointments during which questions could be asked and the child prepared for theatre, those attending for urology surgery were not offered such appointments. Furthermore, because of the poor communication and relationship between the surgical and paediatric directorates, standardised, age-appropriate patient information leaflets for urology patients were not being provided to parents/carers and their children.

Service planning and delivery to meet the needs of local people

- The Riverbank Unit had six day-case elective surgical bed spaces and six ambulatory beds. We did not receive feedback from parents/carers or children about the accommodation, because no elective cases were being performed during the inspection, and so we had very few opportunities to speak with families and children who had used the surgical service.
- We noted that the children's outpatient area was bright and visibly clean. There appeared to be sufficient numbers of seats for people while they waited for their appointments.
- The Riverbank Unit operated from Monday to Friday and was open between 8am and 7pm. Children could be referred from the urgent care centre if they required assessment by a paediatrician. Outside opening hours, children were assessed by the general medical team and, where necessary, transport was organised to transfer the child to Tunbridge Wells Hospital.

Access and flow

- On the day of our inspection no paediatric operations were taking place. We were told that all cases were elective and no emergency surgery was being carried

out. Children were pre-assessed in most cases, with the exception of children who were undergoing urology surgery; this was because provision for urology pre-assessment had not been commissioned.

- From the data we had, between April and July 2014, 712 children had attended the Riverbank Unit as 'ward attenders'. This was a reduction of 1,675 attendances when compared with the same period during the previous year.
- The service did not collate information on waiting times within the Riverbank Unit, so it was not possible to measure how responsive the service was to individual needs.
- It was difficult for us to ascertain the effectiveness of the children's outpatient department, because performance data for the directorate was included within that for the Tunbridge Wells outpatient department also.
- As of July 2014, the year-to-date rate for children not attending for their first outpatient appointment was 11.6% of total new appointments. This was a marginal increase on the same period the previous year, which was reported as 11.1%.
- As of July 2014, the year-to-date rate for children not attending for their follow-up outpatient appointments was 11.7%. This was an increase on the same period the previous year, which was reported as 9.5%.
- The directorate had acknowledged this increase in non-attendance and had instigated remedial actions including the introduction of a clinic call-reminder system, which had been implemented in May 2014.
- A risk entered onto the directorate's risk register on 20 February 2014 indicated that the trust had a backlog of letters to be typed and sent to relevant healthcare professionals, including GPs. This had been listed as a moderate risk. Data from the children's directorate dashboard indicated that as of July 2014, around 62% of letters were being sent to GPs within 10 days, and the remaining 38% were being sent within between 11 and 30 days. Remedial actions to address the issue included using additional administrative staff and outsourcing dictation to an external company to help reduce the backlog.

Meeting people's individual needs

- Patient information leaflets were available, although it was noted that they were only available in English. In addition, a number of leaflets contained contact information for Zebra Ward, which was at the now-decommissioned Kent and Sussex Hospital.
- By adopting the ambulatory care model, the Riverbank Unit was able to provide a resource to the local population that reduced hospital admissions. Children requiring short-term treatments such as intravenous antibiotics could be assessed, initially treated and then discharged home from the unit on the same day, with follow-up appointments for subsequent doses of antibiotics to be provided in the unit until the course of treatment was completed.
- The environment in which children undergo surgery had not been adapted to be child friendly. Three separate theatres were used, depending on the nature of the surgery. Rooms were decorated in a standard style, with no child-friendly decorations. We noted that the recovery area for children following ophthalmic surgery was a shared area with adults who were also recovering postoperatively.

Learning from complaints and concerns

- Information was available for patients on how to make a complaint and how to access the Patient Advice and Liaison Service (PALS). Dedicated members of staff within each of the clinical areas, including the matron and clinical director, reviewed all formal complaints received and concerns raised within PALS. All concerns were investigated and a centralised recording tool was in place to identify any trends emerging. Learning from complaints was disseminated to the whole team in order to improve the patient experience within the department.
- Overall, the ratio of complaints lodged in the department against the number of admissions and attendances was low. Trends arising from complaints were discussed as part of the clinical governance system within the service. We noted that the directorate had responded to 100% of complaints within the timescales set by the trust's policy.

Are services for children and young people well-led?

Services for children and young people

Inadequate

With the exception of the outpatient unit, which was coordinated by organised and efficient band 5 nurses, the Riverbank Unit was poorly led and lacked effective and consistent managerial oversight. The rotation of nursing staff on the Riverbank Unit had led to a unit within which there was little or no ownership or responsibility.

Although members of the directorate's senior management team were aware of the issues that posed risks to the operational effectiveness of the directorate, these issues had not been transferred to the directorate-level risk register, which we considered to be heavily underused. We found that where risks had been placed on the register, suitable governance frameworks were in place to ensure that those risks were escalated to board level and actions taken to resolve or mitigate the risks.

Although the department used basic feedback questionnaires, there was no overall quality measure to help the service to determine its effectiveness and responsiveness. In addition, no system or process was in place for engaging members of the public and patients in determining how the service operated.

Vision and strategy for this service

- The clinical director confirmed that the children's directorate did not have a written vision or strategy. We were told that although there was no formal vision or strategy, the directorate was keen to improve the quality of care provided to children and their families/carers.
- Two staff were able to recall the trust's values: PRIDE (Patient first, Respect, Innovation, Delivery and Excellence).

Governance, risk management and quality measurement

- Overall governance of the Riverbank Unit was integrated with the monthly directorate governance meetings that took place on the Tunbridge Wells Hospital campus.
- A monthly report from the children's directorate was provided to the quality and safety committee, and minutes of these meetings and a copy of the report were kept.
- The children's directorate was represented at board level. Arrangements were in place for ensuring that the board received reports on safeguarding children; the chief nurse was the lead for the safeguarding children's committee, which provided reports to the quality and safety committee. From the information we were given, we found that the quality and safety committee received a brief from the safeguarding children committee in July 2014.
- The directorate held governance meetings, which took place 10 times each year. Incidents and complaints were discussed. From the minutes we were given, it was not apparent whether an attendance record was kept. The clinical director reported that all consultants, the safeguarding lead nurse and the matrons for the neonatal unit and paediatrics attended. The meetings were also open to all grades of staff working within the directorate. It was not clear whether a named professional responsible for the Riverbank Unit ever attended these meetings.
- It was reported that any residual action plan from the governance meetings was disseminated to all those who attended the meeting; there was no clarity whether, or assurance provided that, the action plan was disseminated to individuals who had sent their apologies or to those health professionals who routinely did not attend the meeting.
- Risks associated with the provision of services were logged on the directorate's risk register. Two risks were logged; one regarding the paediatric emergency care pathway and the second referred to a backlog in the dispatch of clinic letters to external healthcare professionals. There was evidence that these risks had been escalated within the trust and there were remedial action plans in place. However, we considered that the risk register was an underused resource.
- During our discussions with staff, we were repeatedly told that issues existed with the timely transfer of patients between hospitals or to their homes; this was because of the poor service provided by the commissioned transport provider. Patient transport had been discussed during the paediatric governance meetings in January, March, June, July and September 2014. Although this issue had been recognised by the trust and had been reported on during the May 2014 quality and safety committee meeting, it was unclear whether the paediatric directorate had taken any remedial action to mitigate the risks associated with the poor transport provision. There was no local action plan and the issue was not recorded as a risk on the

directorate's register. We did, however, note that according to the 2014 paediatric clinical governance annual report, a patient transfer audit was underway, and so while not supported by a rationale or identified as a risk to the operational effectiveness of the directorate, the need for further review of patient transfers had been acknowledged.

- We were also told of the poor relationship between the general paediatric medical service and a number of surgical specialties. Between January and September 2014, a number of incidents relating to surgical patients had been reported and discussed at the paediatric directorate governance meeting. It was unclear whether these issues had been referred back to the surgical directorate for investigation. The issue of poor communication and fragmented relationships with surgical specialties was not listed as a risk on the directorate's register, and we were not provided with the necessary assurances that the matter was likely to be resolved in a timely way.
- Furthermore, the exisiting governance arrangements were insufficiently effective to demonstrate that action was being taken to resolve under reporting of incidents.
- The directorate used a dashboard to help monitor the overall quality of services being provided to children. With the exception of monitoring ward attenders to the Riverbank Unit, all other information seemed relevant only to paediatric and neonatal services at Tunbridge Wells Hospital.

Leadership and culture of the service

- The Riverbank Unit lacked any form of substantive leadership. Governance and managerial oversight of the unit appear to fall within the auspices of the paediatric matron and clinical director. The monthly governance meeting paid little or no attention to the operational functioning of the Riverbank Unit other than to discuss the small and infrequent incidents that were reported within the department.
- Because of the rotational nature of the nursing workforce, no one individual assumed overall responsibility for the unit. Although a band 6 nurse had been allocated to oversee the Riverbank Unit, the approach to management of the unit seemed ad-hoc at best.
- Discussions with the senior management team regarding the performance of the Riverbank Unit demonstrated that managerial oversight was poor. As an example of the poor oversight of the unit, senior managers relied on a band 5 substantive staff nurse working in the outpatient department to provide us with performance data for the department.
- Staff voiced concerns that the senior management team within the directorate could be more visible with more engagement from the matron. Furthermore, staff reported that they rarely saw members of the executive team.
- Staff working in the outpatient department reported good team working among the consultants and the three substantive nurses who worked in the department. Staff reported that other members of the paediatric team were approachable and that they felt as though they were a part of the trust.

Public and staff engagement

- Patient feedback was sought; however, there was no evidence that feedback had been discussed or reviewed.
- No systems or processes were in place to seek the engagement of members of the public, including parent groups, to help shape the future of the service.

Innovation, improvement and sustainability

- There appeared to be little senior management engagement or ownership of the Riverbank Unit, and it was unclear how this service would remain sustainable in the long term. The number of children booked for elective surgery varied weekly, with some lists being cancelled at short notice because of low numbers of children booked onto them; this leads to an inconsistent service, which ultimately has an impact on the quality of care provided to children in the local community.

End of life care

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

Information about the service

Maidstone and Tunbridge Wells NHS Trust provides end of life care (EoLC) services across both Maidstone and Tunbridge Wells Hospitals. EoLC is not seen as the sole responsibility of the specialist palliative care team (SPCT).

The SPCT consists of 1.2 whole-time equivalent (WTE) palliative care consultants, 3.9 WTE clinical nurse specialists (CNS) and an EoLC facilitator (15 hours per week). The team works in association with the respective community palliative care teams and in partnership with local voluntary sector hospice providers. In addition, a chaplaincy team provides multi-faith support. The SPCT is available five days per week, Monday to Friday, from 9am to 5pm. Out of hours, the SPCT service is covered by telephone support from the Heart of Kent Hospice at Maidstone Hospital.

During the inspection we visited a variety of wards across Maidstone Hospital, including Lord North, Foster Clark, John Day, Chaucer, Mercer and John Saunders Wards. We also visited chemotherapy and radiotherapy outpatient units, the mortuary, the bereavement office and the chaplaincy to assess how EoLC was delivered. We spoke with a wide variety of staff, including palliative care leads, medical and nursing staff, patient liaison officers, porters and the hospital's chaplain.

We reviewed the medical records of six patients who were receiving EoLC and observed the care that medical and nursing staff provided on the wards. We also spoke with family members of two patients receiving end of life care.

We received comments at our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed performance information held about the trust.

End of life care

Summary of findings

The specialist palliative care team (SPCT) was available five days a week for face-to-face contact, and the Heart of Kent Hospice provided out-of-hours and weekend cover by telephone. Medicines were provided in line with guidelines for end of life care. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms were not consistently completed in accordance with the trust's policy, and there were no standardised processes for completing mental capacity assessments.

The SPCT provided four study days per year for trained nurses, and trust staff were able to access palliative care study days provided by the Heart of Kent Hospice in the Weald. Medical end of life training was delivered as part of the doctors' formal education programme. Leadership of the SPCT was good; quality and patient experience were seen as priorities.

All patients requiring EoLC were referred to the SPCT. However, often no specialist input was required by the team. Patients were cared for with dignity and respect and received compassionate care. There was a multidisciplinary team approach to facilitate the rapid discharge of patients to their preferred place of care. Relatives of patients receiving end of life care were provided with free car parking.

Are end of life care services safe?

Good

Staff were encouraged to report incidents. The wards and mortuary viewing area we visited were clean and well maintained. The mortuary was secured to prevent people entering inadvertently or inappropriately. Syringe drivers were available across the trust to support EoLC patients with complex symptoms to deliver consistent infusions of medicine. The specialist palliative care team (SPCT) included two palliative care clinical nurse specialists (CNSs). The SPCT's CNSs were highly trained in specialist palliative care.

Across the wards we visited we found evidence that paper medical records were used that documented each patient's personalised care and treatment. However, accurate coding of EoLC care issues was an issue (with very low reporting). Therefore, members of the coding team were being invited to the EoLC steering group to develop methodologies on how EoLC incidents could be coded to improve oversight across the hospital.

Incidents

- Systems were in place across the trust to deal with incidents. At the end of life steering group it was agreed that incidents relating to end of life care (EoLC) would be submitted to the lead palliative care nurse, who would, in future, be involved in any investigation. The lead palliative care nurse will inform any action plan to ensure issues identified as relating to EoLC would be shared across the trust to embed the learning so as to improve the quality of care.
- An accurate picture of EoL incidents across the trust was not available. The palliative care consultant told us that accurate coding of EoLC issues was an issue (with very low reporting). Therefore, members of the coding team were being invited to the EoL steering group to develop methodologies for coding EoLC incidents to improve oversight across the hospital.
- In all the areas we visited, we found that staff were encouraged to report incidents. Mortuary staff and porters told us that two incidents that involved a deceased patient had been reported in the last year (2013/2014). The mortuary technician told us that all incidents were reported on the trust's electronic

incident reporting system. As a result of both incidents, staff had received further training and protocols had been updated to ensure similar incidents do not occur in the future across the trust.
- No Never Events relating to end of life care services had been reported in the past year (2013/2014).

