Medway NHS Foundation Trust

Medway Maritime Hospital

Quality Report

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Date of inspection visit: 25, 26, 27 August, 8, 9 & 13 September 2015
Date of publication: 07/01/2016

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

Ratings

Overall rating for this hospital	Inadequate
Urgent and emergency services	Inadequate
Medical care	Inadequate
Surgery	Inadequate
Critical care	Requires improvement
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Medway NHS Foundation Trust serves a population of approximately 400,000 across Medway and Swale. The trust became a foundation trust in April 2008 and has a workforce establishment of 4,139 staff; at the time of this inspection, there were 3,683 staff employed by the trust. The trust has two locations registered with the Care Quality Commission (CQC): Medway Maritime Hospital which is the main acute hospital site and the Woodlands Special Needs Nursery which did not form part of this inspection.

Medway Maritime Hospital hosts a Macmillan cancer care unit, the West Kent Centre for Urology, the West Kent Vascular Centre, a regional neonatal intensive care unit and a foetal medicine unit, as well as providing a dedicated stroke service the local population.

Medway NHS Foundation Trust was identified as a mortality outlier for both the hospital standardised mortality ratio (HSMR) and the summary hospital mortality indicator (SHMI) for 2011 and 2012. Consequently, Professor Sir Bruce Keogh (NHS England National Medical Director) carried out a rapid responsive review of the trust in May 2013; the findings from the review resulted in the trust being placed into special measures in July 2013.

In response to information of concern received, we undertook unannounced inspections of the maternity service in August 2013 and the emergency department in December 2013; CQC utilised its enforcement powers and issued a range of warning notices which required the trust to make significant improvements within a specified period of time. The CQC undertook a comprehensive inspection of Medway Maritime Hospital in April 2014 because the trust was rated as high risk in the CQC's intelligent monitoring report and because the trust remained under special measures. We rated the trust as inadequate overall; the emergency department had made insufficient progress since we had issued warning notices in December 2013 and was rated as inadequate as was the core surgery service. We found the maternity service had made significant improvements although there was limited evidence to demonstrate sustained improvement. The service was rated as requiring improvement along with medical care, end of life care and outpatients. Critical care and care of children and young people had been rated as good.

We re-inspected the emergency department in July and August 2014. As a result of those inspections we undertook enhanced enforcement action and imposed conditions of the providers registration which required them to undertake an initial assessment of all patients who presented to the emergency department within 15 minutes of their arrival. During this most recent inspection we were satisfied that the trust was meeting this condition and will remove this condition from the trusts registration.

This most recent announced inspection took place between the 25 and 27 August 2015, with follow up unannounced inspections taking place on 8, 9 and 13 September 2015.

Our key findings were as follows:

Safe

- Whilst we acknowledge that incident reporting had improved in some areas we remain concerned that not all incidents were being reported. We are also concerned that senior staff responsible for reviewing and investigating incidents did not always have the time to carry out these duties across all departments because of staffing levels.
- The environment within ED was not adequate to meet patient demand. There were frequent occasions when the number of patients requiring treatment exceeded the number of cubicles available. This meant that patients spent

a long period waiting in corridors. We found that systems in place to monitor these patients were not safe and patients were not adequately monitored. We also found their privacy and dignity was not maintained. The process for admitting patients to wards was very slow and this meant people had to spend very long periods cared for in the ED. This meant that care was delayed in some cases.

- Some areas of the trust were unable to show how they had learned from, or made improvements as a result of, complaints, comments and incidents.
- Staffing levels throughout the emergency, surgical and medical departments and the medical high dependency unit (MHDU) were insufficient to meet people's needs. This was also identified at the last inspection. The trust remained heavily reliant on the good will of staff to undertake extra shifts and temporary agency and bank staff in the interim to ease the pressures. There was a lack of robust induction procedures and records for these staff.
- Children who received treatment and care at the hospital were kept safe; their safety was assured through vigilant monitoring of any deteriorating child and in providing optimum staffing ratios; the effectiveness of services were geared to reducing emergency re-admission rates and the caring was evident throughout the whole service where a team multidisciplinary approach to care prevailed.
- Maternity and gynaecology safety performance showed a good track record and steady improvements. There were clearly defined and embedded systems, processes and standard operating procedures to keep women safe and safeguarded from abuse.

Effective

- Staff practice did not always comply with the requirements of the Mental Capacity Act, Deprivation of Liberties Safeguards. We also found staff were not always supported in their development through appraisal in some areas of the trust.

Caring

- There was a limited approach to obtaining the views of patients. Staff were caring and supportive with patients and those close to them. Staff responded with compassion to patients in pain or emotional distress, and to other fundamental needs. Staff treated patients with dignity and respect and people felt supported and cared for as a result.

Responsive

- Patients were unable to access the care they needed because of inadequate management of demand and patient flow through the hospital. The flow of patients through the hospital did not function as intended. Patients were frequently treated in mixed-sex wards.
- The trust was consistently not meeting their two week targets for patients suspected with cancer and in addition to this there was an inequality in waiting times between patient groups. The latest referral to treatment time's data revealed that the trust was below the NHS England target. Increasing numbers of investigations were being sent to external agencies for reporting, but the trust had no robust assurances of its own that the quality of reporting.
- The patient service centre was not always able to give patients appointments within the target times set by NHS England and the clinical commissioning groups. At the time of our inspection we were unable to see any clear strategies to develop robust systems and processes to be able to monitor and maintain these targets.
- The End of Life Care Policy (2014) provided by the trust was not robust as it was aimed at care of the dying patient only and there were no prerequisites for advance care planning.
- Discharge planning was inadequate and there were high levels of delayed transfers of care.

Summary of findings

- Staff were unaware of complaints at a directorate level which had influenced change.

Well-led

- The vision and values of the organisation were not well developed or understood by staff.
- Strategic planning and operational management were hindered at all levels by the lack of reliable, easily understood data. Staff satisfaction was mixed, and some staff reported feeling bullied.
- The leadership of core services and divisional leads was lacking consistency and in the latter case, substantive appointees to fill the posts. The structure of the organisation had undergone various reviews since our previous comprehensive inspection; there remained uncertainty about the divisional structures of the organisation, which remained at consultation stage during the inspection.
- Whilst the appointment of the chief executive was seen as a pivotal moment in ensuring the leadership of Medway Maritime Hospital was sustainable in the long term, there remained key leadership roles which were filled by interim appointments, with little or no forward vision or plan of how these roles would be appointed to by substantive individuals in the future.
- Staff morale had been left in a poor state as a result of ineffective engagement, management and constant changes to directorate teams. The results of the most recent staff survey continued to raise concerns about staff welfare, moral and organisational culture at the trust.
- The outpatient nursing team demonstrated good clinical leadership, competent staff, forward thinking and planning with regards to capacity issues. They regularly assessed their environment, sought feedback from and worked with patients regularly to improve the patient experience

We saw several areas of outstanding practice including:

- The orthotics department demonstrated a patient centred approach. They had been identified by NHS England as a service to benchmark against, because of the waiting times (90% of all patients seen the same day or next day), low cost per patient and clinical evaluation of each product they used.
- The maternity team had "Team Aurelia", a multidisciplinary team that provided support for women identified in the antenatal period as requiring an elective caesarean section. The team undertook the pre-operative review prior to admission for elective caesarean section.
- Women were seen by an anaesthetist prior to surgery and an enhanced recovery process was followed to minimise women's hospital stays following surgery. The hospital play areas for children were very well equipped with a commendable outdoor play area that was well used.

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

The trust must:

- Take immediate action to improve patient flow. This must be achieved without impacting other services provided within the departments and have a risk balanced approach so not to impede on other services delivered.
- Review the environment within the emergency department (ED) to meet patient demand effectively.
- Take actions to ensure patients are discharged from the critical care unit within four hours of the decision to discharge to improve the access and flow of patients within the critical care services.
- Ensure that staffing levels within adult ED meet patient demand.
- Ensure that all patient records in ED are accurate to ensure a full chronology of their care has been recorded.

Summary of findings

- Ensure there is an effective clinical audit plan in place.
- Ensure that major incidents arrangements are suitable to ensure patients, staff and the public are adequately protected and that patients were cared for appropriately in the event that a major incident occurred.
- Urgently review the two week cancer pathways for each speciality and ensure that there is clinical oversight of those patients waiting in order to mitigate the risks to those patients.
- Provide clinical oversight of patients waiting on incomplete pathways to ensure they are seen on a basis of clinical need in accordance with the trust Access Policy.
- Review and provide assurance that processes that are in place to ensure that World Health Organisation (WHO) checklists are completed prior to an interventional radiology procedures.
- Ensure Trust wide incident reporting processes and investigations are robust, action plans are acted on and systems are in place to ensure that lessons are learned.
- Have robust procedures in place to give assurance of the quality of radiology reporting done by external companies.
- Address the risks associated with reducing exposure to radiation in the diagnostic imaging departments. This specifically relates to the wooden door frames supporting the protective lead doors that are cracking under the weight. Although entered on the risk register there were no plans in place to address this potential breach radiation protection regulations.
- Ensure that the medical staffing levels in MHDU meet the requirements of the intensive care core standards.
- Ensure that MHDU complies with the Department of Health best practice guidance: Health Building Note HBN-04.01.and intensive care core standards.
- Ensure that governance and risk management systems reflect current risks and the services improve responsiveness to actions required within the risk register.
- Ensure clinical areas are maintained in a clean and hygienic state, and that the monitoring of cleaning standards falls in line with national guidance.
- Store confidential patient records securely.
- Improve the completion of mandatory training rates.
- Ensure there are adequate numbers of nurses on duty at all times to meet its own needs assessment and national guidance.
- Review mortality and morbidly in those specialities where outcomes are below national averages to determine if there are any contributing practice considerations to address.
- Ensure that all staff understand their responsibilities under the Deprivation of Liberties Safeguards (DoLS) and discharge these in line with legal requirements.
- Improve the quality of discharge plans to decrease the number of delayed transfer of care.
- Improve the timeliness of responses when managing to formal complaints.
- Ensure that governance meetings, including mortality meetings are held as scheduled.
- Improve the quality and availability of performance and safety information to all departmental managers and the divisional management team.

Summary of findings

- Ensure patients undergoing cardiac procedures where they required sedation are treated by appropriately competent staff at all times as outlined in national guidance to minimise the risk to patients.
- Ensure clinical oversight of activity provided and ensure appropriate audit trails and quality measurement tools are in place.
- Review its current handover practice. This should include a focus on the structure, quality, and format of the actual handovers. It should also review the process to ensure that patients dignity, privacy and Confidentiality is not compromised.
- Review the capacity of the safeguarding team and ensure more effective communication and working collaboration from the safeguarding team.
- Ensure that local policy and protocol around EOLC are reviewed to ensure they are consistent with national and best practice guidance.
- Ensure robust leadership at board and non-executive level to provide an EOLC service as per national guidelines.
- Take action to ensure that EOLC patients are not moved in their final hours.
- A review of the competency levels of staff responsible for making these decisions should be undertaken and relevant training provided when deficiencies are noted.
- A review of the out of hours discharges and frequent bed moves may be useful to identify trends and themes.
- Improve the governance, risk and quality management processes in the surgical department.
- Review the quality of the senior leadership to ensure efficient, supportive and quality leadership.
- Review its current strategy to improve engagement, moral, recruitment and retention. It must also ensure that it reviews the bullying reported to ensure staff welfare.
- Approved temperature monitoring devices in ICU and HDUs should be used to demonstrate compliance with recommended temperature ranges and to ensure the quality and integrity of medicinal products is not compromised during storage.
- Ensure theatre lists are staffed by appropriately competent staff at all times as outlined in national guidance to minimise the risk to patients.
- Store medicines according to the manufacturer's instructions. Ensure that inappropriate medicines are not stored in ward areas. Ensure it complies with FP10 tracking as dictated by national guidance.
- Ensure that IV morphine is not being administered in inappropriate opiate clinical areas by staff that may not be competent to deal with the side effects.
- Produce a critical medicines list to comply with NPSA/2010/RRR009. Improve mandatory training compliance rates.
- Ensure fridges and Medication storage temperatures are recorded in line with national guidance and best practice.
- Ensure staff follow trust policy for the administration of anticipatory medication for EoLC patients.
- Medicines in adult ED must always be stored in accordance with trust policy.
- Manage allegations of bullying and whistleblowing, and performance management in line with agreed policies. The trust must also ensure it is meeting its duty of care toward staff who are under the care of Occupational Health.