Cleanliness, infection control and hygiene

- The wards and mortuary viewing area we visited were clean and well maintained. In all the patient areas, the surfaces and floors were covered in easy-to-clean materials that allowed high levels of hygiene to be maintained throughout the day.
- We saw that ward and departmental staff wore clean uniforms with their arms bare below the elbows. Personal protective equipment (PPE) was available for staff to use in all clinical areas. In the mortuary, we saw adequate supplies of PPE for undertakers, porters and the police to use when visiting the mortuary.
- Clear guidance was available for staff to follow to reduce the risk of infection when providing end of life care or caring for people after death. Guidance was available to staff in the care of the dying policy and procedure, the last offices checklist and the communicable disease report. We saw, for example, that adequate numbers of body bags were available for deceased patients. Porters and ward staff showed good knowledge of when body bags should be used.

Environment and equipment

- The mortuary was secured to prevent people entering inadvertently or inappropriately. Access was through a coded door, and the porters held a key. Fridges were lockable but were not locked out of hours because porters required access to them; this meant there was a risk of unauthorised access.
- Up-to-date service records were available for the serviceable equipment in the mortuary. Servicing was contracted out to a third party. We were told that the fridges in the mortuary did not have alarms; therefore any faults would not be identified in a timely manner. On the day of the inspection, all equipment was working correctly and there were no issues about repairing or replacing equipment in a timely manner.
- Everyone we visited on the wards who was receiving EoLC had their individual needs assessed on admission and was being cared for on a mattress that suited their needs. Patients requiring an air mattress were assessed by the tissue viability nurse, and where required a mattress was allocated to them. On Pye Oliver and Chaucer Ward, two registered nurses told us they had no issues around obtaining the necessary equipment for EoLC patients.
- Syringe drivers were available across the trust to support EoLC patients with complex symptoms by delivering consistent infusions of medicine. The ward manager on the stroke unit told us that syringe drivers were available 24 hours a day, seven days a week, from the equipment library. If syringe drivers were not immediately available, the site manager was contacted to locate an available syringe driver.

Medicines

- Medicines guidance had been agreed and implemented that clearly set out the medicine necessary to support the management of dying patients. This covered five recommended areas, including pain, agitation and restlessness, and nausea and vomiting. The guidance was in easy-to-follow flow diagrams as part of the best practice guidance for care of the dying pathway. The guidance prompted ward teams to get the necessary anticipatory medicine prescribed in accordance with the patient's medical condition.
- Medicines guidance included supportive information that signposted staff to the SPCT or pharmacists if patients had complex medical conditions such as renal failure. This was to ensure that patients' safety was paramount and specialised skills supported the prescribing process.
- Staff on the stroke unit told us that medicine for EoLC was available on the ward and was easily accessible. The ward manager told us they had access to the on-call pharmacist if non-routine EoLC drugs were needed out of hours. This prevented EoLC patients having to wait for the necessary medicine.
- The choice of medicines at the end of life had been aligned to local community guidelines to support safe and consistent practice between care providers.
- Patients who might respond to some treatment, such as antibiotics for an acute infection, received these.

Records

- Across the wards we visited we found evidence that paper medical records were used that documented the patient's personalised care and treatment. The SPCT entered patient reviews into patients' medical records

and entered their findings in individualised palliative care notes that were kept with the SPCT's clinical nurse specialists (CNSs). Information gathered included preferred place of care, 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) status, advanced care planning in place and reason for referral. This enabled the SPCT to record activity and keep accurate care and treatment records for each patient, to discuss at multidisciplinary team meetings.

- The SPCT lead nurse told us that EoLC patients reviewed by the team had an initial holistic assessment that identified their individual situation such as previous medical history and any physical, psychological, social and/or family concerns. We reviewed one EoLC patient's medical records on Chaucer Ward. The holistic assessment was clearly documented, signed and dated. This showed that accurate personalised records were maintained. On all the occasions, the SPCT's CNS reviewed the patient. We observed that information such as clinical information and notes of conversations with the family were recorded in detail.

Assessing and responding to patient risks

- On the stroke unit the ward manager told us that EoLC patients received a Waterlow pressure ulcer risk assessment on admission. Depending on the patient's score and the ward manager's clinical judgement, the patient would be allocated preventative aids such as air mattresses to prevent pressure ulcers developing.
- The hospital used the 'patient at risk' (PAR) score to identify patients at risk of sudden deterioration. The tool monitors items including the patient's heart rate, blood pressure, temperature and urine output. On Lord North Ward, the sister told us that patients were observed four-hourly, but if the score increased (5 and above), the doctor would be called to review the patient immediately. The critical care outreach team monitored the PAR score remotely and the sister told us that they provided support if the nursing staff were concerned about the patient. The outreach team was available from 7.30am to 8.30pm, seven days per week.
- On Chaucer Ward we observed a patient who had a PAR score of 6. The registered nurse was able to describe the actions to take to manage the patient's condition and support the patient with the necessary treatment and care.
- On the wards we visited we reviewed the medical notes of four EoLC patients. We found that patients were regularly reviewed by the SPCT, depending on the needs of the patients. The level of intervention varied according to the needs of the patients. A level 1 intervention would involve a one-off discussion with health professionals, and a level 3 intervention was where advice and support were given over a short period. This meant that systems were in place to support EoLC patients with specialist input when required.
- Ward staff on Culpepper Ward told us that EoLC patients were reviewed every two hours to ensure that any changes in their condition could be managed in a timely manner. On the urgent medical ambulatory unit, we were told that patients' medicine was reviewed hourly and any changes in a patient's condition were recorded in the hourly nursing records. Because doctors were available on the ward until 9.30pm, a doctor could review any changes in an EoLC patient's condition in a timely manner. For patients where the progression of their illness was clear, the amount of intervention was reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible at all times.
- In the outpatient chemotherapy unit, the unit manager told us that systems were in place to monitor and assess patients before and during the administration of palliative chemotherapy .This included a visit to the pre-chemotherapy clinic, where a nursing assessment was completed, reviews in medical and nurse-led clinics before each cycle of chemotherapy, and continuous assessments of the patients while receiving chemotherapy. This meant that patients would experience safe and appropriate care and treatment that met their individual needs.
- The chemotherapy unit's manager described very knowledgably the systems in place on the unit to support a patient who might suffer a reaction to chemotherapy. These included immediate access to medical staff. This meant that procedures were in place for dealing with any emergency that arose during the delivery of chemotherapy.

Nurse staffing

- The specialist palliative care nursing team included two palliative care CNSs. The CNSs were highly trained in specialist palliative care. This brings a level of expertise and good understanding of current issues within the

nursing team. This expertise was available face to face five days per week across the trust. However, EoLC was the responsibility of all staff, and was not limited to the SPCT staff and CNSs.

- The palliative care lead nurse told us that during 2013/14, staff shortages had resulted in the SPCT having to work flexibly and creatively to maintain service provision with as few gaps as possible. The response times from referral to review confirmed service provision: 88% of referrals were seen within 24 hours.
- During our inspection we asked ward managers about their staffing levels and whether they had enough staff when they had to nurse EoLC patients. The ward manager on Pye Oliver Ward told us that it was a busy ward, and therefore if extra support was required to nurse an EoLC patient, this would be granted. However, on Chaucer Ward the registered nurse told us that no extra staff would be allocated to support an EoLC patient.
- In the chemotherapy outpatient unit, the vacancy rate had reduced during 2013/2014 from 8% to 3.3%. Permanent staff were supported regularly by agency staff to ensure safe staffing levels during the delivery of chemotherapy.

Medical staffing

- Specialist palliative care medical consultants were available to provide advice and support five days a week. Out-of-hours support was through a telephone advice service provided by the on-call palliative care consultant at the Heart of Kent Hospice.
- The SPCT multidisciplinary team consisted of 1.2 whole-time equivalent palliative care medical consultants, who were based across the trust, working on Monday and Thursday at Tunbridge Wells Hospital and the rest of the week at Maidstone Hospital. Following a review by the directorate, the palliative care consultant's hours were reduced by four hours per week, which equated to one clinical session. No junior doctor support was available to the team.
- A new palliative care consultant was recent appointed who will work three sessions at the trust and work at the Heart of Kent Hospice for the rest of the week. This will improve continuity and management of patients across the different service providers.
- On the chemotherapy day unit, medical cover was available from 9am to 7pm daily, with a junior doctor allocated to the unit every day. This meant that patients had access to medical support when required.

Major incident awareness and training

- The mortuary had systems in place to ensure that if there was a sudden surge in demand for refrigerated mortuary space (such as following a major incident or utility failure such as mains electricity failure or mechanical breakdown)), the trust had a contract with a local undertaker and access to extra refrigerated space at Tunbridge Wells Hospital.

Are end of life care services effective?

Requires Improvement

The SPCT based its care on National Institute for Health and Care Excellence (NICE) quality standards relating to end of life care (EoLC) and provided evidence-based advice to other professionals as required. The trust discontinued use of the Liverpool Care Pathway on 1 July 2014. Staff were asked to follow the guidance set out in the best practice guidance for the care of the dying and use it to support the care delivered to all patients approaching the end of their life. However, we did not find individualised care plans relating to end of life care and how care would be delivered around patients' needs and preferences.

Results from the 2013 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) audit showed improved compliance from 2011, but the trust's standards were still not being met. There was no evidence that mental capacity assessments were carried out when a patient might not be able to decide about their treatment, care or DNA CPR wishes.

Evidence-based care and treatment

- Maidstone and Tunbridge Wells NHS Trust had implemented the National Institute of Health and Care Excellence (NICE) quality standards for improving supportive and palliative care for adults with the introduction of a specialist palliative care team (SPCT) that demonstrated a high level of specialist knowledge. The SPCT provided wards and departments across the trust with up-to-date holistic symptom-control advice for patients in their last year of life.

End of life care

- The trust's care of the dying policy and procedure outlined the expected standards of care for patients and their carers as people approach the end of life.
- Following the national review of the Liverpool Care Pathway (LCP), the trust responded to the recommendations of the review by undertaking targeted work. The trust had formulated guidance for all staff caring for patients at the end of life, called the best practice guidance for the care of the dying, which contained the steps necessary to create an individualised care plan, specialist palliative care staff contact details and medicines guidance. Staff were asked to follow this guidance to support the care delivered to all patients approaching the end of their life.
- The Leadership Alliance for the Care of Dying People has published One Chance to Get it Right (July 2014); this was a response to the recommendations set out in More Care, Less Pathway, the independent review of the LCP. The updated version of the best practice guidance for the care of the dying (version 2) will incorporate national recommendations set out by the Leadership Alliance.
- The palliative care consultant told us that the LCP had been removed from the trust on 1 July 2014. Before this date, the LCP had to be consultant led. Because of the short timescale to get the new best practice guidance for the care of the dying in clinical use, members of the SPCT visited wards, along with an intranet launch to inform the trust's clinical teams. Minutes of the end of life steering committee meeting in June 2014 confirmed that the palliative care consultant had attended medical and surgical governance meetings to promote the care of the dying guidance.
- The best practice guidance for the care of the dying listed a number of core principles that were thought to be crucial to good care in the last few days of life, incorporating NICE quality standard QS13 for end of life care. The guidance was a checklist that aimed to support healthcare workers as a memory aid. We saw evidence during the inspection of the guidance being used on the stroke unit and John Day, Pye Oliver and Foster Clarke Wards. On Culpepper Ward, we found evidence of the best practice guidance, which was signed and dated by the consultant and registered nurses.
- Staff we spoke with told us the SPCT or medical teams would seek verbal consent from patients and/or families before moving a patient onto the best practice guidance for the care of the dying. A nurse on Pye Oliver Ward told us they felt "in limbo" following the removal of the LCP, and that staff would like more information on EoLC to support patients and families.
- The palliative care lead nurse told us that the best practice guidance for the care of the dying (version 2) was being developed with prompts to ensure all areas of good EoLC were addressed and details of the preferences of end of life patients were readily accessible to all healthcare professionals. An individualised care plan template was being taken to the medical records committee and standards committee before being piloted on the stroke unit and Cornwallis, Foster Clarke and Pye Oliver Wards over the coming months.
- On reviewing medical records of six EoLC patients across the wards we visited, we did not find individualised care plans. We saw evidence that generalised care was delivered and recorded, but we did not see any information on how the staff intended to deliver individualised care. On the urgent medical ambulatory unit, general care plans were completed on admission, but we found no special section with information to support EoLC patients.
- While reviewing the notes, we saw evidence that demonstrated that the SPCT had provided evidence-based advice, for example on complex symptom control and on providing psychological support to patients and families. This specialist input by the SPCT ensured that a high level of expertise was used to ensure the best possible care was delivered to EoLC patients and that they had a positive experience of care.
- We were told that the trust was not actively engaged in the NHS Improving Quality Transform Programme (phase 2). (This programme aims to encourage hospitals to develop a strategic approach to improving the quality of end of life care.) However, the trust had expressed an interest in using AMBER (Assessment Management Best practice Engagement Recovery uncertain) care bundles. These are used to support patients who are assessed as acutely unwell, deteriorating, with limited reversibility and where recovery is uncertain. However, because of a shortage of staff, the use of AMBER care bundles has not progressed within the trust.
- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) in May 2013. The information gathered offered some insight into the trust's practices

at that time and areas that would benefit from improvement strategies, as well as aspects of care the trust was delivering well. Areas highlighted for improvement included bereavement leaflets that explained the grieving process for families, clinical protocols promoting comfort and dignity, identifying and meeting spiritual needs, and seven-day working of the palliative care team. The clinical section of the audit was reviewed in detail and an awareness of the need for good documentation and communication was highlighted.