The trust should:

- Provide a stable and focussed leadership in divisional teams.

Summary of findings

- Ensure all staff understand the organisations strategic recovery plan and their personal role and responsibilities in delivering the plan.
- Engage patients in the planning, design, delivery and monitoring of services.
- The trust statement of vision and values should be translated into a credible strategy with well-defined objectives that are understood and acted upon by staff working in critical care services.
- Review the results of the annual infection control audit undertaken in all outpatient and diagnostic imaging areas and produce action plans to monitor the improvements required.
- Introduce a policy and protocol to ensure that clinic letters to GPs are dispatched in a timely manner with audits to maintain assurance.
- Difficult airway management equipment on SHDU should be checked using a checklist, and a record kept of those checks, to ensure it is readily accessible and fit for purpose.
- Ensure all storage areas are fit for purpose and that items are store appropriately. Consider how the fabric of clinical areas is maintained.
- Ensure records of 'intentional rounding' are consistently completed. Benchmark its acute medical unit performance against the standards set by the Society of Acute Medicine.
- Ensure that 'as required' pain relief is adequately evaluated. Progress the use of specialised pain assessment tools for those with cognitive impairment. Complete and implement the 'Percutaneous Endoscopic Gastroscopy Nutrition Policy'.
- Ensure all staff receive an annual appraisal and that there are arrangements for clinical supervision for those who require or request it.
- Consider how ward staff could be assured of the clinical competencies of agency staff.
- Consider how seven day therapy services could be provided on the stroke unit.
- Study the level of service required in ambulatory care to better understand the level of demands and how to meet it.
- Audit the dementia friendliness of the design of clinical areas and take appropriate remedial actions.
- Consider how 'Better Care Together' and matron visit initiatives could be used to drive improvements. Continue to work towards full provision of seven day services for EOLC.
- Children’s services should enhance play specialist provision in line with national guidance.
- Assure itself that staff understand the new Duty of Candour regulations.
- Assure itself that agency staff are reporting and know how to report an incident.
- Conduct a service review of pressure area care and urinary tract infections (UTI’s) to identify any care failings or necessary improvements that are required.
- Take action to address the excessive temperatures patients and staff are exposed to on McCullough ward.
- Ensure that its medication prescribing policy is being followed.
- Review the quality of service provided by the new patient transport provider.
- Review the staffing levels in the pain team against the demands of the service to ensure it can meet people’s pain needs and provide an appropriate level of support for ward staff.

Summary of findings

- Review theatre start and finish times and staffing arrangements for over runs to ensure the department is working to maximum capacity to meet the demands of the service and to minimise the risk to patients from long referral to treatment times (RTT).

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	Inadequate 	The Emergency Department (ED) at Medway Hospital was inadequate. Whilst the department had undertaken initiatives to resolve the long standing capacity issues which frequently impacted on the ability of the department to move patients through the emergency care pathway, the department was stilll not consistently meeting national targets; patients therefore experienced delays, some of which were significant delays. The primary cause of this was a lack of available hospital beds and disjointed multi-professional working. The environment within ED was not adequate to meet patient demand. There were frequent occasions when the number of patients requiring treatment exceeded the number of cubicles available. This meant that patients spent long periods of time waiting in corridors. We found that systems in place to monitor these patients were not safe and patients were not always adequately monitored. We also found their privacy and dignity was not maintained. Consultant cover was provided 15 hours per day, seven days per week. Most patients told us they felt well cared for although they felt staff were very busy. The process for admitting patients to wards was very slow and this meant people had to spend very long periods cared for in the ED. There were arrangements for safeguarding people in vulnerable circumstances from abuse, although we found a few examples where trust policy had not been consistently followed. Senior medical leadership was clearly defined and staff were able to identify the managerial lines of responsibility. Nursing leadership was poorly organised with no single individual providing strategic nursing leadership. This meant junior nursing staff lacked clear managerial supervision. Staff told us that the trust's senior management lacked understanding of their challenges and that members of the senior team did not offer support when they were very busy.

Summary of findings

Staff compliance on mandatory training fell well below the trust target, particularly for nurses. Very few staff were encouraged to undertake additional courses of study.

Medical care

Inadequate

We found the learning from some serious medicines incidents had not become embedded in practice. Rates of harm free care were worse than England averages. We observed medicines that were inappropriately stored. Clinical environments were not clean and hygienic and some needed refurbishment. Not all staff were completing their mandatory training. Nurse staffing levels showed frequent short-falls and there was an over reliance on agency nursing staff and medical locums.

We found patients' outcomes were worse than expected in some specialities with mortality rates higher than the national average. Practice did not always comply with the requirements of the Mental Capacity Act, Deprivation of Liberty Safeguards. We found staff were not always supported in their development through appraisal. However, services were generally available seven day a week. There were adequate arrangements to ensure patients received pain relief and had enough to eat and drink.

Services were not responsive to people's needs as patients were unable to access the care they needed as a result of inadequate management of demand and patient flow through the hospital. The flow of patients through the service did not function as intended. Patients were frequently treated in mixed-sex wards. Discharge planning was inadequate and there were high levels of delayed transfers of care.

The vision and values of the organisation were not well developed or understood by staff. The leadership of the service was constantly changing which meant there was no clear focus on achieving objectives and management time was predominantly spent managing staffing and patient flow crises. Strategic planning and operational management were hindered at all levels by the availability of reliable, easily understood data. Staff satisfaction was mixed, and some staff reported feeling bullied. There was a limited approach to obtaining the views of patients.

Summary of findings

We observed staff interactions and relationships with patients and those close to them as caring and supportive and they responded with compassion to pain, emotional distress and other fundamental needs. Staff treated patients with dignity and respect and people felt supported and cared for as a result.

Surgery **Inadequate** 

We found evidence the concerns raised following the CQC's last inspection had not been addressed. Our main concerns related to staffing levels, discharge processes, access and flow, ineffective management and leadership, governance and risk board effectiveness's and quality of care and patient experience.

Whilst we acknowledge that incident reporting had improved in the department we remain concerned that not all incidents were being reported. We were also concerned that senior staff responsible for reviewing and investigating incidents did not have the time to carry out these duties due to the impact of staffing levels. We identified a high tolerance to incident reporting in the department. Staff told inspectors that they tried to report all of the incidents however, it was not always possible because of the time and staffing constraints. Agency staff were not consistently reporting incidents.

The trust was not meeting referral to treatment times (RTT) in surgery.

Staffing levels throughout the department were found to be insufficient to meet people's needs. This was also identified at the last inspection. The trust remained heavily reliant on staff good will to undertake extra shifts and temporary agency and bank staff in the interim to ease the pressures.

There was a lack of robust induction procedures and records for these staff.

Cleanliness data for the surgical unit was reviewed as part of the inspection process. Our observations identified the areas we visited as being clean and tidy. However, when we reviewed the cleanliness data it highlighted a significant failing in achieving the national standards of cleanliness, and major shortfalls in the audit processes used to measure compliance.

There is a concern that the surgical clinical unit is not learning from, or improving quality, from

Summary of findings

complaints and comments made. Staff remained unaware of complaints at a directorate levels which had influenced change, except from the ones made directly to them regarding noise, lights at nights, or communication problems.
Staff morale had been left in a poor state as a result of ineffective engagement, management and constant changes to directorate teams. The results of the most recent staff survey continued to raise concerns about staff welfare, morale and organisational culture at the trust.

Critical care **Requires improvement**

Improvements are needed in the safety of MHDU, in particular responsiveness to patient needs and leadership across the critical care services. The services were found to be caring and effective. Whilst we saw many examples of safe practice, there were inconsistencies across the services. Safety on ICU and the Surgical HDU was judged to be good, however we were concerned about medical staffing and cramped conditions on MHDU. Since our last inspection medical staffing of MHDU continues to be under-resourced, with periods of inappropriate medical skill mix. This meant medical staffing was not always in accordance with Core Standards for Intensive Care Units, 2013 (the core standards) published by the Intensive Care Society in partnership with the Faculty of Intensive Care Medicine and Royal Colleges.
The environment in MHDU did not comply with Department of Health best practice guidance: Health Building Note HBN-04.01 or core standards. Bed spaces were significantly under the recommended 3.6m, and bathroom facilities were only accessible through circulation routes. The close proximity of patients not only presented difficulties with privacy and dignity and risks to infection prevention and control, but also to safe use of equipment located around the beds. There was no documentary evidence that regular checks were carried out on equipment on the Tracheotomy trolley on SHDU. This poses a risk that equipment would not be ready for use in an emergency.
Generally occupancy rates within the trust and within the critical care service exceeded the national average. Of a total 55,898 in-patient admissions to the trust in 2014-2015, in excess of

Summary of findings

2,000 patients were admitted to the three critical care units. This is higher than peer groups. In spite of a recovery (improvement) plan designed to address flow and capacity within the organisation, there was insufficient bed capacity throughout the hospital. This meant a significant amount of patients experienced delayed discharge or transfer to other wards and that patients were being discharged out of hours, at a rate that was higher than similar units, and that was not meeting the core standards.

Whilst the trust had stated vision and values, we saw no evidence of a comprehensive plan guiding the improvement and sustainability of the critical care services. Risks, issues and poor performance were not always dealt with appropriately or in a timely way. For example, it was unclear what specific actions were in place to mitigate long standing extreme risks. In addition, medical staffing, delays admitting people from recovery and delayed admission to MHDU, both identified as risks prior to our April 2014 inspection, were not shown to have sufficiently improved since at least July 2013.

We also found areas of good practice:

Medical staffing in ICU and SHDU met the core standards. There were sufficient numbers of appropriately trained and supervised nursing staff available within the services. There were effective systems in place to: safeguard people from abuse, ensure safe medicines management, and for infection prevention and control. Staff were up to date with mandatory training.

Care and treatment was delivered in accordance with best practice and recognised guidance and standards. We saw that patient outcomes for ICU were monitored and measured, and submitted to ICNARC. Data submitted by the trust to ICNARC for 2013-2014 was made available to us as the data for 2014-2015 was not published at the time of writing this report. However, the most recent (unpublished) data subsequently made available to us was March 2015 and this has been considered and reflected in some of the statistical data in this report.

Summary of findings

There was collaborative working amongst the multi-disciplinary team. There had been improvements in recording mortality and morbidity.
Verbal feedback from patients and those close to them was generally positive. We saw people were supported in decisions about care, where appropriate, and they told us staff were kind and helpful.
Staff were generally positive about improvements to the culture and leadership within the trust and at departmental level, following recent management changes. Staff reported that leaders were supportive and supported innovation.

Maternity and gynaecology

Good

There was a process in place to report serious incidents. Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they were fully supported when they did so. Monitoring and review activities enabled staff to understand risks and gave a clear and accurate picture of safety.
Maternity and gynaecology safety performance showed a good track record and steady improvements. When something went wrong, there was an appropriate thorough review or investigation that involved all relevant staff and women who used services. There were clearly defined and embedded systems, processes and standard operating procedures to keep women safe and safeguarded from abuse.
Staffing levels and skill mix were planned, implemented and reviewed to keep women and babies' safe at all times. Any staff shortages were responded to quickly and adequately.
Risks to women were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies. Staff recognised and responded appropriately to changes in risks to women and babies. The environment on the maternity care unit (MCU) was restrictive for staff due to its size. Staff told us the suitability of the MCU environment was under review.