- An NCDAH action plan had been developed and updated (dated 6 October 2014) around the key audit findings. We saw evidence during the inspection that the action plan was in the process of being actioned. We found on the wards we visited that a new bereavement booklet from Macmillan and Marie Curie Cancer Support had been introduced, and the end of life facilitator was developing a new local EoLC information booklet, which we saw was in draft format at the time of the inspection. The ward manager on the stroke unit told us that the new Macmillan booklet was being reviewed before being shared with the team and being made available to patients and relatives.
- The trust performed poorly in the NCDAH on the spirituality support offered to patients and relatives. To address this, the draft copy of the new individualised care plan for the dying patient had a section that asked healthcare staff to ask whether patients required spiritual support. This will prompt staff and offer support to patients and their relatives.
- The SPCT had recently registered with the EoLC quality assessment tool. The SPCT could use this to self-access and track progress against the NICE quality standards, and develop a service-improvement programme around the outcomes.

Pain relief

- The SPCT supported effective pain control as an integral part of the delivery of EoLC. On reviewing an EoLC patient's medical records on the stroke unit, we saw that the SPCT's CNS and palliative care consultant were actively involved in daily reviews of the patient's pain management. We saw that the medical teams on the stroke unit were proactive in prescribing EoLC medicine.
- Best practice guidance for care of the dying included guidance on prescription of anticipatory pain relief for patients at the end of life. The guidance had been developed from the Kent Palliative Medicine Forum's Symptom control and caring for the dying patient: palliative care guidelines (University of Kent, 2009).
- One of the SPCT's CNSs was a non-medical prescriber. We were told that this was an important part of the CNS's role because it allowed the timely prescribing of required medicine. The SPCT was involved in prescribing patients' EoL medicine. Staff on the wards we visited told us that all patients who needed a continuous subcutaneous infusion of opioid analgesia or sedation received one promptly. The amount of analgesia and sedation was often increased as death approached. Staff made it clear to relatives that this increase was always a response to the patient's symptoms. Information for patients and relatives on end of life medicine was available in the "End of Life: a guide" booklet.
- On the urgent medical ambulatory unit, the sister told us that patients' pain was reviewed hourly. If the ward team was unable to manage pain effectively, the SPCT or acute pain team would be called to review the patient. On Foster Clarke and John Day Wards we found that pain-relief medicine had been prescribed and was delivered as required. If necessary to manage pain effectively, medicine was sometimes delivered through a syringe driver. On Pye Oliver Ward, the nurse told us that the SPCT provided support to patients with intractable pain.
- On John Day Ward, we observed that a pain assessment tool was being used for patients with dementia. For example, patients' facial, vocal, body language, behavioural and physical signs were used to monitor their pain.
- On the chemotherapy unit, the nurses liaised with the SPCT or hospice team to ensure that medicines were prescribed for patients who were attending the hospital for chemotherapy, so they were in place before patients left the hospital.

Nutrition and hydration

- In the best practice guidance for the care of the dying, section 10 states, "multi professional teams must pay specific attention to the patient's nutritional and fluid requirements". The guidance includes a prompt to ensure that patients' and families' preferences around nutrition and hydration at the end of life were explored and addressed. On the wards we visited, nursing staff

told us that nutrition and hydration needs were being met for EoLC patients. We were told that separate menus were available, such as with soft and pureed food.

- On a patient's admission, a nurse completed a risk assessment for the patient. The ward manager on John Day Ward told us that a malnutrition universal screening tool (MUST) assessment was carried out weekly; this identified patients at risk of poor nutrition, dehydration and swallowing difficulties. Patients identified as at high risk were directly referred to the dietician and speech and language therapist. The ward manager on the urgent medical ambulatory unit told us that a red-tray scheme was being used to indicate those patients who needed additional help at meal times. Meal times were protected, which meant staff ensured people could eat uninterrupted except for urgent clinical care.
- On John Day Ward, the ward manager told us that protected meal times were in place and that staff encouraged relatives to support family members at meal times. On reviewing a set of medical notes, we found that a fluid chart was being completed daily and weekly MUST assessments were being undertaken.
- On Culpepper Ward, we reviewed the notes of an EoLC patient and observed that a food record and a dietary action plan were in place that stated that the patient should be encouraged to take oral meals and extra snacks. A weekly MUST assessment was performed and the red-tray system was being used. This showed that the trust had systems in place to support patients' nutritional and hydration needs.

Patient outcomes

- The trust supported patients to achieve their preferred place of care, either through rapid discharge to home, hospice or nursing home, or by delivering high quality care for patients who wanted to die in hospital. We were unable to review how the trust was achieving patients' preferred place of care, because data had not been consistently collected during 2013/14 as a result of staffing constraints.
- During our visit to the accident and emergency (A&E) department, staff told us that the A&E department had links with the SPCT to provide emotional and practical support for relatives and seek advice to significantly reduce the number of admissions. People could be treated, have improved symptom control measures put in place and return home. For patients that needed to be discharged home to be cared for, the SPCT facilitated the fast-track discharge process.
- Patients that were recognised as deteriorating or dying would be started on the EoLC pathway using guidance set out in the best practice guidance for the care of the dying. Staff told us that the EoLC pathway would be started after discussion with the consultant and multi-professional team, including the SPCT, and with the patient and their relatives.

Competent staff

- EoLC training was not mandatory across the trust. The National Care of the Dying Audit of Hospitals (NCDAH) action plan, under "update of progress", stated that EoLC would not be included in mandatory training for nursing staff. The trust was looking at an e-learning package for end of life care. The palliative care consultant told us that the SPCT's role was to help empower staff to manage EoLC patients and to prevent the deskilling of the frontline medical and nursing staff by talking through any processes with them.
- The General Medical Council (GMC) had revalidated the palliative care consultant during 2013. We were told that the consultant's continuing personal development diary was up to date; recent courses attended included one on advanced symptom control and neurological palliative care.
- The CNSs from the SPCT were highly qualified in palliative care; all team members had completed the advanced communications skills course. Two members of the team were now undertaking study at master's level. One CNS had attended the 'Sage and Thyme' facilitator course and was now able to support patients who might become distressed. The palliative care consultant told us that the SPCT supported the process and would get involved in the transition from active treatment to the supportive phase of care.
- The SPCT was actively involved in training staff in EoLC, providing four study days per year for trained nurses – two at level 1, with an emphasis on symptom control, complex discharge and EoLC issues. In addition, two study days were at level 2, with an emphasis on communication, spirituality and advanced care planning. Hospital staff also had access to palliative care

study days provided by the hospice. During the inspection, we were unable to see records to confirm the number of staff across the hospital who had attended training in end of life care.

- The CNSs and palliative care consultant supported all grades of staff across the hospital to ensure that ward staff felt confident to deliver EoLC, by providing visits to the wards and communicating recommendations to clinicians. The SPCT participated in induction days for new staff.
- We were told that doctors in foundation year 1 and 2, and doctors completing core medical training received EoLC training as part of their formal education. The palliative care consultant and the trust's clinical ethicist provided the training. During the inspection, we were unable to confirm the percentage of doctors that had received training in the last year.
- The chemotherapy unit's manager told us that chemotherapy nurses had completed their N59 certificate in care of patients having cytotoxic chemotherapy, with two further nurses currently undergoing their training. Competencies around the delivery of chemotherapy were carried out annually, with updates from Christ Church University every six months. Two clinical support workers were training to be assistant practitioners. The assistant practitioners will support the nursing staff by performing procedures such as blood transfusions, flushing lines and sub-cutaneous injections, as well as monitoring patients in the day rooms. This will ensure the skills of the workforce are maximised and used effectively across the unit.
- The SPCT's CNSs were line-managed by the Macmillan lead palliative care nurse. Appraisal rates within the cancer and haematology directorate were 45.4% for the year to date, which fell short of the expected rate of 90%. One CNS confirmed their last appraisal had been in September 2013. The appraisal system ensured that staff were adequately supported to develop their skills and deliver high quality care.
- Guidance was available in the spiritual and religious care directory, on wards and on the intranet, to support staff in providing care in accordance with people's religious and cultural preferences. Staff could obtain specialist advice from the chaplaincy if they needed clarification on religious issues.
- Syringe driver pumps to deliver analgesia continuously were available to all EoLC patients. We saw that staff were trained to use the pumps. Training records were available and showed that sessions ran regularly. In 2013, staff training on syringe driver pumps was delivered during intravenous therapy study days. In 2014, training on syringe driver pumps was changed to being delivered through medical devices training. However, because staff attendance had dropped, the trust has reverted to delivering the training at intravenous therapy study days.
- Across the trust, EoLC link nurses were present on the wards. On visiting Pye Oliver and John Day Wards, we saw that both wards had EoLC link nurses. A nurse on John Day Ward told us that the link nurses gave staff on the wards "regular updates around EoLC to keep their knowledge up to date". Another nurse told us that link nurses "share knowledge and learning through updates at team meetings; the advice they give is really helpful." We were told that because of recent staff shortages in the SPCT, EoLC link nurse study sessions had not taken place, but plans were in place to reinstate these.
- The porters told us that they had received training in moving deceased patients to the mortuary. The on-the-job training had included the use of the mortuary out of hours, to ensure that mortuary procedures were maintained. The porters we spoke with were able to describe the process in a knowledgeable manner and were able to demonstrate how they treated deceased patients with dignity and respect.

Multidisciplinary working

- We saw evidence across the wards of multidisciplinary team (MDT) meetings that took place throughout the week to review patients' management plans. On the urgent medical ambulatory unit, the ward manager told us that a board round was performed each morning involving the nursing and medical staff, physiotherapists and occupational therapist. On John Day Ward, a daily ward round took place that nurses attend. This allowed a multi-professional approach to care, and for specialist input to take place to improve patient outcomes.
- On Lord North Ward, the ward manager told us that an MDT meeting took place on Mondays and included physiotherapists, an occupational therapist, dietician and discharge coordinator, and nursing and medical staff. Patients requiring a review could be discussed at any time. This allowed any changes in a patient's condition to be reviewed in a timely manner and changes in care to be put in place.

End of life care

- The SPCT was visible to staff across the hospital. Nursing staff in all departments and wards we visited were aware of how to contact the SPCT, and could cite examples of the SPCT's Involvement with specific patients. Junior doctors were able to book sampler weeks with the palliative care consultant as a means of building on their knowledge of the end of life process.
- The SPCT held a weekly MDT meeting (on Tuesday morning) at Maidstone Hospital to discuss treatment plans for new and current patients. The SPCT told us that an ongoing challenge was to provide a useful forum that incorporated a range of practitioners involved in providing palliative care and caring for EoLC patients. Following the weekly MDT meetings, a management plan was agreed and was documented in the patient's individual palliative care notes. This information could be given to the patient if they required a record of the discussion or plan.
- The CNSs worked closely with the cancer and non-cancer, site-specific CNS in order to give support with complex symptom management at the end of life. An SPCT member attended the lung MDT meetings, but SPCT members did not attend other multidisciplinary team meetings, because of a shortage of staff. However, the SPCT received referrals from the gastrointestinal and gynaecological MDT meetings.
- The SPCT told us it worked alongside other specialties including the acute oncology team and community and hospice teams. The new medical consultant will work sessions at the hospital and Heart of Kent Hospice, providing streamlined care across care providers and a more standardised model of care across the local healthcare economy.
- On the chemotherapy unit, the unit manager told us they worked closely with the family liaison team from the hospice, for young patients receiving treatment. Hospice nurses attended the hospital to learn about the treatments their patients received and to learn about line flushing and blood transfusions so patients could receive these in the hospice and not have to travel to the hospital to receive care.

Seven-day services

- The SPCT based at Maidstone Hospital offered services from Monday to Friday, from 9am to 5pm. Staff on the wards told us they felt confident in the support mechanisms in place for EoLC patients outside these hours. No seven-day face-to-face specialist care was available from the SPCT. However, systems were in place to provide timely telephone advice from 5pm onwards from the palliative care consultant on call at the Heart of Weald Hospice, for people approaching the end of life.
- Chaplaincy cover was provided 24 hours per day; outside 9am to 5pm, the service was for emergencies only. The chapel was open 24 hours a day for prayers.

Access to information

- All staff had access to the care of the dying policy and procedures, version 2.2. This gave guidance to staff on all aspects of caring for dying patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Ward staff told us that if there was any question around whether a patient was able to make decisions around their treatment and care or 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) wishes, a mental capacity assessment would be completed by the admitting doctor and a best interests decision would be made. However, we saw no evidence of this process during the inspection.
- The trust had a resuscitation policy that set out the use of DNA CPR orders, which was available to all staff. We were shown data from the last two DNA CPR audits undertaken across the trust in 2011 and 2013. Results from the 2013 audit showed improved compliance in 2011, but in 2013 the trust's standards were still not being met. We were told that the 2014 audit was still in draft form.
- On visiting the ward areas, we randomly checked 14 medical records containing DNA CPR orders. We saw that all decisions were recorded on a standard form with a red border that was placed at the front of the notes, allowing easy access in an emergency.
- The trust's policy required the red copy of the DNA CPR order to be placed in the medical notes and a grey copy of the order to be place in the nursing notes. On Chaucer Ward, we reviewed four orders and found no grey copies of the orders in the nursing notes.
- Where DNA CPR orders were in place, we saw that patients with capacity were involved in discussions. However, where the patients lacked capacity, we saw no evidence of assessments being undertaken or documentation of the assessment. Where patients lacked capacity, we noted that family members were involved in the discussions about the level of care to be

provided. On Pye Oliver Ward, we observed that a patient who lacked capacity had an abbreviated mental test performed, but no mental capacity assessment. A consultant told us that they would not necessarily perform a mental capacity assessment for DNA CPR; instead, procedural and best interests decisions would be made.