Summary of findings

We reviewed maternity and gynaecology medicines and medicines procedures. We found that Ocelot ward did not have a pharmacist who completed regular checks on medicine supplies.

Women's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. Women's needs assessments included consideration of their clinical needs, mental health, physical health and wellbeing. The expected outcomes were identified and care and treatment was regularly reviewed and was routinely collected and monitored. This information was used to improve care. Women and babies experienced consistently positive outcomes that generally met their expectations. However, the number of caesarean sections performed by the service was slightly higher than the national average.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services.

Women and babies were cared for by a multidisciplinary team. Staff felt supported and had access to training. Consultant support and presence was provided over seven days.

Women were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from women who used the service and those close to them were positive about staff's kindness and compassion. Women's relationships with staff were positive. Women told us they felt supported and staff were caring. Staff communicated with and received information in a way women could understand. Women understood their care and treatment. Women's privacy and confidentiality was respected.

Women's needs were met through the way services were organised and delivered**.** The maternity service delivery plan was targeted at the specific needs of mothers, partners and babies known to be at risk of less positive outcomes.

The maternity unit was closed on four occasions between December 2013 and May 2015. However, two of these were due to construction work on the neonatal unit and twice due to a lack of available beds.

Summary of findings

The needs of women were taken into account when planning and delivering services. A picker institute patient survey 2013 found that the trust performed slightly better than the national average for staff responding to patients who rang the call button. The vision, values and strategy of the maternity and gynaecology service was driven by quality and safety. The service's strategy had well-defined objectives that were based on an action plan following a joint strategic needs assessment (JSNA) and the previous CQC inspection. Strategic objectives were supported by measurable outcomes, which were cascaded throughout the maternity and gynaecology service and the trust's board. Staff morale was good and staff were optimistic about the direction of maternity and gynaecology services. The governance systems within maternity and gynaecology services functioned effectively and interacted with other services and directorates appropriately.

Services for children and young people

Good

Children's services at Medway Maritime Hospital provide effective, caring and responsive support to premature babies, sick children and their families. However, we judged that 'Safety' required improvement.

There was no electronic flagging system in the children's ED and this posed a risk that children seen or admitted who were known to be at risk of abuse may not have been readily identified. We saw several examples where there were lapsed in recognising and managing child protection. The trust-wide safeguarding team was not adequately resourced to meet the demands on the service. There were good systems in place to identify a deterioration in the condition of children on the unit but we found an instance where a child suffered a perforated appendix due to delays in identifying and treating the presenting condition. There was an open and transparent approach to reporting and learning from incidents. Infection prevention and control measures were in place to minimize risks to those who used the service. Medicines were managed safely and staff followed relevant guidance to ensure the best outcomes for children and young people.

Summary of findings

Patient safety was assured though vigilant monitoring of any deteriorating child and in providing optimum staffing ratios, effectiveness of services were geared to reducing emergency readmission rates, caring was evident throughout the whole service where a team multidisciplinary approach to care prevailed. Responsiveness of the service was manifest through close working arrangements with community-based services, which ensured that children could expect to be cared for at home via community nursing services. The service was well led and all the staff we interviewed spoke positively about providing high quality care that was aligned to the trust-wide vision of ensuring that patients received safe, clean and personal care. Although there were some discrepancies in optimum staffing levels of doctors and nurses, arrangements were in place to minimise risk.

End of life care — **Requires improvement** 

We found that at a local level the EOLC CNS and HPCT worked hard collectively to provide good end of life care. Their aim was to provide and maintain end of life educational sessions across the hospital and to introduce the EOLC competency framework. We found staff at ward level provided patient centred care and wanted to deliver good care through training and support but they were unclear about their roles in delivering EOLC. There was no training for EOLC and the Chief Nurse confirmed that the EOLC education budget was not used. The hospital staff provided sensitive, caring and individualised personal care to patients who were at the end of life. Patients and their relatives told us that staff were caring and compassionate and treated patients with dignity and respect. On the wards we visited we observed staff that were doing their best to provide caring and dignified EOLC. This was due to previous knowledge obtained and pride in their work rather than due to specific training from the trust.

The EOLC CNS demonstrated a high level of evidence based specialist knowledge and worked effectively in conjunction with the HPCT. We observed that they both supported and provided advice to other staff and they were highly regarded across the trust.

Summary of findings

There was evidence that systems were in place for the referral of patients for assessment and review to ensure patients received appropriate care and support. We saw evidence that urgent referrals were seen on the same day. In the period November 2014 to April 2015 there was a total of 618 referrals (approximately 1,200 per annum) made to the hospital palliative team. In 2014 there were 1,373 deaths at the hospital.

The National Care of the Dying Audit 2014 made organisational and clinical recommendations to ensure that dying people and their families got the care and support they needed and deserved. Results of the audit showed that Medway Maritime Hospital achieved two out of seven for organisational indicators and seven out of 10 of clinical indicators compared to the England average.

The End of Life Care Strategy, published by the Department of Health in 2008, set out the key stages and the National Institute of Health and Care Excellence's (NICE) End of Life Care Quality Standard for Adults (QS13) set out precisely what EOLC should look like. These were both for adults diagnosed with a life limiting condition in all care settings. EOLC is defined as a patient with less than 12 months to live no matter the diagnosis. The End of Life Care Policy (2014) provided by the trust was not robust as it was aimed at care of the dying patient only and there were no prerequisites for advance care planning.

The hospital did not have an EOLC strategy in place. The EOLC action plan was not fit for purpose and did not link to the EOLC steering group agenda. Without service improvements the EOLC provided by the hospital was unsustainable. This was due to the reduced specialist palliative resources, lack of EOLC education and leadership. Additionally, the absence of a robust policy and strategy did not provide a suitable framework and guidelines for staff to adhere to.

The EOLC service provided by the hospital had significant governance issues. There was no governance framework to support delivery of good quality care. There was no comprehensive assurance system or service performance measures in place.

Summary of findings

There was no overall leadership of the EOLC service in the hospital. There was little evidence of divisional or consistent board input. The National Care of the Dying Audit 2014 recommends that the trust had a named board member with responsibility for care of the dying. The Chief Nurse confirmed there was an absence of a non-executive lead.

The hospital were unable to make a clear distinction who the hospital medical lead for EOLC was. Additionally, it was unclear what the Chief Nurse was responsible for regarding EOLC. Further questioning of the Chief Nurse regarding EOLC at the hospital resulted in their admission that the service was not adequate. They were unable to provide any evidence of plans for the future or those said to be in progress or underway.

Outpatients and diagnostic imaging

Inadequate

Overall we found outpatient and diagnostic services at Medway Maritime Hospital to be inadequate.

We were concerned how the trust managed and responded to incidents. Some staff reported incidents but not all staff had access to the system for reporting incidents. There was no evidence to suggest that lessons had been learned following a never event.

The trust was consistently not meeting their two week targets for patients suspected with cancer and in addition to this there was an inequality in waiting times between patient groups. There were delays in patients getting scans and the results of these scans. This impacted on them getting treatment in a timely manner. The latest referral to treatment times data revealed that the trust was below the NHS England target. The patient service centre was not always able to give patients appointments within the target times set by NHS England and the clinical commissioning groups.

The Computerised Tomography (CT) scanner had been identified as a risk with potential for mis-diagnosis and the quality of the outsourced radiology reporting could not be assured. The radiology department were sending increasing numbers of scans to be reported by external companies.

The diagnostic imaging services had inconsistent data for waiting and reporting times. This made it

Summary of findings

difficult for the trust to plan services for the future and there was no future planning in place. Some data indicated patients were waiting up to 84 days before a diagnosis was made. This meant they did not start treatment within the 31 or 62 day timescale. Increasing numbers of investigations were being sent to external agencies for reporting, but the trust had no robust assurances of its own that the quality of reporting.

There was no plan in place for developing future services in radiology. Staff acknowledged that the trust was making changes and that the senior management team were more visible. However, many staff told us that there was a barrier between senior management and a divide between their teams and the management team. Some staff reported a bullying culture. At the time of our inspection we were unable to see any clear strategies to develop robust systems and processes to be able to monitor and maintain these targets.

Infection control audits were consistently below the trust target in many areas of outpatients and diagnostic services and there were no action plans to address these shortfalls.

We found there were good systems for the storage of medicines and the management of confidential records.

The outpatients nursing team worked to maintain a good patient experience within their department and patients we spoke with told us they were treated with dignity and respect. Staff training records were up to date.

The Orthotics department was providing an effective and efficient service to patients. We found that treatment generally followed current guidance. We found that there were arrangements to ensure that staff were competent to look after patients. Patients generally had access to clinics out of normal working hours and were cared for by a multidisciplinary team working in a co-ordinated way.

Staff had received appropriate training in their obligations under the Mental Capacity Act.

Staff acknowledged that the trust was making changes and that the senior management team

Summary of findings

were more visible. However, many staff told us that there was a barrier between senior management and a divide between their teams and the management team.
Patients and their relatives were positive about their experience of care. Patients were treated with privacy and dignity and were given the right amount of information to support their decision making and patients could get the emotional support they needed.

Medway Maritime Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Medway Maritime Hospital

Medway NHS Foundation Trust has been a foundation trust since 1 April 2008. The trust employs 3,683 staff (budgeted establishment of 4,139 whole time equivalent (WTE) staff) and has 652 beds. The trust's turnover is £282 million; it reported a deficit of £30.5 million in 2014/15.

Medway NHS Foundation Trust was placed into 'special measures' in July 2013 to improve and rectify failings in patient care and governance as identified in the review under Professor Sir Bruce Keogh.

At the time of this inspection the executive team comprised four permanent executive positions and three interim executives. The chairperson was appointed in September 2014 after having joined the trust as a non-executive director in January 2014. The Chief Executive had been in post since May 2015. The positions of the Finance Director and Chief Nurse were interim appointments; the Chief Nurse was due to leave the trust in October 2015. The Medical Director was absent at the time of our inspection; the duties of the Medical Directors office was being fulfilled by a deputy and associate medical directors. The Chief Operating Officer was a substantive employee but had tendered their resignation shortly prior to the inspection; they had been in post since November 2014. The trust had appointed a Chief Quality Officer who took up post in October 2014.

As of June 2015 the trust is being supported through a formal buddying arrangement with Guy's and St Thomas' NHS Foundation Trust (GSTT). The scope of the agreement is for GSTT to provide advice and support to Medway NHS Foundation Trust to effectively and quickly improve their performance in a range of areas including clinical leadership, mortality, medical and surgical pathways, and access and flow across the acute service.

Our inspection team

Chair: Tim Ho, Medical Director

Head of Hospital Inspections: Nick Mulholland, Care Quality Commission

The team of 49 included: CQC Inspectors, a planner, analysts and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics; an anaesthetist; physicians and junior doctors; a midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses'; an imaging specialist; an outpatients manager; a child and adult safeguarding lead; estates and facilities directors and experts by experience.

Detailed findings

How we carried out this inspection

To understand 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 inspected the following eight core services at the Medway Maritime Hospital:

- Accident and emergency
- 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

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included clinical commissioning groups (CCG) for Medway, Swale, Dartford and Gravesham, Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch team.

Representatives from the hospitals Patient Advice and Liaison Service (PALS) and an inspector from the CQC facilitated a stall in the entrance to the hospital during the inspection where people stopped and shared their views and experiences of Medway Maritime Hospital with us. We also spoke with staff, patients and carers via email or telephone, who wished to share their experiences with us.

We carried out the announced inspection visit between 25 and 27 August 2015. We held focus groups and drop-in sessions with a range of staff in the hospital including; nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested. We talked with patients and staff from the majority of ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out unannounced inspections on 8, 9 and 13 September 2015. We looked at how the hospital was run out of hours, the levels and type of staff available and the care provided.

Facts and data about Medway Maritime Hospital

Local demographics

Medway local authority was ranked 136th of 326 local authorities in the English Indices of Deprivation 2010 (1st is 'most deprived'). The Public Health profile indicates that Medway is significantly worse than the England average for 13 of 32 indicators (41%) including smoking prevalence, percentage of physically active adults and recorded diabetes. Male and female life expectancy is also significantly worse. Additionally, nine of 32 indicators (28%) were similar the England average and 10 (31%) were significantly better than the England average.

Activity

Between 2014 and 2015 the trust facilitated:

- 55,898 inpatient admissions
- 20,932 day case admissions
- 327,412 outpatient attendances
- The emergency department had 99,162 attendances between April 2014 and March 2015

Context

Detailed findings

- Foundation trust since 1 April 2008
- Serves a population of approximately 400,000
- Employs around 3,683 staff with a budgeted establishment of 4,139 whole time equivalent staff

Intelligent monitoring - May 2015

- Number of risks: 16
- Number of elevated risks: 15
- Overall risk score: 46
- Number of applicable indicators: 9

Intelligent monitoring - Safe

- Risks: 3
  - Never event incidence
  - Composite of Central Alerting System (CAS): Dealing with CAS safety alerts in a timely way
  - A & E survey Q7: From the time you first arrived into the A&E Department, how long did you wait before you were examined by a doctor or nurse?

Intelligent monitoring - Effective

- Risks: 8
  - Composite indicator: In-hospital mortality - Cardiological conditions and procedures
  - Composite indicator: In-hospital mortality - Endocrinological conditions
  - Composite indicator: In-hospital mortality - Gastrological and hepatological conditions and procedures
  - Composite indicator: In-hospital mortality - Conditions associated with mental health
  - Composite indicator: In-hospital mortality - Respiratory conditions
  - Composite indicator: In-hospital mortality - Trauma and orthopaedic conditions and procedures
  - Composite indicator: In-hospital mortality - Vascular conditions and procedures
  - Composite of hip related PROMS indicators (Patient Reported Outcome Measures
- Elevated Risks: 4
  - Summary Hospital-level Mortality Indicator
  - Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ration Indicators
  - Composite indicator: In-hospital mortality - Infectious diseases
  - SSNAP (Sentinel Stroke National Audit Programme) Domain 2: overall team centred rating score for key stroke unit indicator

Intelligent monitoring - Caring

- Risks: 3
  - Inpatient Survey Q68 (2014): "Overall..." (I had a very poor/good experience) (Score out of 10)
  - Inpatient Survey Q25 (2014): Did you have confidence and trust in the doctors treating you?"
  - A&E Survey Q19: If you needed attention, were you able to get a member of medical or nursing staff to help you?
- Elevated risks: 4
  - Inpatient Survey Q66 (2014): Overall, did you feel you were treated with respect and dignity while you were in the hospital? (Score out of 10).
  - A&E Survey Q14: Did you have confidence and trust in the doctors and nurses examining and treating you?
  - A&E Survey Q22: If you were feeling distressed while you were in the A&E department, did a member of staff help to reassure you?
  - A&E Survey Q42: Overall, did you feel you were treated with respect and dignity while you were in the A&E Department

Intelligent monitoring - Responsive

- Risks: 1
  - Composite indicator: Referral to treatment
- Elevated risks: 3
  - A&E Survey Q18: Were you given enough privacy when being examined or treated?

Detailed findings

- Composite indicator: A&E waiting times more than 4 hours
- CQC concerns and complaints

Intelligent monitoring - Well-led

- Risks: 1
  - GMC - Enhanced monitoring
- Elevated risks: 3
  - Monitor - Governance risk rating
  - Monitor - Continuity of service rating
  - Snapshot of whistleblowing alerts

Intelligent monitoring - Cross cutting indicators

- Elevated risks: 1
  - Composite of PLACE indicator

Patient Led Assessment of the Clinical Environment (PLACE) scores for 2014 for food were 75.5 %, the national average for 2014 being 88.8%. PLACE scores for 2015 were 85%; the national average for 2015 being 88%. There had been a 9.75% improvement in the 2015 score against the 2014 score suggesting that the catering service had improved since we last inspected.

Trust-wide indicators

Safe

- Four never events reported in previous 12 months (May 2014 -April 2015)
- 65 STEIS Incidents reported (May 2014 - April 2015)
- Incidents reported VS national reporting averages (April 2014 -September 2014):

Category	Medway Maritime Hospital	England Average
Deaths	25 (0.8%)	0.1%
Severe harm	10 (0.3%)	0.4%
Moderate harm	196 (6.5%)	4.0%
Low harm	643 (21.5%)	21.8%
No harm	2,123 (70.8%)	73.7%

- Three trust-assigned MRSA infections reported during 24 month period.
- Low but persistent rates of C.diff and MSSA; rates similar to England average.
- A consistently high prevalence of pressure ulcers categories 2-4 over a twelve month period.
- High prevalence of Catheter related urinary tract infections.

Effective

HSMR Weekday: Higher than expected

HSMR Weekend: Higher than expected

HSMR Overall: Higher than expected - 111.2 (April 2015 – June 2015)

SHMI Overall: 1.24(January 2014 – December 2014)*

* The SHMI figure of 1.24 was subject to a known submission error. The Trust calculated the correct figure to be 1.18.

Caring

- Performing worse than other trusts for discharge delays.
- Patient Led Assessments of the Care Environment (PLACE) scores were worse than the England average in all catagories of cleanliness, food, privacy, dignity and wellbeing, condition, appearance and maintenance.
- Trust rated in the bottom 20% of trusts for 16 of the 34 indicators for cancer patient experience survey results for the last two years.
- 'Friends and Family Test' (Mar 2014 – Feb 2015) showed the trust was consistently below the England average.
- CQC inpatient survey:
  - No. of items in top 20%: 0 (0%)
  - No. of items 'average': 40 (67%)
  - No. of items bottom 20%: 20 (33%)

Responsive

Detailed findings

- Bed occupancy consistently higher than the England average over the last year.
- Number of complaints in 12 months: 535, June 14 – May 15
- RTT non admitted (completed pathways):62%, June 15 only
- RTT admitted (completed pathways): 83%, June 15 only
- Cancer 2 week wait: 72.1%, April – June 15
- Cancer 31 day wait: 95.1%, April – June 15
- Cancer 62 day wait: 78.3%, April – June 15

Well Led

- GMC Survey 2015 showed worse than expected results for doctors induction and feedback.
- NHS Staff Survey 2014 Key Findings showed 9 Negative RAG ratings.

Staff survey:

- Overall response rate 41%
- No. of items in top 20%: 3 (10%)
- No. of items average: 19 (66%)
- No. of items bottom 20%: 7 (24%)

Staff Survey key finding 18: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months:

- 28% of staff reported experiencing harassment, bullying or abuse from patients, relatives or staff; this was higher (worse than) the national reported average of 25%.
- Of note, 27% of staff who reported experiencing this form of harassment, bullying or abuse described themselves as "White" versus 33% of black and minority ethnic (BME) staff.

Staff Survey key finding 19: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months:

- 28% of staff reported experiencing harassment, bullying or abuse from staff; this was higher (worse than) the national reported average of 22%.
- Of note, 26%of staff who reported experiencing this form of harassment, bullying or abuse described themselves as "White" versus 33% of black and minority ethnic (BME) staff.

Staff Survey key finding 28: In the last twelve months have you personally experienced discrimination at work?

- 12% of staff reported personally experiencing discrimination at work; this was marginally higher (worse than) the national reported average of 11%. However, whilst the overall rate is similar to the national average, there was a statistically significant variance between the number of BME staff who reported experiencing discrimination in this category; 25% of BME staff versus 7% of white staff.

CQC Inspection History

- Maritime Medway Hospital has been inspected 12 times since November 2010.
- The most recent trustwide inspection was a routine inspection in April 2014, and was conducted under the new methodology. The April 2014 inspection resulted in an overall rating of 'Inadequate' for the trust.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate	Inadequate
Medical care	Inadequate	Inadequate	Good	Inadequate	Inadequate	Inadequate
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Critical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate

Notes

The trust had started to take action to transform the estates and facilities division management and governance. At the time of our inspection the board was considering a transformation proposal submitted by the interim Director of Estates. It was planned that the new structure would provide clear leadership through stewardship from senior management across the division. A number of new management groups had been established including a steering group focusing on performance and governance.

The trust had identified risks with fire safety due to deficiencies with building fire compartmentation this includes damage to fire doors though out the estate. A programme of replacement fire doors has been implemented with a significant number of doors having been replaced.

The risk has been reviewed by the trusts Fire Safety Advisors in collaboration with the local fire brigade.

We were advised by the Fire Safety Advisor (ACT) that they were in constant liaison with the Kent Fire & Rescue regarding the current fire risk mitigation measures being employed by the trust.

Due to the potential risk from fire doors not correctly operating staff had been trained to move patients to a place of safety at least two compartment doors away from the zone in fire. This was tested in Emergency Department by asking a member of nursing staff what they would do in the event of a fire alarm. The member of staff advised us that they would move patients to a place of safety at least two sets of doors away from the fire.

The early warning fire detection system does not have the capacity to provide L1 coverage. A new system is currently being installed however it is not known when this system will be fully operational. The fire alarm detection system together with the above ceiling compartmentation deficiencies and the continuing fire door damage are significant risks.

The 'Computer Aided Facilities Management' system had been identified as an area for investment. The current

maintenance records system is limited as regards management information. The trust were looking to invest in a new system that uses the latest technology (hand held mobile electronic devices). This system will be more efficient to use and be able to provide better management information.

The trust operated a 'backlog' risk adjusted maintenance register. This register was used to identify and prioritise capital replacement of assets. The register was regularly reviewed at the Capital Finance monthly meeting.

Health Technical Memorandum (HTM's) promote the safe and professional management of various specialist Estates areas. The trust confirmed they are looking to appoint an AE Ventilation. Specialised ventilation systems management and validation evidence was provided. While the trust do not currently have an AE (Vent) appointed the records indicate suitable management and verification is being undertaken in line with the requirements of HTM03-02.

The trust uses 'Copper/Silver Ionization' to control legionella in its water systems. The system was managed by an external company who maintained the dosing system and external company undertake regular testing of the water systems in line with the requirements of L8 and HTM.

The trust had undertaken a legionella risk assessment and was undertaking a programme for the removal of dead legs across the site. They had also established a 'Water Management Group'. Regular flushing of taps was undertaken by facilities staff and recorded centrally. Records of the flushing were reviewed on Gundulph Ward and appeared to be satisfactory.

The local councils inspect all food premises according to risk classification; all hospitals receive a high risk rating due to the vulnerable nature of the patients. The ratings for food hygiene are 0–5 with 5 being the highest. Medway Maritime Hospital received a rating of 1 on the 13 December 2013 and therefore had a rating of 1 when we inspected in April 2014. The reasons for this poor rating had been resolved and as a result at this inspection we were shown the EHO inspection report and scoring of the 17 July 2015 where the catering department had achieved a score of five stars.

The trust were not cleaning or auditing cleaning to required standards. We checked nine very high risk areas over the preceding five months to our inspection (March 15 to July 15). This amounted to 45 audits, as the trust was auditing very high risk areas monthly. The National Specification for Cleanliness in the NHS (NSC) states that very high risk areas should be audited weekly. The trust was not meeting the audit frequency for very high risk areas as defined in the NSC.

National Specification for Cleanliness in the NHS requires trusts to achieve a pass percentage of 98% in this risk category. Out of the 44 audits carried out 25 achieved the criteria giving a percentage of 56.8% achieved the criteria which meant that 43.2% of audits failed to meet the NSC required standard. Oliver Fisher Ward, Renal and Delivery did not achieve the required percentage at all during this period.