- A consultant countersigned all DNA CPR orders; however, on four of the orders we checked, we found that patients and families were not consulted, and in one case no review date was evident where the patient's condition was improving. We concluded that there were variations in the completeness of the forms across the hospital.
- Our findings showed that DNA CPR orders did not always provide evidence that trust's policy had been followed; this indicated that more work was required in this area. Completing the DNA CPR forms ensures that appropriate decisions are made about the care of patients.
- On the chemotherapy unit, recent training had included training in domestic abuse and the Mental Capacity Act (2005). The unit manager told us that the unit worked closely with the safeguarding lead nurse, and we were given an example of where a positive outcome had been achieved by working in collaboration.

Are end of life care services caring?

Good

Staff at Maidstone Hospital provided compassionate end of life care to patients. Hospital staff we spoke with demonstrated a strong commitment to empathy towards dying patients. We saw that families were encouraged to participate in care such as mouth and personal care.

Compassionate care

- Hospital staff we spoke to demonstrated a strong commitment to showing empathy towards dying patients. The care of the dying policy and procedure stated that staff would "approach the dying process in a caring and sensitive manner, paying attention at all times to the spiritual and cultural needs of the patient and their relatives and carers".
- On Culpepper Ward, a family member told us that the staff were "brilliant and very helpful" and that their relative was checked regularly and turned for comfort.
- On John Day Ward, relatives told us that nursing staff were very attentive, very kind and responded quickly when called. During a discussion with a doctor regarding a DNA CPR order, the relatives felt they were spoken to in a sensitive way and given ample time to decide, without any pressure.
- On Chaucer Ward, a family member told us that "care was excellent", and that the nurses had gone above and beyond in the care they were providing; also, how the staff had offered their family member drinks throughout the day. We were told that during a discussion about a DNA CPR order, the doctor had been very calm and honest and put no pressure on the family. After 10 days, the family had been offered free parking, which the ward had organised. The relative told us that when they left the hospital at night, they felt their relative was safe.
- The porters explained to us the procedure to remove a deceased patient from the ward to maintain the person's dignity and respect. Arriving on the ward, the charge nurse would close off all the bays and ask people to stay in their bays, while the porters quietly and respectfully brought the concealment trolley into the ward. During the transfer, a member of the nursing team would be available to support the porters. A nurse on Chaucer Ward confirmed the respectfulness of the porters when they arrived on the wards.
- On the chemotherapy unit, the unit manager told us that patients receiving treatment during lunch time were offered sandwiches and a drink after their treatment. To make the experience more personalised and less clinical, a plate, napkin and individual hand wipe were offered to the patient.
- The chemotherapy unit was visited by the Red Cross, who undertook hand massages on patients during their treatment.
- When we visited the mortuary, the mortuary technician told us that all deceased patients that come from the wards are prepared in accordance with the trust's policy on personal care after death. If a patient arrived not prepared correctly, the technician would raise an incident report and offer the ward in question extra training around the care of deceased patients.
- The spiritual and religious care directory was available on the wards to support staff, so that appropriate consideration was given to patients' needs .The ward

manager on Lord North Ward was able to give us an example of where consideration had to be made for a travelling family whose relative was receiving EoLC. Staff would, whenever possible, meet the needs and wishes of EoLC patients.

- The trust did not perform a local bereavement survey, but it does undertake a patient satisfaction survey.
- The ward manager on the chemotherapy unit told us that the unit regularly referred patients to the community and hospice teams for community support in between chemotherapy cycles. However, we were told that the hospital teams did not always receive feedback from the community teams and patients often did not always receive the necessary support.

Understanding and involvement of patients and those close to them

- Medical records showed that the CNSs were actively involved both with the patient and the relatives, providing support and keeping families involved in management of the patient, with the patient's consent.
- On Lord North Ward, the sister told us that recognising and accepting that a patient was dying was difficult. Discussions took place with the family, doctors and a senior nurse. Wishes and preferences were discussed along with spiritual or religious needs. The staff on the ward worked to ensure that the patient's wishes were achieved. After the death of a patient, some families wanted to be involved in after-death care, but others did not.
- The sister on Pye Oliver Ward told us how important it was to get families involved in the care; for example, staff encouraged relatives to get involved in patient's mouth care if they wanted to, and families could be asked to support relatives at meal times. One family on Chaucer Ward told us they felt very involved in their relative's care and would do anything they could to help.
- The trust contributed to the National Care of the Dying Audit of Hospitals (NCDAH) 2013. On the key indicators, the trust was performing in line with other trusts; however, the audit highlighted the need for better documentation and communication with patients and families. The trust recognised the importance of improving communication and documentation and had included these in the NCDAH action plan.
- The ward manager on the stroke unit told us that as part of the ongoing discussion with end of life patients and their relatives, the level of care was discussed and documented.

Emotional support

- All CNSs had completed the training necessary to enable them to practise at level 2 for the psychological support of patients and carers. On Lord North Ward the sister told us that referrals were made to the SPCT to provide ongoing support and advice to patients and their families. Other forms of support included referral to the cancer councillor, which can be helpful when children are involved; referrals were also made to the hospice team.
- On the chemotherapy unit, the unit manager told us that systems were in place to support patients during chemotherapy. This included referrals being made to the cancer councillor and the nurse-led chemotherapy clinic, by visiting the Macmillan information centre, and through peer support groups.
- The chaplain was available to provide spiritual and religious support.
- Volunteers were available from the chaplaincy to provide emotional and spiritual support when asked by the patient or family and medical and nursing staff. A volunteer visited the chemotherapy unit three times a week and spent a morning on the unit talking to patients and their carers.
- The chemotherapy unit undertook staff debriefing sessions. Staff who had been involved in a difficult case were encouraged to talk about their experiences and support each other. The unit's manager had an open door policy and encouraged staff to talk about their experiences.
- Bereavement services were not available in the hospital. Minutes of a meeting of the end of life steering committee on 8 September 2014 stated that the SPCT will approach the commissioner to explore what services could be provided locally. In oncology, the nursing teams referred families to the hospice for support, but no similar facilities were available to non-cancer patients.

Are end of life care services responsive?

End of life care

Requires Improvement

One objective of the end of life action plan was to expand the service to a seven-day service. Patients receiving end of life care (EoLC) were, whenever possible, to be cared for in single rooms. However, this was not possible because of a shortage of single rooms, and most EoLC patients were nursed in bays. Facilities for patients and relatives on the wards we visited were poor apart from in the emergency department.

Most medical certificates of cause of death took longer than five days to be released to families, which delayed families having the death registered and delayed the body being released to the funeral directors.

All patients requiring EoLC were able to access the SPCT. The SPCT supported complex and fast-track discharge processes so that patients achieved their preferred place of care.

Service planning and delivery to meet the needs of local people

- Data on referral patterns, patient demographics and patient activity was collected manually and sent to the National Council for Palliative Care's Minimum Data Set (NCSPC MDS) to be collated for local and national comparison. Information collected included the number of people using the service, breakdown of diagnosis and mean length of care. The trust used this information to benchmark its service, and used the report to negotiate with commissioners around service provision.
- The SPCT was a widely embedded service and worked in all clinical areas of the hospital we visited. Staff on the wards told us they referred a high percentage of their patients entering end of life care (EoLC) to the SPCT. However, often the SPCT input was not required as the majority of patients could be appropriately managed by ward staff, at a local level; the SPCT ensured that specialist input and advice remained accessible to all ward based nursing and medical staff. As referrals for EoLC increased, plans needed to be made for how the trust would support an increase in demand for SPCT services. The minutes of the meeting of the end of life steering committee in July 2014 stated that discussions were being undertaken and a business case was being written to increase the SPCT workforce.

Meeting people's individual needs

- We were told that patients at the end of life were assessed by the medical and nursing teams to develop individualised care plans to meet their needs. However, on the wards we visited we did not see any individualised care plans for EoLC patients.
- We visited the mortuary viewing suite where families can spend time with their relatives. The viewing suite was divided into a reception and viewing room. The suite had no religious symbols, which allowed it to accommodate all religions. We were told families were supported during the viewing, and relatives were advised what to expect. Appointments could be organised through the bereavement office or mortuary from Monday to Friday. Viewing times were available all day between 9am and 4pm.
- Information leaflets for families whose relatives were receiving EoLC were available and were handed out by ward staff. The information leaflets included "End of life care; a guide" and "Guidance following bereavement". Ward staff we spoke with told us they gave relatives these leaflets and a brief overview of the information, and offered to explain anything. The end of life steering group, in September 2014, had discussed developing a leaflet explaining the facilities available for relatives and friends.
- The patient liaison officer carried out the administration of a deceased patient's documents and belongings, provided practical advice and signposted relatives to support services such as funeral directors and the registrar (for registering the death). The office was open from Monday to Friday, from 10am to 3.30pm. We found that the office, as a working office, was not appropriate for meeting grieving relatives in.
- We found that signs to the office of the patient liaison officer were not clearly evident in the hospital, which could add stress to already grieving relatives.
- Six weeks after a death, a card was sent to relatives with relevant numbers of support services.
- Families require medical certificates of cause of death in order to register a death. We were told that most certificates take longer than five days to be released to the family, which meant delays to families being able to register the death, and delays to the deceased patients being released to funeral directors. When certificates had to be ready in less than five days for religious or cultural reasons, the certificates were processed quickly

and were always completed. No audit information was available to monitor how responsive the trust was in completing medical certificates of cause of death. The patient liaison officer told us that if relatives were unhappy with any aspects of care, they will contact the ward managers or direct the relatives to the Patient Advice and Liaison Service (PALS) team.

- A variety of religious and spiritual meetings took place in the hospital during the week. These included a Christian service in the chapel every Sunday, prayers in the quiet room on a Friday, and lunchtime reflection for all took place on a Tuesday. The chapel itself was Christian; however, the quiet room provided a place of worship for people of other faiths.
- The chaplains were on call and the point of contact for other faith leaders. One chaplain and around 20 volunteers were available at each hospital. Volunteers had regular clinical areas to visit, with some available on call.
- A book of remembrance was on display in the chapel, and a letterbox was available in which to place messages and prayers for the chaplain. A chaplaincy volunteer told us they received a list from the patient database of all new admissions to the hospital; they visited the wards to say hello to EoLC patients and left a calling card if the patient was asleep. They also received calls from the wards requesting they visit a patient.
- We spoke with the porters about the arrangements for transporting patients to the mortuary. We were told that porters received six weeks' training, which included meetings with the mortuary staff to ensure that the necessary procedures in the mortuary were maintained at weekends and overnight. The porters we spoke with could tell us about the protocol they followed.
- The mortuary manager told us that effective systems were in place to log patients into the mortuary. We were walked through the process and were shown the ledger-type book that contained the required information. We observed that the book was completed appropriately and neatly and was completed in a respectful way. Confidentiality was maintained at all times.
- On our visit to the mortuary we were shown where deceased patients left the hospital with the undertaker or with family. The area outside the mortuary was within the hospital grounds and was not a public walkway.
- The care of the dying policy and procedure signposted staff to consider the multicultural needs of their patients and the importance of the specific requirements relating to the care of the EoLC patient before and after death. A spiritual and religious care directory was available to healthcare staff to ensure that EoLC patients were managed in line with their culture/faith. The directory covered the care of the end of life patient, their diet, post-mortems and organ donation.
- Nursing staff and allied health professions involved in delivering palliative chemotherapy and radiotherapy felt that systems were in place to ensure that patients they felt were too ill to receive active treatment were discussed with the relevant medical team and alternative care was offered.
- In the chemotherapy unit, 75% of the chemotherapy was palliative. The unit manager told us that nursing assessments were carried out before starting chemotherapy. This allowed nursing staff to run through the chemotherapy drugs and the risks associated with them. We were told that, in the last year, four to five patients had not proceeded to chemotherapy because of their poor general condition. Good team working allowed concerns to be raised. Patients were then referred to the community palliative care team for supportive care.
- We were told that patients receiving EoLC would, whenever possible, be cared for in a single room. However, staff on the wards told us that there was a shortage of single rooms, and therefore most EoLC patients were nursed in the bays. This contradicted what the ward manager on Lord North Ward told us, who said around 95% of end of life patients were nursed in a single room. The ward manager did say that although the ward had eight single rooms, infection control patients were the priority. On Foster Clarke Ward we were told of an EoLC patient who had required a single room; the ward manager had escalated the need for a single room on two occasions in the last week, but no positive outcome had been achieved. This meant that the needs of the patient were not always being met by the trust.
- On the urgent medical ambulatory unit, the ward manager told us that the unit had two single rooms; however, infection control patients took priority. EoLC patients were nursed in large bays with only four patients in each bay and were able to have their relatives staying with them during the night in a 'put-up bed' if they wished. Visiting times on the unit were 8am to 8pm, but the relatives of EoLC patients were allowed

unrestricted visiting hours. Staff sometimes had to find a room in which to break bad news to relatives, or if relatives were distressed; this might have to be a clinic room, which was not ideal.

- We found that patients' and relatives' facilities on the wards we visited were poor; however, in the emergency department we saw that relatives' facilities were available. In the minutes of the end of life steering group (September 2014), it was reported that the trust was continuing to explore day room facilities going forward.
- The SPCT worked collaboratively with the cancer and non-cancer CNSs across the hospital to provide seamless EoLC. Cancer and non-cancer patients received support from site-specific CNSs. The CNSs provided support when patients developed complex symptoms. However, we found that patients undergoing palliative chemotherapy were not supported by a CNS after they left the care of the surgical teams. This meant that arrangements had not been made to minimise disruptions in care, because patients lost their point of contact and their support as they entered a new phase of illness management.
- On the urgent medical ambulatory unit, we observed that patients were allocated a named nurse, and that the name of the consultant was above the patient's bed. On Chaucer Ward, a relative of an EoLC patient told us that each day, a named nurse was allocated to each bay. This meant that the nursing and medical teams responsible for the patient were clearly communicated to all staff, patients and their relatives.

Access and flow

- We were told that systems were in place to facilitate the rapid discharge of patients to their preferred place of care. We observed in the minutes of the end of life steering committee that a trial of rapid discharge will be undertaken; this will be attached to fast-track referrals. Although this pathway formed part of the care of the dying policy, the SPCT found it had not been well used. We were told that it would be re-launched with the best practice guidance and individualised pro forma in the autumn.
- Referrals to the SPCT could be made by completing a referral form, which could be accessed on the intranet. Any members of the multi-professional team could make a referral. The team aimed to see patients within 24–48 hours of referral. We saw data that confirmed that 95% of patients were seen within two working days. Of these, 88% were responded to within 24 hours (many on the same day as receipt of referral) and 7.5% within 48 hours. A nurse on John Day Ward told us that the SPCT was "good for advice and will come quickly when needed, providing support for both patients and staff".
- Patients discharged from the acute setting who did not have specialist palliative care needs were initially followed up by district nurses, who acted as the patient's keyworker. The option was available to refer to the community palliative care team at any time.
- The SPCT told us that systems were in place to rapidly discharge patients to their preferred place of care. The staff caring for the patient on the ward led the discharge process, which was supported by the SPCT, the discharge liaison team, community liaison team, physiotherapist and occupational therapist. On Lord North Ward, the ward manager told us that the ward had its own physiotherapist and occupational therapist, which was beneficial during complex discharges. The introduction of the discharge liaison nurse had made the process easier; we were given an example of where the SPCT managed to discharge a young patient home within six hours.
- The rapid discharge pathway sets out clear instructions for staff to follow, including tasks for the ward doctor such as prescribing medicine and completing a valid 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) order. Tasks for the day of discharge were clearly set out and included what staff should do following discharge, such as calling the GP, district nurse/nursing home, hospital palliative care team and family to confirm that the patient had left the ward. Ward staff ensured that contact was made with district nurses, GPs, community and hospice palliative care teams before patients were discharged.
- The trust is not part of an electronic palliative care coordinating system. This system would support better care by recording patients' preferred place of care and prevent inappropriate admissions to hospital.
- There was no EoLC alert system in place that informed the SPCT of any emergency admissions to the A&E department of palliative care patients previously known to the team. This would support the early assessment and management of patient care and sometimes prevent an inappropriate admission.
- The CNSs told us that referrals had increased during 2013/14 to 400 referrals patients entering EoLC. The SPCT supported patients with cancer and those

suffering from other conditions. All patients starting on the care of the dying guidance were referred to the SPCT for audit reasons. On Foster Clark Ward we saw a patient receiving end of life care who was receiving support from the Parkinson's disease CNS because the patient was known to them.

- The CNS reviewed patients, depending on their needs, offering support and reviewing their care needs. Patient contact depended on the needs of the patient and their family, with many EoLC patients requiring more than one contact in a day. Palliative care medicine consultants reviewed complex cases and spoke to medical teams and carers.
- The trust's oncologists attended mortality and morbidity meetings in order to audit the number of patients that had died within 30 days of receiving chemotherapy and radiotherapy. The palliative care consultant also attended these meetings. Information about the management of the deceased patients was reviewed and discussions took place on any learning points. Points of discussion such as 'no protocol in place' or protocols that needed updating were referred to the relevant disease-specific Kent-wide oncology groups to ensure that protocols were consistent across Kent.

Learning from complaints and concerns

- We were shown a number of complaints relating to EoLC. There had been six complaints relating to EoLC in the last 14 months. The palliative care lead nurse had asked to be involved in responding to the complaints; the palliative care lead nurse would be sent details of all complaints in the trust about EoLC, so trends and patterns could be identified and the end of life steering committee informed. This allowed for strategies to be devised to address issues identified. However, learning from EoLC complaints was not being cascaded through the trust, which meant staff were not learning from the complaints made.

Are end of life care services well-led?

Good

An end of life steering committee including key personnel in the delivery of end of life care (EoLC) had been set up to develop and implement an end of life strategy to meet the needs of patients. An action plan had been developed that set out the key areas the trust would like to develop around palliative care in 2014/15. These included exploring the options for a seven-day service across the trust and reviewing the model of service delivery, including education programmes to facilitate, support and develop clinicians to provide high standards of palliative/end of life care.

Leadership of the SPCT was good; it was led by the palliative care consultant. The SPCT team members worked well together, which supported and improved patient outcomes. Staff spoke positively about the service they provided for patients. Quality and patient experience were seen as priorities and everyone's responsibility, and this was evident in the SPCT's patient-centred approach to care.

Vision and strategy for this service

- An end of life steering committee had been set up to develop and implement an end of life strategy to meet the needs of patients. We found reference to this strategy in the minutes of the end of life steering committee (September 2014) and in the action plan for the palliative care team for 2014/15. However, the trust's vision around EoLC remained unclear in terms of the direction the trust was heading in and what stakeholders should expect.
- The action plan developed for palliative care in 2014/15 included exploring the options for a seven-day service across the trust. It also included a review the model of service delivery, including education programmes to facilitate, support and develop clinicians to provide high standards of palliative care/EoLC, improve the process of rapid discharge home for EoLC patients, and appoint development posts (band 5/6 nurses) to rotate through the team and obtain feedback from patients. These objectives were at different stages of implementation at the time of the inspection.
- The trust had developed a care of the dying policy and procedure, version 2.2 (reviewed August 2014), which provided the trust with a comprehensive policy relating to the care of the dying patient. This was being updated by the relevant team members across the trust. Staff we spoke with who were delivering care knew about the policy but were unable to describe the trust's vision around EoLC.

End of life care

Governance, risk management and quality measurement

- The SPCT's operational policy stated that all team members were required to adhere to all relevant trust policies and procedures to ensure compliance with the organisation's governance requirements.
- EoLC was discussed by the end of life steering committee, which was set up in July 2014 and was chaired by the director of nursing. This group reported to the standards committee chaired by the medical director. The medical director was the trust's lead for EoLC, with the director of nursing reporting on EoLC matters to the trust's board.
- The palliative care medical consultant chaired the trust's clinical ethics committee. This committee drew up a trust response to the report into the withdrawal of the Liverpool Care Pathway (LCP). This prompted the development of best practice guidance for the care of the dying, which the trust implemented in place of the LCP.
- The EoLC steering committee reviewed any risks associated with EoLC across the trust. Members of the steering group included key clinical leads in EoLC and specialist palliative care, senior representatives from surgery, medicine, dementia care and the chaplaincy, and the trust's ethicist. This wide membership ensured that EoLC was the business of all across the trust and not just the SPCT.
- The SPCT implemented the action plan for the palliative care team, led by the palliative care lead nurse. Updates were fed into the EoLC steering group, which reported directly to the standards committee, which in turn scrutinised the work of the SPCT, highlighted issues and challenged their processes.
- We saw that the trust used other committees to support the development of the SPCT. These included the patient experience committee, where EoLC updates were discussed, and the medical records committee, where new individualised EoLC plans were ratified.

Leadership of service

- Leadership of the SPCT was good, led by the palliative care consultant. We observed that the team worked well together, which supported improved patients outcomes.
- All the staff we spoke with thought that their line managers and senior managers were approachable and supportive. They were also able to name members of the SPCT, and gave examples of their involvement in optimising patient care.

Culture within the service

- All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important EoLC was and how their work had an impact on the overall service.
- We spoke with staff about how supported they felt in their roles. They all described how they felt supported and told us how approachable their managers were. On the stroke unit, a member of staff told us that they felt supported by the ward manager, and that good team dynamics were in place. However, they commented that they had only seen the chief executive officer "twice in five years". The director of nursing had visited the ward a couple of months ago.
- Mortuary staff told us that they felt a sense of belonging to the wider hospital team and had lots of contact with non-mortuary staff. There were frequent visitors to the mortuary such as the chaplain, porters and undertakers, who they got to know quite well. The mortuary staff were able to see where their work fitted into the provision of EoLC services.
- All staff spoke positively about the service they provided for patients. Quality and patient experience were seen as priorities and everyone's responsibility, and this was evident in the SPCT's patient-centred approach to care.
- Across the wards we visited, ward staff told us that members of the SPCT worked well with nursing and medical staff. There was obvious respect between not only the specialties but across all disciplines.

Public and staff engagement

- The trust did not receive feedback on EoLC, and no bereavement surveys were undertaken across the trust.
- A patient satisfaction survey was completed during December 2012 and January 2013. A total of 30 surveys were sent out, and the SPCT received 21 responses through the Patient Advice and Liaison Service (PALS), achieving a response rate of 70%. Survey responses are notoriously low within palliative care.

End of life care

- In 2013, the SPCT introduced stalls at the front of the hospital and in the staff canteen to promote dying week. The palliative care consultant told us that very few people took an interest, and therefore no initiatives had taken place this year.

Innovation, improvement and sustainability

- The SPCT gave examples of practice of which the team was proud. These included: prompt responses to referrals, standard assessment within 24–48 working hours, and increasing referral profile of non-malignancy patients.
- All palliative care CNSs had completed advanced communications training.
- The SPCT had been networking with other providers, community services and GPs to offer better care closer to home.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at Maidstone Hospital are mainly located in one area on the ground floor and are served by one reception desk. Orthopaedics and the fracture clinic are nearby with a separate reception desk. The oncology team provides outpatients, radiotherapy and chemotherapy services within the Kent Oncology Centre at the hospital for patients in Kent and East Sussex. Maidstone Hospital offers clinics across areas of medicine such as cardiology, neurology, rheumatology, diabetes, respiratory and elderly medicine. There are surgical clinics such as ear, nose and throat, colorectal, vascular, orthopaedics and trauma. The ophthalmology clinics serve a considerably wider population than served by the rest of the outpatient services. Blood test services are provided within the outpatient department. The radiology department supports outpatient clinics as well as inpatients and emergency and GP referrals. The sonography service is located within the women's and children's outpatient area.

During our inspection we spoke with more than 15 patients as well as some of their relatives. We also spoke with over 20 members of staff including reception and booking staff, secretaries, managers, cleaning staff, nurses of all grades, doctors and consultants.

We observed care and treatment. We received comments from our listening events and from patients and the public directly. We also reviewed performance information about the department and the trust.

Summary of findings

All the patients we spoke with told us they had been treated with dignity and their privacy protected. They spoke highly of the staff in outpatients and radiology. They found staff polite and caring. However, many patients complained to us about the waiting times in the outpatient clinics.

Staff were reporting incidents, and these were discussed at the clinical governance meetings within the directorates. Systems were in place to reduce the risk and spread of infection. Medicines were stored and administered safely. The department held its own training records, which were up to date and demonstrated that most staff had attended mandatory training.

The trust had met its national targets and consistently performed higher than the national average in regard of radiology waiting times. There had been a backlog in reporting computerised tomography (CT) and magnetic resonance imaging (MRI) scans for several months, but there was evidence at our visit that this was being resolved. There was an ongoing backlog in clinic letters being sent out that had not been resolved. There was a risk to patients of receiving delayed or inappropriate treatment and considerable stress caused to the staff.

Staff demonstrated a commitment to patient-centred care. We found many examples of such care and of attention to patients' conditions and preferences.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

Staff were reporting incidents in line with the trust's policies and demonstrated knowledge and understanding of the system. Incidents were investigated, with feedback and learning shared at the monthly clinical governance meetings. Wider trust learning was through the intranet and monthly Governance Gazette. Some staff considered that they did not always receive feedback from incidents they reported.

Systems were in place to reduce the risk and spread of infection however it was noted that a room used to decontamine nasendoscopes was not fit for purpose; the current configuration did not allow for sufficient separation of clean and dirty instruments, increasing the potential for cross contamination. Medicines were stored and administered safely.

Training was managed and monitored within the outpatient department. The records were up to date and demonstrated that most staff had been trained and had updates within the required timeframes.

Incidents

- The trust used an electronic incident reporting system to record accidents, incidents and near misses. Training was in place on the use of the system.
- Staff we spoke with demonstrated knowledge and understanding of the trust incident reporting system. They knew what to report, and had reported incidents. We were given examples of reporting in phlebotomy, radiology and outpatient nursing and by clerical staff such as of lack of patients' records, delayed transport and where a tourniquet had been left on a patient's arm.
- Staff told us that learning from incidents was discussed at team and departmental meetings. We saw various examples of minutes that demonstrated learning being discussed at meetings. However, not all individual staff who reported incidents felt that they received feedback from investigations.
- The trust informed us of a Never Event that had occurred in radiology scanning in May 2014 that resulted in a patient having a chest drain inserted on the wrong side. This was reported as a serious incident, investigated jointly with A&E, and an action plan developed. We saw evidence of actions implemented, such as the introduction of annotation markers together with a policy and procedure. We saw the letter and email sent out to all staff describing the incident, the actions taken and how these would be monitored. Use of annotation markers was being audited at the time of our visit. We saw evidence of wider learning, such as presentations for emergency department and trauma staff. We also saw that the Never Event had been described on the trust's intranet as a prompt for all services to consider their own checking systems. Good practice of note was that radiographers were reassured that these measures were not to target individuals, but to ensure action and learning so that the incident did not occur again.
- We were told that, following the implementation in July 2014 of a Kent-wide radiology imaging reporting system, a backlog in reporting computerised tomography (CT) and magnetic resonance imaging (MRI) scans had developed. This was because of reduced reporting times, staff vacancies and access to staff training on the new system. The backlog had been outsourced but, because of continuing issues with the new system, had taken some months to reduce. We saw five examples of serious incidents reported regarding these delays. There were full investigations, and the issues with the new system have been logged. Weekly meetings with the system provider and all hospitals in Kent involved in the new system were put in place to manage the issues and share learning and good practice. The trust instigated checks to search for any delayed reports and took action when these incidents were identified.
- The radiology department had specific patient information and event report forms for identified risks in some procedures such as extravasation of x-ray contrast media and contrast reaction incidents. Staff demonstrated awareness of the importance of reporting any occurrences.
- We saw examples of clinical governance meetings where there were mortality and morbidity presentations for shared learning.