We checked 25 high risk areas over the preceding five months (March 2015 to July 2015) effectively 125 audits. The trust was auditing these areas monthly which is in line with the NSC auditing frequencies.

The NSC requires trusts to achieve a percentage pass rate of 95% for this risk category. Out of the 125 audits checked 54 failed to meet the percentage required by the NSC, effectively 43.2% of audits. Keats ward did not achieve the standard required at all during this period. Waverly, Arethusa, Pembroke, Pheonix and Dickens wards only achieved the standard once during this period.

Although we did not see any audits for significant risk areas we were told that due to staff shortages this risk category was being audited every 4 months. The NSC requires this risk category to be audited every 3 months.

The NSC states that if there are concerns over cleaning standards and areas are not meeting the requirements in their risk category then the auditing should go up to the next level of auditing frequency. For example if high risk areas (audited monthly) do not meet the requirement consistently they should go to the next level of auditing (weekly) until such times the areas consistently meets the percentage required and only when this happens can the auditing go back to monthly auditing. We saw no evidence of this having taken place.

We saw the vacancy panel submissions for June where the domestic department had put forward 30.8 whole time equivalent vacancies, the 'outcome of panel' response was recorded in the form as 'on hold'. We were told that if the department was allowed to recruit the

manager was confident they would be able to fill the vacancies as they perceived there were no recruitment problems in the area for this grade of staff. The manager also told us that the recruitment was on hold until a value for money exercise had been completed; there was no information as to when this would be completed at the time of our inspection.

Concerns were raised with us during the inspection and from stakeholders and trust staff regarding the management of safeguarding within the trust. The department was under resourced with three WTE roles unfilled. Recruitment into these roles had not been agreed or advertised by the trust. Concerns were raised with us from outside agencies that were unable to get support from the trust in their investigations of safeguarding concerns.

The reporting of Deprivation of Liberty Safeguard applications to the CQC by the trust had not been submitted in a timely manner. The lead for the trust told us that this had been because they had not had capacity to manage the work involved in this process due to staff shortages within the team.

Urgent and emergency services

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

Information about the service

The emergency department (ED) provides a 24 hour service, seven days per week to the local population. Between April 2014 and March 2015, the ED facilitated 99,162 attendances of which 21% (20,800) were children aged 0-16 years. 15.4% of total attendances were subsequently admitted into the hospital.

Patients present to the department by walking into the reception area, arriving by ambulance or by helicopter via a helipad based on the roof. Adult patients transporting themselves to the department take a ticket from a dispenser and are first seen by a nurse, followed by a receptionist who takes their details. Children who attend do so through a separate entrance into a separate area of the department.

The department consists of cubicles for patients, a resuscitation area for up to five patients and a clinical decision unit (CDU) where patients can be admitted for up to 24 hours if an immediate decision about their care and treatment cannot be reached.

The department was undergoing building work during our inspection and as a result the minors area was being temporarily accommodated in an outpatient area some distance from the rest of the department; the trust envisaged that remedial works to the minors department would be concluded by December 2015.

Inspection history

On 31 December 2013 we carried out an unannounced inspection of the Emergency Department (ED) at Medway Maritime Hospital in response to information we had received from an anonymous source regarding the safety and effectiveness of the ED. We found that the service was failing to meet the national standards that people should expect to receive. As a result, we issued formal warning notices to Medway NHS Foundation Trust, telling them that they must improve in a number of areas within a specified period of time.

We carried out further unannounced inspections of the ED on 27 and 28 July 2014 and again on 26 August 2014. On 28 July 2014 we also reviewed the surgery department to determine whether the trust had commenced making the necessary improvements to the service.

During our inspections of the ED in July and August 2014, we found that the ED lacked robust clinical leadership. The ED had failed to review and optimally utilise its escalation policy within the ED to avoid the need to 'stack' or 'cohort' patients. Whilst patients were being stacked they were not undergoing regular nursing observations, and were not being seen in a timely manner by medical staff. We therefore took urgent action to impose additional conditions on the trusts legal registration with the Care Quality Commission. These conditions required the trust to operate an effective system which ensured that patients could expect to undergo an initial assessment by a skilled and qualified health care professional within 15 minutes of presentation to the Emergency Department. We also required the trust to report to us on a weekly basis, any patients who were not assessed within 15 minutes to determine whether those patients experienced sub-optimal care or had a poor experience upon initial presentation to the department.

Urgent and emergency services

Our reason for imposing these conditions was to ensure that staff working in the ED were acutely aware of all patients present in the department; this helped to enhance the safety of the department; we had previously found that patients who were acutely unwell could experience long delays before being initially assessed.

We carried out a further unannounced inspection of the ED on 9 December 2014. The department continued to experience significant issues with transferring patients to wards once a decision had been made to admit them. Delayed transfer of patients was resulting in patients experiencing delays in being treated once they had presented to the ED. However, the trust had implemented initiatives including undertaking an initial assessment of all patients within 15 minutes of their arrival to the ED. Improvements were required to ensure that patients arriving by ambulance received the same level of care as though who self-presented. This included ensuring that trust policies and procedures were consistently adhered to, including those relating to the management of "cohorted" or "stacked" patients.

Summary of findings

The Emergency Department (ED) at Medway Maritime Hospital was inadequate. Whilst the department had undertaken initiatives to resolve the long standing capacity issues which frequently impacted on the ability of the department to move patients through the emergency care pathway, the department was stilll not consistently meeting national targets; patients therefore experienced delays, some of which were significant delays. The primary cause of this was a lack of available hospital beds and disjointed multi-professional working.

The environment within ED was not adequate to meet patient demand. There were frequent occasions when the number of patients requiring treatment exceeded the number of cubicles available. This meant that patients spent long periods of time waiting in corridors. We found that systems in place to monitor these patients were not safe and patients were not always adequately monitored. We also found their privacy and dignity was not maintained.

Consultant cover was provided 15 hours per day, seven days per week. Most patients told us they felt well cared for although they felt staff were very busy.

The process for admitting patients to wards was very slow and this meant people had to spend very long periods cared for in the ED.

There were arrangements for safeguarding people in vulnerable circumstances from abuse, although we found a few examples where trust policy had not been consistently followed.

Senior medical leadership was clearly defined and staff were able to identify the managerial lines of responsibility. Nursing leadership was, however, poorly organised with no single individual providing strategic nursing leadership. This meant junior nursing staff lacked clear managerial supervision.

Staff told us that the trust's senior management lacked understanding of their challenges and that members of the senior team did not offer support when they were very busy.

Urgent and emergency services

Staff compliance on mandatory training fell well below the trust target, particularly for nurses. Very few staff were encouraged to undertake additional courses of study.

Are urgent and emergency services safe?

Inadequate

The emergency department (ED) at Medway Maritime Hospital did not adequately protect patients from avoidable harm.

Arrangements for streaming adult patients to the relevant part of ED were not adequate. Staff said that there were frequently occasions when the number of patients was more than the numbers of cubicles available. As a result, patients were cared for in inappropriate areas of the department such as in the middle of the majors area and two corridors. We found that the risk assessments used for placing people in these areas were not safe and patients sometimes received care without appropriate monitoring. Staff told us that there was no limit set on the maximum number of people who could be cared for in these areas and we saw examples where the departments staffing ratio of one nurse to four patients was exceeded.

We found there was a strong culture of incident reporting and senior members of the department met regularly to discuss incidents. There was also effective ways to inform junior members of staff about incidents.

The department appeared visibly clean during our inspection, although the trust's training data identified poor compliance with staff participating in infection control training. We saw multiple examples when staff did not use personal protective equipment such as gloves when undertaking procedures where these were required.

Medicines, particularly controlled drugs, were not always administered in accordance with the trust's policy for medicines administration.

Early warning scores were used in the department. However, we found that these were not used universally and we saw some unsafe practice in the way clinical observations were taken.

Generally arrangements for safeguarding people in vulnerable circumstances were in place but we found one example where the policy was not followed effectively. The

department had up to date equipment which had been safety tested within the last year. There was a current policy and equipment to support the department in the event of a major incident.

Incidents

- Since January 2015 a total of 568 incidents were reported by staff working in the emergency department utilising the trust electronic incident reporting system. 253 incidents were subsequently reported to the National Reporting and Learning System (NRLS). The majority of these related to pressures ulcers that had developed prior to admission to the department although lack of bed capacity within the department was also a frequent theme. Four incidents were reported as resulting in patient death and two as severe (one incident was attributed to the transfer of a patient from another hospital whose condition deteriorated during the transfer and so the incident was not attributable to care provided by staff at Medway Maritime Hospital). 12 incidents were reported as resulting in moderate harm.
- Individual patient safety case reviews were undertaken where it was identified that the outcome to the patient was severe or had resulted in the patients death.
- The department had an action plan to manage incidents with senior members of the clinical team assigned to investigate and provide recommendations. This ensured that there was a clear understanding among staff as to who was investigating and suggesting actions.
- We saw that incident forms regarding high numbers of patients waiting outside cubicles highlighted that staff felt they were unable to provide safe and dignified care for people who were having to wait for treatment in the department's corridors.
- Since January 2015 a total of one serious incident requiring investigation (SIRI) had been reported.
- We were told that serious incidents were discussed at the ED Clinical Governance meeting. We looked at minutes from the meetings and confirmed this. Outcomes of patient safety case reviews were also reported within the ED quality and safety report during which lessons learnt were discussed and recommendations made to reduce the risk of similar incidents happening again. There was however, no formal log of each of the recommendations made and so it was difficult to determine the governance oversight of recommendations to ensure that appropriate actions were taken and reviewed to ensure changes to practice occurred and that those changes were evaluated to determine their effectiveness.
- The ED clinical governance meeting minutes highlighted a lack of some items of equipment. When we visited the department we found that these items had been purchased and were in use. This showed that on this occasion, there was an appropriate response when concerns were identified.
- The staff we spoke with told us that feedback from serious incident investigations were shared with those involved.
- The ED produced a patient safety data report which was shared with staff in the department. This included a broad review of falls and hospital acquired infection rates and a number of individual patient incidents with the actions that should be taken as a result.
- Most staff told us they were encouraged to report incidents and were able to tell us of changes that had been made as a result of incidents. However we did speak to one junior member of staff who had witnessed an episode of potentially unsafe care but, despite being aware of the correct reporting procedures, had not reported it as it involved a senior member of staff. Learning from incidents was circulated to staff through email. Staff we spoke to said they received these e-mails.

Cleanliness, infection control and hygiene

- There were policies and procedures in place to reduce the risk of cross-infection. Staff knew how to access these via the intranet. There were two reported incidents whereby patients had presented to the ED with diarrhoea; incident forms had been completed because there had been an identified failure of staff to follow local infection pathways which would have ensured the patients were isolated in a side room so that they did not pose a risk to other patients.
- We observed that the department appeared clean in most areas during our inspection and the staff we spoke with did not report any infection control issues.

- We were provided with data for hand hygiene audits conducted on a monthly basis. Compliance with the trusts standard varied widely from 47% (July 2014) to 100% in November 2014 and January 2015. We observed multiple instances when staff did not wash their hands in line with World Health Organisation guidance (Five Moments of Hand Hygiene).
- We observed a number of instances when staff did not use personal protective equipment when preparing intravenous medication in accordance with trust policy.
- Staff were aware of the trust's aseptic non-touch technique guidance which aimed to reduce infection, although we observed this was not consistently followed. We saw a number of examples where intravenous fluids were attached to patients where the staff member was not wearing gloves. This had been identified as an area of concern during our comprehensive inspection of the ED in April 2014.
- The overall completion rate for infection control training in the department was 75% for nurses and 94% for doctors.
- There was a lack of hand washing facilities for staff to use when caring for patients in the department's corridor.
- We looked at the way the department segregated and stored clinical waste. All the sharps containers we examined were stored correctly, and clinical waste was segregated effectively and disposed of safely.
- There were no methicillin resistant Staphylococcus aureus (a form of bacteria) acquisitions associated with the ED between May 2014 and April 2015 (most recent data provided).