Cleanliness, infection control and hygiene

- All the outpatient areas we visited were clean. We were told there were designated cleaners for the area. Most areas had cleaning schedules displayed.

Outpatients and diagnostic imaging

- Patients we spoke with felt that the areas were always clean. The outpatient survey carried out scored 99% for cleanliness.
- Mandatory training records showed that all staff had received infection prevention and control training within the last two years. Staff we spoke with demonstrated knowledge and understanding of cleanliness and control of infection.
- Hand gel was available in all clinical areas. Notices were displayed regarding hand washing and infection control.
- We saw examples of hand hygiene audits in a variety of clinics such as audiology, ophthalmology and orthopaedics, with results displayed on the department's noticeboard.
- Personal protective equipment such as gloves and aprons was readily available in clinical areas.
- We saw the process and pathway for decontaminating flexible endoscopes used in various clinics such as gynaecology and ear, nose and throat. Following use, they were taken to the endoscopy suite for cleaning. There was good separation of dirty and clean areas, with all appropriate equipment available for staff.
- An audit of the oncology outpatient department and decontamination of nasendoscopes was undertaken in February 2014. The rooms used for decontamination were not purpose-built, and the audit found that clean and dirty processes were not adequately separated. Following the audit, a business case was developed for refurbishment of the treatment rooms and sluice. The action plan from the audit was in progress to mitigate risk until the refurbishment has been completed.

Environment and equipment

- All areas of outpatients that we visited were tidy and well lit, including corridors and stairwells. The atmosphere was generally calm, even where the clinics were very busy.
- Information boards in all waiting areas informed patients of which staff were working that day and whether there were any delays. These required updating manually.
- The phlebotomy service worked from a room without windows, and had noisy fans to control the temperature. Staff felt this was a poor environment for them to work in and also for the patients to come for blood tests. They had raised this with their manager and were hoping to move in due course, but were not aware of a timeframe.
- We saw evidence of daily performance checks of equipment as well as quality assurance checks.
- Single-use equipment was available in the clinical areas.
- All equipment we looked at was visibly clean and stored appropriately.
- Emergency resuscitation equipment had been checked appropriately in all areas we visited.
- The trust's electrical maintenance engineering department was responsible for annual portable appliance tests. We found a few examples where these were not up to date, and discussed this with staff in the department at the time.

Medicines

- Medicines were stored in locked cupboards in the department. Nursing staff ordered all medicines through the hospital pharmacy. Two nurses checked medicines taken from the locked cupboards. A lockable medicines fridge was in place, with daily temperature checks.
- Most medicines were administered by doctors. Where nurses administered medicines such as analgesics, these were prescribed by the doctor and recorded in the patient's record. Once medicines were administered, nurses signed and dated the medicine record.
- FP10 prescription pads were stored in a desk drawer in an office in the outpatient department. The desk drawers were not locked during clinics. The outpatient department also had a supply of the trust's own pharmacy prescription pads stored in the same place. We were told that the hospital pharmacy had requested that the trust's prescriptions were not used for the last few weeks, because of staff shortages in pharmacy; therefore the outpatient department was using the FP10 prescriptions for patients to take to an external pharmacy to avoid long waits for patients at the hospital pharmacy.
- Emergency trollies were checked every day.

Records

- From the patient records we reviewed, we found that risk assessments were. Staff described the risk assessments, which varied in accordance with the patient's condition and its complexity.
- Pathways of care were in place for cancer patients, patients with other conditions such as stroke and for those needing cardiac care.
- Notes were stored securely in the department.

Outpatients and diagnostic imaging

- We were told that sometimes patients' records were not available for patients' outpatient appointments, particularly if patients with complex conditions were visiting both hospital sites within a short time. Clerical staff created a temporary set of notes, and the electronic patient records system meant that the referral letter and any previous clinic letters were available. However, on rare occasions, a patient could not be seen if the full set of notes was not available.
- The trust's outpatient incident log in respect of patients' records from April 2013 to March 2014 showed 14 incidents, which included misfiled records, inaccuracies and missing records. These were investigated and the actions demonstrated that the incidents had been discussed with the patients concerned and rectified.

Safeguarding

- Staff told us that they received training in safeguarding for both children and vulnerable adults. We saw evidence of training undertaken.
- Staff demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. They understood their role in protecting children and vulnerable adults.

Mandatory training

- Staff we spoke with told us they were able to attend mandatory training and that they were generally up to date with that training. Staff held their own mandatory training records. Managers monitored training and reminded staff where required. We saw that mandatory training was discussed in team meetings.
- We were told there were good e-learning packages as well as face-to-face training on both hospital sites.
- We saw examples of staff training records showing completed training. We also saw examples of monitoring showing that all mandatory training, such as health and safety, infection prevention and control, blood transfusion and basic life support had been carried out. The last training date was recorded and the system flagged when an update was due or overdue.

Assessing and responding to patient risk

- There was evidence of risk assessments included in the patient pathways in the patients' records we looked at. Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for elderly or frail patients with more than one medical condition.
- We saw that staff received annual basic life support training, and that this was monitored, with those staff that were due to undertake refresher training in the next couple of months flagged on the system.
- Adult resuscitation equipment was stored within the department. We saw evidence that this was checked regularly and that staff signed to show that the equipment was checked and within the expiry dates.

Nursing, allied healthcare professionals and other staffing

- There was one matron for the outpatients department. On each hospital site, a senior and junior sister supported the staff nurses, clinical support workers and plaster technicians in the department.
- Nursing staff told us that although they were busy, they felt they provided good and safe patient care. They felt that staffing was generally sufficient, use of bank staff was rare, with many areas saying that they never used bank staff. When staff were absent, an escalation process enabled staff to be reallocated.
- The sisters managed the process for booking annual leave so that staffing numbers and skill mix remained at safe levels.
- We were told that turnover of nursing staff was low. There were a few vacancies, with recruitment well underway.
- The trust's radiation protection adviser was based at Maidstone Hospital, together with four radiation protection supervisors.
- Radiology staff told us that the radiology department had several vacancies in both magnetic resonance imaging (MRI) and computerised tomography (CT), and that recruitment took some time. However, there were always applicants and staff retention was high. There were five students for each student year group in training placements.
- We were told that no agency staff were used in the radiology department. When extra staff were required, this was covered by staff working overtime or by using bank staff. We saw the induction procedures and the completed paperwork for bank staff.
- Staff in the radiology department spoke proudly of their strong team working and support for each other.
- We spoke with phlebotomists, who told us that they were working that day at 50% strength – seven staff instead of 14. The service supported all hospital wards and outpatient clinics as well as providing a service for

another provider; the service for the other provider had been cancelled on the day of the visit because of the lack of staff. There were no bank staff for this service. There was some long-term sickness and vacancies; staff felt generally unsupported, although aware that recruitment was underway. We spoke with a senior manager for both hospitals, who informed us that management reconfiguration was underway and recruitment was proceeding through the trust's processes. We discussed the issues staff raised with us about lacking support and were told that these would be addressed.

Medical staffing

- The individual specialties arranged medical cover for their clinics. Medical cover was managed within the clinical directorates, who agreed the structure of the clinics and patient numbers. Some clinics, such as ophthalmology and ear, nose and throat, were managed by the clinical specialty and run by its doctors and nurses. Other clinics, such as the cardiology and respiratory clinics, were managed by the outpatient nursing staff.
- Doctors we spoke with felt they had a good relationship with outpatient nursing and clerical staff. They said they could discuss issues with and were well supported by these staff.
- Generally, doctors worked on both hospital sites. We were told that traffic between the hospitals could be heavy, which sometimes resulted in delays to the start of clinics.

Major incident awareness and training

- Senior staff had completed major incident training and were able to describe the department's role in the event of a major incident.
- We saw that regular exercises were carried out across the trust.
- The trust had major incident cascade systems in place.
- Learning from exercises was evidenced, such as ensuring contact numbers were also available as paper copies in appropriate areas.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

There was evidence that staff competency was checked and that staff received appraisals and opportunities for further training. We found examples of good multidisciplinary working both within and across teams. Additional clinics were run at weekends when required.

Evidence-based care and treatment

- We saw examples of guidance from the National Institute for Health and Care Excellence (NICE) being cascaded to outpatient teams.
- Protocols were in place for radiology examinations such as cervical spine and orthopaedic x-rays.
- We saw protocols in place to ensure fast tracking where there were significant imaging findings for known or unknown cancer diagnoses, as well as severe abnormalities relating to benign or malignant pathology. These findings were reported to the referrer and passed immediately to the multidisciplinary team for review and action. Clerical and electronic system procedures were included in the protocol.

Competent staff

- All staff we spoke with told us they had annual appraisals where training and development needs were discussed. We saw examples of completed appraisals and of the monitoring process in place.
- An induction process was in place for new staff, and we saw an example of one completed.
- In addition to mandatory training, nursing staff undertook training such as catheterisation and wound care. We also spoke with medical staff and saw an example of the electronic training records of completed learning for a doctor in training.
- Nurse practitioners provided face-to-face training; e-learning courses were also available.
- Clerical staff told us they had weekly team meetings where issues such as availability of patients' records was discussed.
- We saw several examples of meetings of various teams which included representatives from the medical records staff group, sonographers and superintendent radiographers. All minutes we saw showed that relevant clinical updates and training requirements and opportunities were discussed.

- Radiography staff told us they were encouraged to participate in further education and advanced practice training. We saw evidence in a weekly staff update where an opportunity was offered to staff for a radiographer to train in the cardiac catheter laboratory.
- Some staff such as phlebotomists and radiographers had six-monthly competency checks. We saw examples of completed competency checks.
- Spot checks were in place for nursing staff to ensure their practice was consistent and in line with trust policies and procedures.
- Students we spoke with said that qualified staff supported them well in their learning.
- Counselling was provided for staff following a Never Event.

Multidisciplinary working

- All staff we spoke with told us how well they worked together within specific teams as well as with others such as therapists, the medical records service and the clinical administration unit. For example, we observed nurses communicating with both doctors and reception staff to facilitate the smooth running of a clinic or mitigate delays that had occurred.
- We observed and were told of strong multidisciplinary working within the radiology department, where staff worked closely with, for example, physiotherapists and occupational therapists.
- We heard how the pathology department worked with outpatient services to ensure that results were available for the clinics. In this way, required information was available for patients' appointments. However, on some occasions we heard that it was difficult to move patients' records from one site to the other, if appointments were too close together and not known about by both specialties.

Seven-day services

- The trust monitored the demand for outpatient appointments and the utilisation of the clinics available. Cancelled clinics and the reasons why they were cancelled were also monitored. Where the demand for appointments was greater than clinic availability, we were told that further clinics would be created. At the time of the inspection, for example, Saturday clinics were being arranged to accommodate a backlog of hearing-aid patients.
- The radiology department and pathology department provided seven-day services.

Access to information

- We found access to relevant patient information in all areas of the outpatient services that we visited. Information included a map of the hospital, general outpatient information, and information about personal data confidentiality and coming into hospital. There was also information on the Patient Advice and Liaison Service (PALS) and how to make a complaint. In addition there was information on infection prevention and control as well as MRSA and Clostridium difficile diarrhoea.
- Condition-specific information such as on hormone-replacement therapy, cataract surgery and barium swallow and meal investigation was available in the relevant clinical areas.
- Patients we spoke with told us they felt well informed. The patient survey confirmed these findings.
- Each outpatient area had a board that displayed the names of the nurses, the numbers of staff there should be and the actual staff numbers; the waiting time for individual clinics was also written on the board.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence that staff had undertaken training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff demonstrated knowledge and understanding of MCA and DoLS.
- We saw examples of MCA assessments undertaken.
- A patient survey undertaken for the computerised tomography (CT) colonography service showed that 49 out of 50 patients stated they were asked for their consent for the procedure. (One answered "don't know".)
- Staff told us that doctors discussed treatment options during the consultation. Where written consent was required, this would be obtained in the outpatient clinic or at pre-assessment clinics. We saw examples of completed consent forms in some of the records we looked at. However, in others we did not find either written or verbal consent recorded, for example for one patient who had had a sigmoidoscopy (examination of the large intestine) performed in outpatients.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services caring?

Good

All the patients we spoke with were complimentary about the way staff had treated them. We observed staff constantly checking on patients and updating them on waiting times. The area was calm, and patients felt well informed about their care and treatment.

Compassionate care

- Patients we spoke with in the main waiting areas praised the staff and told us they were very helpful.
- Other comments from patients we spoke with included, "Staff are really lovely" and "Staff are marvellous and we have been looked after well everywhere in the hospital."
- Patients we spoke with in the oncology outpatient department were all very positive about the care they received from staff. One patient said, "It is wonderful, wonderful, wonderful here." We heard that staff asked patients what they wanted to be called, and that patient dignity and privacy were respected. Patients were asked whether they wanted their family or friends to be present during consultation and treatment.
- A relative of a patient contacted the Care Quality Commission (CQC) providing positive feedback about their experience in various departments in the hospital, which included oncology outpatients, and stated, "I wouldn't hesitate to recommend Maidstone Hospital to anyone in need of medical care."
- We saw that clerical staff in clinics assisted patients promptly and were friendly and efficient in what were busy clinics.
- Staff were trained to keep patients informed of waiting times and the reasons for delays, and were expected to do so. We observed this happened in all areas of outpatients during our inspection.