Environment and equipment

- The major treatment area had eight cubicles and two side rooms for monitoring and treating patients as well as an assessment cubicle. The nursing station was central to the majors area and had unobstructed views of all of the cubicles. However, it was not possible to view the corridor, where many patients were cared for at times of high activity, from the nursing station. We saw that there was a member of staff who was assigned to the patients in the corridor but there was no workspace or computer available for them there so they frequently had to return to the nursing station to complete clinical notes; this meant they could not observe their patients.
- Access to the paediatric emergency department was by way of a secured door with an entry phone which enabled staff to control and monitor those entering the department.
- The resuscitation area had five bays. All had monitors and equipment was organised clearly to ensure that it was available quickly in an emergency. There was equipment available for staff in the event of a patient requiring resuscitation. We looked at the equipment provided in the adult and paediatric area and found this was checked regularly and was easily accessible. This was an improvement when compared to our previous inspection findings.
- Staff told us that one of the resuscitation bays was designated for the care of children. We saw a number of occasions when this bay was used for treating adults. This meant that there was no space to resuscitate a child in the resuscitation area should one arrive via private transport. We noted that an incident which occurred in June 2015 during which a paediatric cardiac arrest case was received into the department, concerns were raised that the equipment in the resuscitation bed space to which the child was admitted was not appropriate; examples included incompatible blood pressure cuffs and no oxygen saturation probes; this had led to delays in the patient being transferred. The outcome of the incident included a reiteration that staff checked the paediatric bay daily to ensure it was appropriately equipped, as well as a reported reduction in the "Inappropriate use of the paediatric bay by adults patients reduced since the resus admission policy was revised and the ED consultant had enforced a no misuse of the bed area for adults." A further incident was reported in August 2015 whereby a paediatric case was being transported to the ED; staff noted that the lead required to monitor an ECG (electro-cardiogram) on a child was not present, requiring the staff member to source an appropriately sized lead from the paediatric ED.
- All but one of the bays in the resuscitation area were very small; we witnessed ambulance crews having

difficulty transferring patients from the ambulance trolley to the cubicle trolley; staff told us that they sometimes had difficulty transferring patients on to trolleys due to the lack of space within the department.

- All of the items of equipment we examined had been PAT tested within agreed timeframes.
- There were four reported incidents whereby patients were not transferred from an assessment trolley to an appropriate hospital bed after six hours because there had been a reported shortage of hospital beds across the hospital. This placed patients at increased risk of developing pressure damage to their skin.
- We examined approximately 100 sets of notes and saw that the majority of patients did not have any documentation regarding their skin integrity or risk of developing a pressure sore. We also observed that patients who had remained in the department for long periods were not always ordered a bed. Patients who waited in the corridor were not able to be put on beds, staff told us this was because it was difficult to fit beds into the corridor.
- It is important to note that the department had not reported any pressure ulcers attributable to the department between January and May 2015.

Medicines

- Records demonstrated that the temperature of refrigerators used for the storage of medicines were being kept and that medicines were being stored within recommended temperature limits. Ambient temperatures of the rooms used to store medicines were not being monitored or recorded.
- We found that they were not being administered in compliance with trust guidance on controlled drugs. We witnessed two occasions where only one nurse checked the patient's identity prior to the administration of a controlled drug; this was contrary to the trust policy which required two persons to check the identity of the patient prior to the administration of any controlled drug. The storage of controlled drugs had been entered as a risk on the ED's risk register; the reported controls in place to manage the risk, which was updated in May 2015, included "Stricter application of 2 nurse administration throughout the complete procedure..." Our observations during the inspection demonstrated that these controls were not being maintained and compliance with departmental control measures alongside trust guidelines remained poor.
- Between January 2015 and August 2015, the trust reported 31 incidents to the National Incident and Reporting System (NRLS) which were associated with medication incidents occurring within the emergency department. 3 incidents were reported as having low harm and the remainder were graded as having no harm. Minutes from the Medication Safety Improvement Group meeting held in May 2015 reported that between 1 February 2015 and 31 March 2015, the emergency department had reported 15 incidents, 3 of which had resulted in temporary harm; this disparity meant that it was difficult to determine the overall impact of harm patients experienced when considering the administration of medicines within the ED.
- Emergency medicines were available for use and there was evidence that these were regularly checked.
- In children's ED we found that medicines were stored in accordance with the trust's guidance and manufacturer's recommendations. Controlled Drugs were stored in line with relevant legislation.
- During our inspection of the emergency department in April 2014, we identified that fridges containing medicines were found to be unlocked on two separated occasions. The security of medicines had been identified as an area which required improvement and had been noted as an action within the February 2015 Medication Safety Improvement Group report. An NHS Protect audit was conducted of the emergency department in August 2015; this audit resulted in a rag rating of red, which was defined as "Issues of significant concern." A report dated 7 April 2015 reported that between 1 - 31 January 2015, of the ten incidents reported with the emergency department which were attributed to medicines, 5 incidents were associated with the security of medicines. Further, a report presented to the Medication Safety Improvement group meeting in May 2015 indicated that of the 15 incidents reported between , 5 incidents were associated with the security of medicines; 2 incidents

related to the loss/theft of medicines; 1 was associated with the loss/theft of a controlled drug and 2 incidents were associated with medicines which were left out or found insecure.

Records

- During our inspection of the ED in April and July 2014, patient records were significantly incomplete. An audit presented by the department in December 2014 identified that of a sample size of 10 patient notes, 87% of records had the patients name on every page; 76% of records included the patients identifier number on every page; 95% of entries were dated; 62% of entries included the time; 86% of entries were signed and had a legible printed name; 0% of deletions/alterations were countersigned and 52% of entries detailed the senior clinician present with responsibility for decision making. During this inspection we reviewed approximately 100 patient records and found that some were missing key data, particularly in relation to the times that clinicians reviewed their patients. We saw examples where it was not possible to tell from the notes the job role of the person completing them. We saw this had been highlighted as a concern at the ED quality and safety governance meeting and name stamps had been ordered. We found that these were not widely used. This was despite the ED Improvement Plan (updated 16 June 2015) reporting that 100% of stamps had been distributed to all clinical staff and reported as 100% complete in February 2015.
- The majority of adult notes we reviewed were comprehensive with regards to including detailed management plans. In one case we found that the management plan for the patient was not fully completed.
- Results from observation audits completed by the department demonstrated that the department had consistently failed to meet the hospital target of 100% between January-May 2015 of NEWS observations being fully completed. Performance on the audit was seen to be worsening rather than improving (January 96%, February 93%, March 94%, April 95% and May 92%).
- We found there were inconsistencies between the computer system and what was documented on the patients' paper notes. In some cases this differed by up to an hour. This meant it was not possible to be sure of the exact times patients were waiting for treatment.
- We examined 80 sets of notes and saw that the majority of patients did not have any documentation regarding their skin integrity or risk of developing a pressure sore. We also observed that patients who had remained in the department for long periods were not always ordered a bed. Patients who waited in the corridor were not able to be put on beds, staff told us this was because it was difficult to fit beds into the corridor.

Safeguarding

- In children's ED checks were made for all children attending the department to determine if they had a child protection plan in place. From the files we reviewed, we saw that checks had been made in all cases. Staff were also required to record whether there were any safeguarding concerns, this was recorded in the majority of records, although we noted a small number where it was not. The health visitor liaison officer checked the files of all children who had attended ED to ensure safeguarding checks and referrals had been made and we saw evidence of this in patient files.
- There were systems in place to make safeguarding referrals if staff had concerns about a child or vulnerable adult. The staff we spoke with talked confidently about the concerns they would look for and what action they would take.
- Staff had identified a risk in the pathway of how specific bone fractures were managed; fractures of certain bones in children can be a sign of physical abuse. Senior members of the clinical team had advised that a new pathway should have implemented a year prior to our inspection in order to remove the risk within the pathway. However, this had not been actioned at the time of our inspection.
- Staff working in the department were required to undertake training in child safeguarding. This training was set a different levels depending on the staff member's role within the department. We saw data that showed that compliance with level 2 child safeguarding training was 50% for nurses and clinical support workers

and 96% for doctors. For level 3 training it was 76% for nurses and 100% for doctors. This was worse than the trust target of 95% for nursing staff but the standard was met for doctors.

- In the case of adult safeguarding training there were two levels of training, both described as mandatory by the trust for nurses, with level one mandatory for doctors. In the case of level one training department data showed 52% of nurses and 96% for doctors had completed the training.
- Level 2 training data showed that 36% of nursing staff had completed the training; this was significantly worse that the trust target of 95%.
- The adult safeguarding data also showed that 11% of the nursing workforce had not received any safeguarding training, this included all four matrons. This meant that the four most senior nurses in the department had not undergone training aimed to ensure the safety of the adults their department treated.

Assessing and responding to patient risk

- Patients who self-presented to ED were required to report to the main ED reception. They took a ticket from a machine and were then called forward to a desk to be assessed by a nurse before being directed to the appropriate area of the department.
- Patients who arrived by ambulance arrived through a separate entrance. Staff in the department would assess the patients within a cubicle, however when there were capacity issues we saw occasions when this assessment was conducted in the communal area of the major treatment area where those with more serious conditions were treated.
- When the department was full, patients were received onto trolleys and cared for in two long corridors leading away from the majors area. Neither of these corridors was directly visible from the nurses' station where we observed the vast majority of staff to congregate.
- Whilst waiting in the corridor none of the patients had access to a call bell, meaning they were unable to easily summon help when required.
- Staff told us that they would only place patients in the corridor if their clinical condition was such that they did not require close observation. However, during our inspection we found multiple examples where those in the corridor required close observation. Whilst there was a tool in place to support staff to identify which patients should be given priority for a cubicle, the application of this policy was inconsistent. Three staff we spoke with who were responsible for caring for patients who were "Stacked" reported that patients waiting would be transferred to a cubicle in time order (i.e. patients would be transferred in order of the time they arrived into the ED). Two nurses and two consultants who were responsible for the leading the shifts at the time of the inspection reported that patients would be moved from the corridor to a cubicle in order of clinical priority. We further noted that
- Staff used a tool for deciding which patients should be given priority for a cubicle however even patients who scored the maximum figure, were still placed in the corridor and waited for a cubicle to become available. Staff were not able to provide us with any criteria that excluded people from waiting in the corridor. This meant we could not be assured that those requiring the closest monitoring in a cubicle were receiving it.
- Senior clinical staff told us that they employed nurses and paramedics to be responsible for patients cared for in the corridor and they operated a ratio of four patients to one staff member. However there was no maximum number set for how many people could be cared for in the corridor and we saw occasions when this ratio was exceeded. Minutes from a senior nursing meeting in July 2015 highlighted an incident where this ratio was one nurse to 20 patients.
- Staff said that patients should only undergo medical treatment in a cubicle. We saw numerous occasions when those being cared for in the corridor were given treatment such as intravenous fluids and oxygen.
- During our inspection we saw examples of care being delayed as patients waited for a cubicle; this included delays in administration of pain relief.
- We spoke to eight junior doctors who had recently begun working in the department. They told us unanimously that their biggest concern was for safety of patients waiting in the corridor; reasons behind these

concerns included the inconsistent clinical and nursing oversight of the patients.We reviewed all of the incident forms reported by the ED between February January and May 2015 and found