Understanding and involvement of patients and those close to them

- Patients we spoke with felt well informed about their care and treatment. Patients understood when they would be seen again and when they needed additional tests or x-rays. We were told patients' care was discussed with them in detail and in a manner they could understand. Patients felt included in decisions made and that their preferences were taken into account.
- Patients in the oncology outpatients department told us that they understood what each member of staff said to them. They said that the information they were provided with was consistent and all questions they asked were answered fully. We were told that patients felt fully informed even where the information was not pleasant, such as about symptoms, and what was going to happen and when.
- The trust scored in the top 20% of the 2013 Cancer Patient Experience Survey regarding explanations and information provided about possible side effects. It also scored as highly in providing good information about diagnostic tests.
- Results we saw from the patient survey demonstrated high satisfaction with information provided and opportunities to ask questions.

Emotional support

- Results we saw from the patient survey showed very positive responses to questions about provision of privacy, and 100% of respondents stating they were supported by staff during their procedure.
- Patients told us that their privacy was protected at all times, with curtains pulled across and doors closed.
- Patients told us that staff asked whether they were happy to have relatives present for consultations.
- The outpatient department was calm and well ordered. We saw staff constantly checking on patients and updating them on waiting times.
- The trust scored in the lowest 20% of trusts in the 2013 Cancer Patient Experience Survey when patients were asked whether staff definitely gave patients enough emotional support.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Some patients arriving for their appointments waited a considerable time to be seen. Results of the trust's patient survey and regular monitoring showed waiting time was an ongoing issue. We also received some comments regarding difficulty parking.

Many clinic letters were not sent out in a timely manner, with a huge backlog for some clinics remaining 10 months after the restructuring of the clerical and administration teams. This was being monitored and reported on regularly, with some extra resource being found for some teams.

A backlog in computerised tomography (CT) and magnetic resonance imaging (MRI) reporting had also built up following the introduction of a county-wide electronic reporting system. The trust had put in place solutions, but these had taken some months to resolve the backlog. Data from the trust showed that this backlog was almost resolved at the time of the inspection.

We observed that staff in the clinics were responsive to patients' individual needs.

Service planning and delivery to meet the needs of local people

- The trust provided various outpatient services at a number of sites other than at the hospital, so that patients could be seen closer to home for such things as ophthalmology, hearing aid replacement and ear care. However, these clinics did not form part of this inspection.
- The trust decided to decentralise the clinic booking teams, and in January 2014 the clinical administration unit (CAU) was implemented. The medical secretaries and booking teams became part of their clinical specialty directorates. There were considerable staff office moves. The consultants' offices are now also in the same area as the respective clerical staff. Without exception, clerical staff we spoke with told us that despite some difficulties with travel, the CAU was a much better way of working. It enabled strong and rapid communication for problem solving and improving the service. A new IT system was also introduced.
- We were told that during the process of implementing the CAU, secretarial staff had been reduced and this, together with problems with the IT systems, had resulted in some very long delays in clinic letters being typed in some specialties. An action plan was in place that identified all the risks and concerns, but at the time of inspection these had not been resolved. Staff told us of their high anxiety levels and the extra unpaid hours some of them were working to try and reduce the backlog. We also heard of the workaround staff had to use to ensure that urgent and high priority patients, such as urgent cancer referrals, received their letters typed in line with key performance indicators. This involved secretaries listening to the whole of a doctors electronic dictation notes in order to pick out and type the urgent letters, which added to the time secretaries spent on each clinic. Trialling dictating into different electronic folders was just being started. We found there was goodwill and hard work from staff to try and reduce the impact for patients, but the volume of work in some areas made this very difficult. Late clinic letters also resulted in more patients making telephone enquiries for staff to deal with, which further exacerbated the situation. Some bank staff hours had been provided in some areas, but the bank staff were not experienced in the clinical specialty, which again had an impact on permanent staff.
- Trust information provided to us on 6 October 2014 for both sites showed that urology, vascular and ophthalmology services had some letters outstanding 41–50 days following the clinic date. In addition to these, trauma and orthopaedic, upper gastrointestinal and ear, nose and throat clinics had letters outstanding 21–30 days following the clinic date. Only gastroenterology, cardiology and breast services had all clinic letters being sent out within 0–10 days. This puts patients at risk of not receiving care and treatment, including prescribed medicines, in a timely manner.
- We reviewed patients' records and saw examples where cancer patient pathways worked well; for example, colorectal patients were seen within the required two weeks from referral, with the clinic letters being typed up one week later.

Outpatients and diagnostic imaging

- The outpatient department provided services for all clinical specialties, with the matron managing all staff including the plaster technicians.
- The outpatient dashboard collected monthly data on activity and a set of key performance indicators. The dashboard showed that total outpatient utilisation across the service was consistently below that planned, with the percentage for the year to date in August 2014 at 79% rather than the planned 85%. We also saw the breakdown of activity for all outpatient locations for August 2014. This showed that actual attendance for both first and follow-up appointments was below capacity. The minutes of the outpatient committee meeting where these figures were discussed suggested that late cancellations might be contributing to low utilisation. We saw that cancellations between zero and three days were around 5% and that the percentage of patients who did not attend was around 9% during August 2014. Possible ways to improve utilisation were discussed and work on this was ongoing across the trust with trials of different processes such as partial booking for some follow-up clinics.
- The trust's percentages for patients that did not attend first appointments and follow-up appointments were consistently above their 5% and 7% standards respectively. New initiatives were in place, such as texting reminders to patients with mobile phones, but no reduction in failures to attend had been apparent.
- The radiology department provided out-of-hours services for the hospital.
- Patients we spoke with were generally positive about the service provision; one patient said, "Excellent service, no problems."
- Doctors and nurses told us that the pathology department provided a very good results service.
- A large backlog of magnetic resonance imaging (MRI) and computerised tomography (CT) scans required reporting. This had caused delays for patients, and the reports were not always available for the patients' follow-up appointments. Staff in outpatients 'chased' the results the day before in an effort to reduce the impact on patients.
- The trust provided information on the work to deal with the backlog of MRI and CT scans. This information explained the reasons for the backlog and the various actions taken in response, such as outsourcing outstanding MRI reports. The trust's board was kept informed, and the issue was closely monitored. The information demonstrated a significant reduction and at 16 October 2014 the department was approaching normal levels of performance with regards to processing and reporting MR and CT scan results.

Access and flow

- Patients told us that appointments generally came through promptly. We were given an example where a patient had been referred for an ultrasound scan just a few days before their appointment. We were told that some patients could wait for up to three months for a new appointment.
- A theme from many patients was concern about transport to the hospital, whether in their own car or by public transport. We were told that car parking was insufficient, which meant patients had to arrive very early or risk missing their appointment. Where clinics were delayed beyond 50 minutes, patients were provided with car parking vouchers. Some patients using the local bus service had to travel into Maidstone first and then change buses to get the hospital, which extended their travelling time. However, some patients also told us that they had not experienced any problems with car parking. A Freephone facility was available for patients to book a taxi.
- The independent patient transport services had been commissioned county-wide. Issues with the quality of the service had been identified and all hospitals concerned were working with commissioners and the service towards improvements. Staff in outpatients were aware of this and were vigilant in supporting patients when there were delays. We were told that the service was improving. Meetings about patient transport included the matron and the transport provider. The trust's transport manager reviewed issues monitored by the outpatient teams.
- There was a single reception desk for general medicine and some surgical clinics, which all patients reported to on arrival. Patients then sat in the main waiting area until either called to a specific clinical specialty such as cardiology, into a consulting room, to the radiology department or for a blood test.
- The fracture clinic had a separate reception desk and waiting area for patients. There were five clinics a week, and we were told the clinics were busy but well managed. Children were seen within two days and adults within one week. Children were seen in order of their age, starting with the youngest. Any children

requiring admission to hospital would be transferred to the Tunbridge Wells Hospital at Pembury, because there were no paediatric inpatient facilities at Maidstone Hospital.
- There were separate areas for women and children's services, head and neck services and oncology. The respective clinical specialties managed these areas and the clinical staff.
- We saw examples of one-stop clinics such as for breast cancer patients. Patients had an ultrasound and/or mammogram and then saw the doctor, all in one visit. This avoided patients waiting and travelling for different appointments.
- The radiology waiting area catered for patients referred from A&E, inpatient wards, outpatient clinics and those referred directly by their GPs. The radiology department operates from Monday to Friday and takes referrals from the fracture clinics. Staff described "peaks and troughs" in patient flow. We were told that staff informed patients when a peak was causing a delay, but we did not observe that during our visit. We were also told that Wednesdays were the worst day of the week, but were not provided with evidence of the workforce being adjusted for high-demand times.
- On the first day of our visit, patients in the main waiting areas for general medicine clinics were generally waiting for between 45 minutes and one hour to be seen. However, we observed staff working hard to manage patient flow, and in some areas such as oncology and ear, nose and throat clinics this worked well.
- We also saw examples where changes had been made. One clinic started half an hour later than scheduled because of the time taken for medical staff to travel between hospitals. Another clinic had spread the appointments out to try and manage waiting times.
- Patients told us that waiting times for blood tests were long, and that this caused delays in clinics.
- One patient said that they chose to come 20 miles to Maidstone Hospital instead of the five miles to their nearest hospital because they received appointments and treatment more quickly.
- The trust carried out patient surveys of the outpatient departments in 2013 and 2014. The results were very positive except about clinic delays. The results show no change in responses from 2013 to 2014 regarding delays, with around 36% of patients stating that their appointment had been delayed. The percentage of patients who felt they had been kept informed showed an improvement from 59% to 72%.
- The only complaints expressed by patients we spoke with were about long waits in clinics.
- The trust had consistently exceeded (better) the national targets for patients who needed to be seen within two weeks over the previous year (2013/2014). Cancer patients we spoke with had nothing but praise for the staff and the service.
- The trust was achieving the 18-week target and was in line with the England average. We looked at data from April 2013 to June 2014.
- The trust also demonstrated consistently good diagnostic waiting times, with patients waiting much less time for an appointment than the England average.
- We observed generally good patient flow in the main waiting areas and a lack of queues, although the area was not spacious.

Meeting people's individual needs

- Translation services were available on request and were generally planned in advance of the clinic appointment.
- Patients told us that when a blood test was required, this contributed to long waits and caused delays in clinics. In addition, we were shown template outpatient letters in which all patients were asked to come in 30 minutes early to have a blood test. However, once patients arrived, some found they did not need the blood test. Booking staff told us that unless doctors and reception staff accurately completed information at the previous appointment, letters will not be altered.
- The outpatient departments were well signposted and colour coded; for example, there were clear signs to the radiology department. However, the main outpatient areas were not spacious, and we observed occasions when some people were standing.
- The oncology outpatient department had a joint information service with Macmillan cancer specialists. Information was available for patients on individual cancers as well as on support groups and counselling services.
- We were told that trust-wide there were five bone-reporting radiographers, three chest-reporting radiographers, one clinical specialist and one consultant radiologist to manage x-rays that required immediate reporting. The imaging reporting system was based

upon voice recognition software;. if the appropriate member of staff was not available on one hospital site, the x-ray was sent by computer link to the other hospital. This meant that the service responded to patients whose x-rays required immediate reporting to support diagnosis and treatment planning.
- We saw the pre-procedure questionnaire for patients undergoing x-ray, which included information on allergies, medical conditions and pregnancy status for female patients.
- Following issues identified with the introduction of the electronic radiology reporting system, weekly meetings were set up to ensure that patients were prioritised appropriately. The electronic system also had colour codes to identify urgent patients.
- In the different clinics we visited we were told that pathology results such as of histopathology, microbiology or blood tests were generally available for patients' clinic appointments.

Learning from complaints and concerns

- Complaints and incidents were discussed at the monthly clinical governance meetings. We were told that most complaints were about delays in clinics.
- We saw boxes inviting patients and their families to comment on and provide ideas for the service.
- We were provided with examples of learning and change from patients' feedback. One example was that middle-grade doctors in training had been provided with communication training.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

There was good monitoring, audit and data collection regarding waiting times and delayed clinics, with staff proactively managing these during clinics. Some adjustments had been made, but we did not find evidence of improvement over the last 12 months.

There were good forums for discussing issues and concerns, and there was evidence of shared learning. Staff generally felt listened to and well supported by their managers. Corporate communication was well managed. Managers were visible in outpatient services and staff evidenced a patient-centred approach to everything they did.

The backlog of clinic letters remained an issue 10 months after the restructuring of clerical and administrative work. Staff had raised concerns and worked hard to try and reduce the backlog. However, the trust had not been seen rapid support with quality extra resources as a priority.

Vision and strategy for this service

- The matrons and sisters we spoke with were aware of the current strategy for the area.
- Staff said that the chief executive's weekly communication was very helpful.

Governance, risk management and quality measurement

- We saw many examples where the trust and the outpatient department collected data and monitored activity and quality. Risk areas were identified and generally action plans were in place. For example, some specialties had high rates of follow-up appointments. This was monitored and investigated in line with best practice. Subsequently the rates were adjusted as part of the 2014/15 contract with commissioners, and the trust was able to demonstrate improvements by August 2014.
- We also saw ongoing work by all outpatient staff to try and reduce waiting times in clinic and delays for patients. We saw minutes of medical records meetings where this was discussed and ways for improvement planned and implemented.
- The patient satisfaction survey carried out in September 2014 in the radiology department demonstrated very positive results from participants. Posters were displayed in the department with the results and proposed improvements from patient feedback.
- We saw examples of audits carried out in various clinical areas and that the results had been discussed in clinical governance meetings together with recommendations and actions.
- Incidents, complaints, patient surveys and any new alerts or guidance were discussed at the monthly directorate clinical governance meetings. Staff described the meetings and the minute we looked at confirmed this.

Outpatients and diagnostic imaging

- An outpatient survey was carried out earlier in 2014. Over 1,700 patients participated and the responses were very positive with 99% of patients stating they would be happy for their friends and family to be treated in the outpatient department. Other responses included 99% of patients who felt they had had time to express their concerns, had understood explanations provided and felt their privacy and dignity were respected. The one poor result was regarding delayed clinics: 39% of respondents said their clinic had been delayed. We saw examples of minutes of outpatient department meetings where delayed clinics were discussed. However it was not clear whether changes to clinic set-up or timings were being considered.
- Patient Advice and Liaison Service (PALS) leaflets were available in waiting areas. These informed patients of the PALS service and invited patients to provide feedback and comments.
- The monthly outpatient department clinical governance meetings were open to the whole department.
- We saw that all the pathology departments had achieved external clinical pathology accreditation in May 2014. We were provided with sample certificates.
- On the trust's risk register dated October 2014 we saw that a risk in respect of radiotherapy equipment had been put on in May 2013. We were subsequently provided with evidence of a full risk assessment and the development of a business case for purchasing new equipment, all of which was good practice. We have also been provided with evidence that the equipment has been bought, tested and is in use. Therefore the risk can be closed. The risk register had not been updated regularly, which meant the trust's board did not have current knowledge of risks or subsequent assurance.
- The trust had published the second issue of Governance Gazette. This monthly leaflet shares learning from Never Events, incidents and complaints. It also raises awareness of risks to patients, such as falls.

Leadership of service

- Staff felt that communication flows from the leadership were good. Several staff specifically stated that the weekly chief executive messages were helpful. Corporate information came by email and was accessible for all staff. This included such things as medical device alerts and National Institute for Health and Care Excellence (NICE) guidelines.
- Throughout the inspection, outpatient staff were welcoming and happy to speak with us. Staff described their role and showed obvious pride in their department.
- Radiology staff were very positive about their service and their work to improve the patient experience.
- Clerical staff in outpatients told us that they could go to their line managers, "with anything – they are very understanding, helpful and approachable and not hard to get hold of".
- Nursing staff told us that they felt well supported by their managers and that the managers were always available to talk to. We observed that the managers were visible throughout the areas covered by their role and that staff were able to seek advice during clinics.
- We received varied responses from medical secretaries with regard to feeling supported by their managers. Some told us they felt very supported, with accessible managers, but others did not feel supported and did not feel able to raise their concerns with managers.
- Concerns about the continued backlog in clinic letters for many of the specialties were clearly felt.

Culture within the service

- Staff we spoke with visibly put the patient at the centre of their work. There were many references to the continuous discussions held in all specialties about ways to improve the patient experience. Where patients needed specific support, this was provided. We saw evidence of where patients were well known to staff and their individual circumstances and pressures taken into account. Staff expressed the wish to provide local care for patients, avoiding unnecessary travel to a different hospital where possible.
- Staff we spoke with described very good team working and communication in the outpatient department, including the radiology and phlebotomy departments. We saw this in practice during our observation periods.
- All the staff we spoke with in the outpatient and radiology departments said they felt able to speak out and that there was a "no blame" culture in the organisation. Staff said they felt listened to.
- Staff told us they felt the trust was a learning organisation. We saw many examples of shared learning in the various team and governance minutes we looked

at. The trust's risk register reflected what audits and surveys carried out had identified, and staff demonstrated awareness of the areas they were working to improve.

Public and staff engagement

- An outpatient survey was carried out earlier in 2014r. Over 1,700 patients participated and the responses were very positive, with 99% of patients stating they would be happy for their friends and family to be treated in the outpatient department. Other responses included 99% of patients who felt they had had time to express their concerns, had understood explanations provided and felt their privacy and dignity were respected. The one poor result was regarding delayed clinics: 39% of respondents said their clinics had been delayed. We saw examples of outpatient department meetings where delayed clinics were discussed. However, it was not clear whether changes to clinic set-up or timings were being considered.
- The fracture clinic carried out a 'reflections of a perfect day' patient and staff survey, where five questions were asked on one day. Twenty-eight patients and eight staff participated. Patient and staff feedback was included in the analysis, and we saw an action plan had been developed from the survey. This demonstrated that the views of staff and patients were invited and listened to within the department.
- Some staff felt that trust executives did not visit their specific areas of work, such as the phlebotomy department. However, in general, staff felt that the trust's leadership was visible.
- The trust provided evidence of the consultation process undertaken for the proposed implementation of the clinical administration unit (CAU). A consultation document was prepared and meetings held for staff to attend. There were expressions of concern that the service could be delivered with a reduction in staff. CAU staff we spoke with felt that this was an ongoing concern with the continued backlog of clinic letters.
- Patient Advice and Liaison Service (PALS) leaflets were available in waiting areas. These informed patients of the PALS service and invited patients to give feedback and make comments.
- The trust had launched a patient and public membership scheme called "have your say". Leaflets in outpatients described the scheme and how to join. The purpose was for members of the public to have a greater say in trust developments.

Innovation, improvement and sustainability

- The trust's leadership and the staff we spoke with were aware of the issues in outpatients regarding long waiting times and delays for many of the clinics. Staff clearly found occasions when these were difficult to manage, but we saw individual staff and teams working constantly to try and mitigate delays for patients. We saw that some changes had been made, but the results of the patient survey did not show any improvement from 2013 to 2014.
- The trust and the outpatient staff continued to work proactively in trying to reduce the number of patients who failed to attend their appointments. This is ongoing work and closely monitored.
- The risk register reflected concerns regarding follow-up appointments for ophthalmology and head and neck patients because of a lack of clinic appointments. New patient appointments were prioritised, and we saw evidence of some work towards managing this with extra clinics planned and a business case for an extra ear, nose and throat consultant. The ophthalmology service covers a 1.8 million population, and the number of patients reflects this. Satellite clinics (not included in this inspection) provide additional clinics locally.
- We heard from the radiotherapy staff that the trust had supported them so that they were an increased team. They felt that ideas from staff were listened to and considered, with opportunities to discuss them.
- The introduction of the clinical administration unit (CAU), a new electronic system, together with a reduction in staffing caused a huge backlog in clinic letters being typed and dispatched to GPs and patients. This has been monitored and reported on throughout the period of the restructuring of the clerical and administration teams. However, 10 months following the changes there are still high numbers of delayed letters in many clinical specialties. We found some extra resources such as bank staff being provided in some areas, but these staff were not necessarily trained in the clinical specialty so were of limited use. The risk of patient care and treatment being delayed is high. The

stress on the staff trying to manage the backlog was very evident at the inspection. Without their goodwill and unpaid extra hours the situation would be even worse.

Outstanding practice and areas for improvement

Outstanding practice

- The Maidstone Birth Centre (MBC) had developed, designed and produced the Maidstone birth couch, which was used by women in labour.
- On Mercer Ward, the role of dementia care worker had been created to focus on the needs of people with dementia and their families. An activities room had been designed, furnished and equipped to meet the specific needs of people with dementia, and was widely used. This project was the subject of an article published in the professional nursing literature.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- The trust must make arrangements to make sure that contracted security staff have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.
- The trust must ensure that intensivist consultant cover at weekends is adequate
- The trust must ensure that sufficient numbers of ward rounds take place in the intensive care unit (ICU) to comply with core standards.
- The trust must ensure that once a decision to admit a patient to the ICU is taken, admission is not delayed for more than four hours.
- The trust must ensure that discharge from the ICU takes place within four hours of the decision, because currently 82% of all discharges are delayed for more than 24 hours.
- The trust must ensure that discharges to other wards from the ICU do not take place at night.
- The trust must ensure that the governance structure within the ICU supports a framework to ensure clinical improvements using a multidisciplinary approach.
- The trust must review the existing management arrangements for the Riverbank Unit to ensure that the unit operates effectively and efficiently.
- Review the arrangement for the management and administration of topical anaesthetics
- Review the children's directorate risk register to ensure that risks are recorded and resolved in a timely manner.
- Review the current PEWS system to ensure that it has been appropriately validated, is supported by a robust escalation protocol and is fit for purpose. Its use must be standardised across the children's directorate (excluding neonates).
- Review the existing governance arrangements relating to water safety to ensure systems are in place to ensure people are protected from the risk of harm associated with health care acquired infections including Legionella.

Action the hospital SHOULD take to improve

- The trust should make arrangements for the safe storage of medicines so that unauthorised access is restricted.
- The trust should make sure that all medical staff in the emergency department have completed training in safeguarding children at the level appropriate to their grade.
- The trust should make sure that the number of consultants in post is sufficient to provide the necessary cover for the emergency department.
- The trust should make sure that up-to-date clinical guidelines are available in the emergency department.
- The trust should review the arrangements for meeting the needs of patients presenting with mental ill health, so they are seen in a timely manner.
- The trust should review the way complaints are managed in the emergency department to improve the response time for closing complaints.
- The trust should review the governance arrangements for nursing staff in the emergency department to ensure effective leadership and devolution of responsibilities.

Outstanding practice and areas for improvement

- The trust should ensure that the ICU outreach service operates in line with national standards.
- The trust should ensure that medical care services comply with its infection prevention and control policies.
- The trust should develop robust arrangements to ensure that agency staff in medical care services have the necessary competency before they administer intravenous medicines.
- The directorate of speciality and elderly medicine should develop systems to ensure that the competence of medical staff for key procedures is assessed.
- The trust should ensure that there are systems in medical care services to ensure that only authorised people have access to the system of digital locks used to secure medicines keys .
- The trust should develop systems to ensure that medicines are stored at temperatures that keep them in optimal condition.
- The trust should ensure that patients' clinical records are stored securely in ward areas in medical care services.
- The directorate of speciality and elderly medicine should further monitor and embed a robust system of medical handover that ensures patients' safe care and treatment.
- The trust should review the ways in which staff working in medical care services can refer to current clinical guidance, to ensure that it is easily accessible.
- The trust should review the way in which it authorises and manages urgent applications under the Deprivation of Liberty Safeguards in medical care services.
- The trust should ensure that patients have access to appropriate interpreting services when required.
- The directorate of speciality and elderly medicine should review its capacity in medical care services to ensure there is sufficient capacity to meet demand, including the provision of single rooms.
- The trust should consider reviewing the processes for capturing information to help the service to better understand and to measure its overall clinical effectiveness.
- The trust should consider reviewing the current arrangements for the provision of elective day case surgical services to ensure that there is parity across the hospital campus.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Regulation 20 HSCA 2008 (Regulated Activities)** **Regulations 2010 Records** **The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of accurate records, because some medical records were incomplete, disorganised and not completed in accordance with the standards set by the Royal College of Surgeons.** **Regulation 20 (1) (a)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 HSCA 2008 (Regulated Activities)** **Regulations 2010 Care and welfare of service users** **The provider did not take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of:** **(b) the planning and delivery of care and, where appropriate, treatment in such a way as to:** **(i) meet the service user's individual needs,** **(ii) ensure the welfare and safety of the service user,** **(iii) reflect, where appropriate, published research evidence and guidance issued by the**

Compliance actions

appropriate professional and expert bodies as to good practice in relation to such care

and treatment.

The regulation was not being met because:

The PEWS system had not been validated and was not supported by a robust escalation protocol that was fit for purpose and was not standardised across the children's' directorate.

There was a lack of cover by consultants specialising in intensive care medicine at weekends; for example, one consultant covered more than 15 patients on two sites. The consultant was not always available within 30 minutes. There was only one ward round per day when there should be two to comply with core standards.

Admissions were delayed for more than four hours once the decision was made to admit a patient to the intensive care unit (ICU).

Discharges from the ICU were delayed for up to a week. Of all discharges, 82% were delayed for more than 24 hours.

Overnight discharges take place from the ICU.

All contrary to the core standards of the Intensive Care Society.

The outreach service does not comply with current guidelines (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2011)).

Regulation 9 (1)(b)(i)(ii)(iii)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

This section is primarily information for the provider

Compliance actions

The provider did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to:

(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this part of these regulations; and

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

The regulation was not being met because:

The process for incident reporting did not ensure that staff were aware of and acted in accordance with the trust quality and risk policy.

The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate.

The children's directorate risk register did not ensure that risks are recorded and resolved in a timely manner.

There were two incident reporting systems, the trust electronic recording system and another developed by consultant anaesthetists and intensivists one for their own use. The trust could not have an overview of all incidents and potentially there was no robust mechanism for the escalation of serious incidents. Therefore opportunities were lost to enable

appropriate action to be taken and learn lessons.

There was a lack of engagement and cohesive approach to clinical governance. Mortality and morbidity reviews were not robust, not all deaths are discussed and there was no available documentation to support discussions.

Regulation 10(1)(a)(b(2)(c)(i)(ii)

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 Health and Social Care Act 2008 Regulated Activities) Regulations 2010: Medicines The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. The Regulation was not being met because: The arrangement for the management and administration of topical anaesthetics was ineffective. Regulation 13

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises People who use the service were not protected against the risks associated with unsafe or unsuitable premises. Improvements are needed in relation to the environment in the intensive care unit to provide toilet/shower facilities for ambulatory patients. Regulation 15 (1)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Cleanliness and Infection Control** **Cleanliness and infection control** **12. (1) The registered person must, so far as reasonably practicable, ensure that –** 1. Service users; 2. Persons employed for the purpose of the carrying on of the regulated activity; and 3. Others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity, are protected against identifiable risks of acquiring such an infection by the means specified in paragraph (2), **(2) The means referred to in paragraph (1) are –** 1. The effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection; **People who use services and others were not protected against the risks associated with health care associated infections because the trust had failed to ensure that an effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of health care associated infections, with specific regard to water quality and safety and more specifically, the management and control of Legionella. Regulation 12(1)(a)(b)(c)(2)(a)(c)**