- In one case we saw a patient who had been immobilised as a result of a potential neck injury. The patient was being cared for on a trolley outside of a cubicle and had no access to a call bell and was not being closely monitored by a member of staff. This represented a risk as in the case of vomiting or other medical emergency, the patient may not have been able to of summons any help. We highlighted this to staff on the day of our inspection.
- When we looked at incident forms we saw that staff had highlighted their concerns about the quality of care they were able to provide for patients in the corridor.
- Staff told us that they used National Early Warning Scores (NEWS) to assess any potential deterioration in a patient's condition but we found that this was inconsistently applied. We reviewed notes and saw that in 10 randomly selected notes from the preceding 24 hours. Four notes did not contain a NEWS score.
- We found that there were examples when patients with documented high NEWS scores were recorded but there was no documented evidence to demonstrate that patients had been escalated, or where there was documented evidence of escalation, there were delays in patients being assessed by a senior clinician, in line with the local NEWS protocol. One incident reported to NRLS indicated that a patient had been triaged by a support worker who escalated the patient to a registered nurse, who in turn escalated the patient to a junior doctor. Additional tests were requested however the patient was asked to return to the waiting area without having been reviewed by a consultant. The support worker repeated the patients physical observations and noted that their observations had worsened with an increasing NEWS score. The patient was subsequently escalated to a consultant who reviewed the patient 1 hour and fifteen minutes after their initial presentation. Learning from this incident included ensuring that staff escalated all patients
- There was a Clinical Decision Unit (CDU) which formed part of the ED. The CDU accepted patients who met criteria and were expected to stay no longer than 24 hours. There were specific exclusion criteria for patients who could not be admitted to CDU. During our inspection we saw two patients within the CDU who, according to the criteria, should not have been admitted. Staff were unable to explain why and how this had happened.
- A review of incidents provided to us by the trust, as well as a review of incidents on NRLS indicated that staff had failed to escalate a number of patients who presented with worsening clinical conditions. For example, one patient was not referred to the intensive care team for approximately 12 hours despite being assessed as being "Critically ill" with a diagnosis of severe sepsis. A second patient experienced a delay of approximately three hours before being referred to a surgical speciality; the patients condition was potentially life threatening due to the high risk of significant internal bleeding. The ED team, whilst correct in their diagnosis, had not considered performing emergency blood tests in the event that the patient suffered life threatening internal bleeding, nor had they considered a timely referral to the surgical speciality to seek their opinion on the management of the patient. We found a third example whereby a patient presented with significantly deranged observations; whilst staff had performed a range of procedures including sampling of the patients blood to assess for signs of sepsis, the patient was not referred for a surgical opinion for approximately four hours. It was also identified that staff had failed to respond to the results of the blood test and consequently failed to prescribe and administer antibiotics to the patient in line with national and local guidelines.
- An audit conducted on the safe management of patients presenting to the ED as a trauma patient identified that "Poor compliance noted in protection of spine" and "Inadequate neurological observations with poor documentation of findings". An incident reported by staff in the ED further raised concerns regarding the management of a patient who was being "Log rolled" (a log roll is a process whereby a patient who may be suspected of having sustained spinal cord injury, is rolled on to their side in a structured and organised way so as to reduce the possibility of further spinal damage, in order that a health professional can physically examine the spine for injuries or deformities). It was reported that a medical professional removed an air mattress from beneath the patient whilst they were

being log rolled, and whilst the mattress was supporting the weight of the patient. This manoeuvre could have placed the patient at increased risk of harm if they had an underlying spinal cord injury.

Nursing staffing

- Staff told us a staffing needs assessment based on National Institute of Clinical Excellence (NICE) guidance for ED had been undertaken. This showed that the majors area of ED should have one nurse for every four cubicles. When we looked at the rota for the preceding month we saw that this was being achieved the majority of the time although the department relied heavily on agency nurses. There were multiple occasions when more than half of nurses on duty were agency nurses.
- Senior staff accepted that a high number of agency staff presented the risk of a lack of continuity and said that they tried to book the same agency nurses regularly. We spoke to two agency nurses who told us they had both worked in the department regularly for a number of months.
- The department had produced an induction pack for agency nurses. This contained documentation that showed these nurses had completed key competencies to ensure ED staff could be assured they were able to provide safe care in the context of an ED. However, in discussion with senior members of the nursing team, concerns were raised that the high use of agency nursing staff posed a risk to the department in that they were not always fully assured of the skill set of individual nurses.
- We asked the trust to provide us with the percentage of shifts that remained unfilled in order to understand if there were times when the department did not have the right number of staff, even with agency nurse support; the trust did not provide this.
- It was noted that the fill rate indicator form presented by the chief nurse to the board did not include details of nurse staffing within the emergency department and there was no reference to fill rates for the emergency department within the board assurance report so it was unclear if the board were fully sighted on the vacancy shortfall within ED.
- The nursing vacancy rate within ED was 43 whole time equivalents (WTE). This represented 50% of the number of junior registered (band 5) nurses. The junior sister (band 6) nurse vacancy percentage was lower at 7%. Senior staff told us that they had a rolling job advert in nursing job bulletins. The trust had recently run a recruitment day. The ED team told us that they had only been given very short notice of the event and had not been able to attend.
- There were 11 incidents reported between May and August whereby staff had raised concerns regarding either poor skill mix of nursing staff or insufficient numbers of staff within the department.
- We observed some multidisciplinary handovers and found these to be effective. Each patient in the department was discussed to ensure staff taking over the next shift had a clear insight into the patient's condition, tests undertaken and plan of care.

Medical staffing

- Consultant cover was provided between the hours of 8am and 11pm which met the minimum requirements set by the college of emergency medicine for a trust this size. Two consultants worked between the hours of 8am and 4pm with one consultant available until 11pm with on-call cover provided offsite overnight. The department had three middle grade doctors on site overnight.
- The number of consultants was very similar to the England average.
- There was a high vacancy rate amongst middle grade doctors and a significant proportion of shifts were covered by locums. Staff told us they had used the same locum doctors over a long period of time in order to improve consistency.
- Junior medical staff told us they had received a full induction programme prior to starting their work in the department.
- We requested details of unfilled shifts for medical staff however the trust did not provide this.
- We raised concerns with the executive team regarding how some senior doctors responsible for the management of individual shifts were not always fully sighted on the clinical condition of each patient within a specified period time who were present in the department. We spoke with one consultant during an

unannounced inspection and asked them to provide us with an overview of a patient who had been in the resuscitation bay for more than four hours. The consultant accepted that they were not fully appraised of the medical condition of the patient, despite the patient being under their care, and accepted that they should have been better briefed to ensure that the patient was being managed appropriately.

- The Children's Emergency department was staffed by doctors from the ED. We were told that the consultant overseeing the paediatric was dual accredited in both paediatric and adult emergency medicine.

Major incident awareness and training

- The trust had a major incident plan which was last updated in September 2015. Within this plan were specific action cards for the ED which included key members of the ED staff.
- We were told that regular major incident training took place and that chemical radiological, biological and nuclear CRBN exercises took place regularly where staff would practice erecting the tent and putting on CRBN protective suits.
- In line with requirements from the Civil Contingencies Act 2004 the trust were required to undertake a major incident practical exercise once every three years. We requested summary findings from these events. The last exercise took place in June 2015. We were shown the report that was written following this exercise. The exercise highlighted improvements needed to be made in communication and some of the equipment that had been used. The plan had outlined clear improvements that were being made as a result. This ensured that staff in the department had practiced what to do in the event of a major incident.
- We reviewed the major incident equipment which was stored in a cupboard. It was clearly organised and well set out allowing staff easy access to everything they required.
- We were told that 95% of the non-medical workforce had attended major incident training however data provided by the trust indicated that none of the doctors in the department had attended training. This meant we could not be confident that all staff groups who would respond to the major incident had received appropriate training.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

The effectiveness of the ED required improvement.

Patient pathways and national guidance for care and treatment had not been followed for all patients. For example, we saw that documentation for patients with head injuries had been completed well, but it was not possible to be assured that time critical targets in treating sepsis were being met due to the way records were completed.

Pain assessments were not always completed and evidence of pain relief given not always recorded.

Nurse mandatory training attendance was worse than the target of 90% at 78%. We also saw that some specific training needs had not been met. For example, there was low levels of staff completion of dementia training and specialist resuscitation courses, such as advanced paediatric life support.

The ED had a comprehensive audit plan for the current year and participated in the majority of many national audits associated with the provision of emergency medicine. including those required by the College of Emergency Medicine (CEM) had taken place during the last year. Completed audit reports discussed ways of improving results. Audits were presented to the ED Clinical Governance Group, and discussed at the quality and safety governance meeting.

Appraisal arrangements were in place. and approximately we were told that 78% of non medical staff had received an appraisal. We were not provided with evidence of the percentage of medical staff who had received an appraisal.

There were arrangements for referring patients to mental health te

Evidence-based care and treatment

- The department undertook a number of clinical audits which were presented at the ED governance day. These included missed fractures and pain relief. These were discussed in the department's quality and safety meeting.
- We reviewed a sample of 132 notes of patients who had attended the ED. We found that most patients had received care in line with national guidance, although we observed through review of some patient notes that this was not always the case. We saw some good examples of guidance having been followed for patients with a head injury who had been treated in line with the relevant National Institute for Health and Care Excellence (NICE) guidance.

Pain relief

- Not all of the patients we spoke with told us that they had received pain relief as necessary. We saw one patient who was unable to receive pain relief as they were being cared for in the corridor and there were no cubicles available to administer the medication.
- An internal audit into the management of renal colic in adults was presented in January 2015 and had been conducted to review the departments practice for the management of renal colic in the ED against the Royal College of Emergency Medicine guidance. 52% of patients had a pain score recorded; this was below the national standard and was worse when compared to the departments previous performance which was audited in 2013 and resulted in 60% of patients having a pain score recorded.
- 46% and 61% of patients with severe or moderate pain associated with renal colic were given analgesia within 30 minutes and 60 minutes respectively; neither of these outcomes met national standards.
- 19% of patients who presented to the ED with a diagnosis of urinary retention received analgesia within 1 hour. 85% of patients received analgesia in accordance with RCEM standards; this was an improvement of the departments performance when compared to their performance in the 2013 audit when 71% of patients had their pain managed in line with national standards.Between January 1 2015 and 31 August 2015, a total of
- The ED had a scoring tool to record patients' pain levels. Pain was scored from 0-10. Adult patients were asked (where possible) what their pain rating was. From a review of files we noted that pain scores had not been consistently recorded and patients were not always offered pain relief in line with policy.
- In children's ED there was effective scoring of children's pain. We reviewed 10 sets of notes for children who attended in the last 24 hours. All had had a pain score and action had been taken to relieve pain in every case it was required.
- Staff within the children's ED used a number of different techniques including distraction therapy and strong pain-relieving medication administered without the use of needles.We reviewed 10 sets of children's notes and saw that reported pain was acted on quickly.

Nutrition and hydration

- We saw that there was provision made for food and drink to be provided to patients during their time in ED. Every patient we spoke to had been offered food and water.
- Nurses we spoke to understood the needs of patients they were caring for and the importance of ensuring they had adequate food and drink.
- There was very limited documentation about who had been offered food and drink and what their intake had been. We saw an example of incomplete records documenting fluid balance in a patient for whom this information was important in order to provide effective care.

Patient outcomes

- Clinical pathways had been developed for a number of conditions and they made reference to national guidance. They were available on the intranet which staff, including agency and locum staff, could access as required.
- Whilst we saw proccess and policies to guide staff in the management of patients who presented with, or who were suspected of being septic (a potentially life threatening condition), patients were not always receiving the appropriate treatment in line with national or local best practice guidance. In one case the documentation was not clear and we could not be sure

that antibiotics had been given within the target time; a review of incidents provided to us by the trust also identified that a number of patients experienced delays in receiving antibiotics, intravenous fluids or oxygen therapy.

- The trust provided us with two figures regarding re-attendance rates to ED within seven days between March 2014 and April 2015. One set of data showed this rate to be 1.53% and the other 9%. The team managing ED were not able to tell us which figure was accurate and we could not be assured in the quality of the data in this indicator. We saw an example of a patient who attended a number of times over a seven day period, but the computer system had not counted any of these as unplanned return attendances despite the fact that the clinical notes indicated they were.
- A review of the management of the fitting child to determine practice against guidance from the Royal College of Emergency Medicine (RCEM) was carried out. 100% of children who met the criteria for audit and who were actively fitting on arrival to the ED were managed in line with National European paediatric life support algorithms; this was in line with the RCEM standard and national median performance. 96% of children had a documented case history; this was marginally below the RCEM standard of 100% however was in line with the national median. 100% of cases had a presumed aetiology documented; again this was in line with national standards. 50% of children who were actively fitting on arrival had their glucose checked and documented; this was significantly worse than the RCEM standard and national median of 100%. Further, 33% of those caring for children who were discharged received written safety information. This was worse than the RCEM standard of 100% however was marginally better than the national median of 25%.
- The RCEM recommends that 90% patients who present to the ED with a diagnosis of urinary retention are catheterised within one hour and 100% within two hours. Between September 2014 and January 2015, 30% of patients were catheterised within one hour and 47% within two hours. This was worse than the national standard with a worsening trend noted for the number of patients catheterised within two hours when compared to 2013 department performance (57% of patients were catheterised within two hours).
- 85% of patients who presented with urinary retention received antibiotics in accordance with guidelines; this was worse than the departments 2013 performance when 100% of patients were prescribed antibiotics according to guidelines.
- We looked at 'Door to Needle time audit for Neutropenic Sepsis' audit performed in December 2014. We found 38% of eligible patients received recommended treatment within one hour. This was better than previous year (27%) but significantly below target of 100%.
- The department demonstrated improvements in four clinical measures for patients who presented with a diagnosis of urinary retention when compared to 2013 performance data; the number of patients who received analgesia (85% in this audit vs 71% in 2013); 83% had residual urinary volumes recorded vs 71% in 2013; 72% of patients had their renal function measured and recorded vs 62% in 2013 and 98% of patients were referred for specialist opinion vs 86% in 2013.

Competent staff

- We were provided with a summary of the percentage of staff who had completed their statutory and mandatory training. Most of the data provided was summarised at emergency and critical care and therefore included staff who worked within ED as well as the intensive care unit. The data showed that only 63% of the staff in the emergency and critical care directorate had completed basic life support in adults and only 45% were trained in basic life support for children. The trust had set a target of 95% compliance against this training. Across the division we saw that 61% of staff had completed training in consent.
- We asked the trust to provide us with training data for all health professionals who had undertaken training in advanced life support; we received a report which indicated that seven staff had been booked ILS (immediate life support training) for dates in October and November 2015. Two staff were reported as having undertaken advanced life support training externally however there were no dates associated with these references.
- There was a local induction process in place for bank and agency nurses, the induction consisted of a checklist used to ensure temporary staff who had no

worked in the ED previously were familiar with the environment and policies used by the trust. Matrons in the unit kept a record of staff which had been fully inducted. We spoke to two agency nurses who confirmed they had received an induction.

Multidisciplinary working

- The staff we spoke with told us that multidisciplinary arrangements worked well for the majority of the time although there were delays in patients being allocated beds due to delays from other speciality teams coming to see patients.
- Patients who presented at ED with mental health needs were treated for their immediate clinical needs and a referral was made immediately to the psychiatric liaison team for review. We spoke to three members of the liaison team who told us they had a very positive working relationship with the ED team. They said that when delays occurred in care this was because of a lack of available mental health beds in the region. ED staff also told us separately this was the cause of delays for patients with mental health patients and was consistent with the incident forms completed by staff.
- Children and adolescents were referred to the Children's and Adolescent Mental Health Service (CAMHS) team during office hours. Out of hours, advice was sought from the paediatric registrar. Children were admitted and referred to the CAMHS team during office hours if there were mental health concerns. Staff told us this system functioned well.

Access to information

- The information needed to deliver effective care and treatment was generally available to relevant staff in a timely and accessible way.
- Some patient records needed to be accessed electronically, using a login, for example x-rays. Staff told us they were able to access this, including locums.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was specific training provision for Mental Capacity Act (MCA) 2005 or Deprivation of Liberty Safeguards (DoLS).Data that showed that 88% of nurses and 97% of doctors had undertaken this training.
- The data provided by the trust showed that only one of the four matrons in the department had undertaken MCA training.
- Most of the nursing staff we spoke with had an understanding of the MCA and DoLS and were able to describe what action they would take if they needed to restrain a patient.
- Staff in the children's ED understood the principles of competence and consent in children. In the case of children. We saw a number of examples when staff asked children for their consent before undertaking a clinical intervention.

Are urgent and emergency services caring?

Requires improvement

The quality of caring provided to patients at Medway Maritime Hospital required improvement.

Most of patients and relatives we spoke with told us that they were satisfied with the care they received and felt that staff were working very hard. However, a number felt dissatisfied in being treated in the corridor and felt it compromised their privacy and dignity.

Compassionate Care

- The patients we spoke to were generally satisfied with the care they had received. However, four out of 28 remarked that staff seemed very busy.
- We saw a number of interactions where staff apologised to those waiting on trolleys outside of cubicles.
- We observed a number of very positive interactions between staff and patients. In one example we saw a consultant use both verbal and non-verbal communication with an elderly patient that obviously provided a great deal of reassurance.
- In other instances, however, we saw that privacy and dignity was not maintained. We saw four examples where staff conducted examinations of patients waiting in the corridor. In some cases this involved removing and lifting items of clothing. There was no visual screening available when this occurred. In three examples, patients were asked to confirm medical

history and in one case, consent to a procedure while they waited in the corridor. Staff in the ED said that this sometimes occurred due to a lack of examination cubicles but all accepted that this practice did not maintain dignity. Whilst these interactions were occurring a number of other staff members walked past, but none intervened.

- Patients who walked into the department discussed their reason for attendance with a nurse who was stationed next to a receptionist at the front desk, situated a very short distance from the chairs of the waiting room. We saw 10 occasions when the receptionist was taking another patient's details at the same time. This meant that both patients were given their information whilst stood next to each other. This meant privacy could not be maintained.
- The 'Friends and Family Test' is a method used to gauge patient's perceptions of the care they received and how likely patients would be to recommend the service to their friends and family. Feedback from patients was consistently below the England average from March 2014 and February 2015.
- We looked at data collected for the national patient's survey. The trust performed worse than the England average on a number of different questions including 25% of those surveyed answering that the staff did not listen to what they had to say and 70% answered that they hadn't the side effects of medication explained to them.
- The trust performed about the same as the England average with regard to questions about explanation of tests and reasons to seek further medical attention.
- Some of the patients we spoke to in the corridor felt they had been forgotten and one patient's relative described the care as "inhumane."
- Patients and relatives being cared for in cubicles were more positive, one relative remarked how compassionate a number of staff had been and that "nothing had been too much trouble," another said that "they have explained everything brilliantly."

Emotional support

- We were told by staff that they provided regular updates to relatives who were in a critical condition and that they were taken to a private room if staff needed to discuss 'bad news'. This room was set away from the resuscitation and included doors leading to a viewing room where relatives could spend time with a recently deceased loved one.
- Staff told us they could contact the hospital chaplaincy service if required.

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

Inadequate

The ED was inadequate in its responsiveness to patients' needs. There was inadequate patient flow through the department.

There were frequently delays in patients being moved from the corridor into the main department and some patients had long waits in ED with the primary causes were due to lack of beds available across the hospital as well as waiting for speciality doctors to assess patients.

Translation services were available although staff did not use these services if relatives were available to translate.

There was a complaints system in place which had recently been altered to improve response times and learning. There was a patient experience report which examined the themes that re-occurred in complaints.

Service planning and delivery to meet the needs of local people

- The ED was in the process of redevelopment when we inspected. One of the first areas of redevelopment which had been completed was the children's ED which was located separately to the adult ED. Patients and relatives in children's ED told us the area was a big improvement compared to the previous service provision.
- The senior team told us that the reason for this development had been an increase in the numbers of patients who attended each year and the age of the current ED. The department risk register stated that the department was designed to see 45,000 patients per year and now saw 95,000.

- Senior staff had identified that space within the department was very limited and that care was being delayed as a result. They had included this on the departments risk register in order to highlight this to senior management.

Access and maintaining flow through the department

- The national target for patients attending ED is for 95% of them to be admitted, discharged or transferred within four hours. The trust provided us with data that showed that Medway Maritime ED had last met this standard for a week in July 2014. On frequent occasions this figure fell below 80%. The senior team acknowledged that performance against this target remained an ongoing issue and various workstreams had been considered in an attempt to improve performance. Initiatives included the intrduction of a frailty pathway which was focused on managing frail elderly patients who met specific criteria. The department identified that whilst the length of stay patients admitted under the frailty pathway was reducing overall, this pathway had had limited impact on the overall capacity issues faced by the department.
- The performance report for the same period showed that an average of 4% of patients left before being seen. This was slightly higher (worse) than the England average for the same period of 3%.
- The previous CQC inspection had highlighted the delays in patient's care being transferred from ambulance crew to the ED staff. In response to this the department had employed their own paramedics and nurses to assume care of the patient waiting for a cubicle in the department. The most recent data for ambulance transfer times showed that 95% of the time the department took over care in 11 minutes. Less than 1% of patients waited longer than 30 minutes.
- During our inspection we observed that some patients remained in the ED for excessive periods of time. Patients could remain in the department for up to 12 hours once a decision to admit had been made. Department of Health guidance states that a patient must be admitted to a ward within 12 hours of a clinician's decision to admit them. We saw that the department was meeting this standard. However, it was only doing so, because clinicians delayed documenting their decision to admit on the patients record. We saw 5 cases where patients waited in excess of 12 hours prior to a decision to admit being made which meant they spent longer than 24 hours in total in the ED department.
- In one case we saw a patient who was very unwell wait longer than 12 hours prior to a decision being made to admit. We asked staff why this was they indicated that this was to help the trust meet its 12 hour admission target. We could therefore not be assured that patient care was not compromised in an attempt to meet national targets.
- We were told that the main cause for patients remaining in the department for too long or waiting for a decision to be made about their care was due to a lack of beds and delays in specialists from other departments coming to assess patients. Many staff said that when beds did become available it was quite late in the day. This meant that staff had to transfer the majority of patients at a time when there increased numbers of people in ED and therefore and increased workload. We witnessed this lead to further delays in transferring patients to the ward as staff were busy with other duties.
- We reviewed the reasons why patients breached the four hour target on the days of our inspection and saw that the primary reason for patients being delayed was due to waiting for an inpatient bed. In some cases the lack of space in ED was the key reason.

Meeting people's individual needs

- The staff we spoke with had a good understanding of how to care for patients with dementia. Some staff told us that patients with dementia would need to be spoken with calmly and cared for in a quiet area and we saw them undertake this in practice. When the ED was busy it was noisy and it was not always possible to provide patients with a quiet place to wait. There had not been an audit which had examined how the dementia friendly the department was.
- A translation telephone service (Language Line) could be accessed for patients who were unable to communicate adequately in English. However, we saw an example of a patient who attended the department with a friend who was able to speak English and Language Line was not initially offered or used. This meant that patients who were unable to speak English

were not offered the option of a translation service, and they may not discuss personal or medical issues via a friend/relative. Staff could not be assured of the quality or accuracy of the translation in this case.

- There were information leaflets about specific accidents, injuries/emergency conditions within the department. However, leaflets were only available in English.
- The paediatric area of ED had toys for children to play with. Children up to the age of 16 could be admitted to Paediatric ED.
- Due to building work, the minor injury treatment area was situated in an outpatients clinic some distance from the main department. The clinic did not have outpatient appointments being undertaken at the same time. This meant staff could clearly identify the group of patients for which they held responsibility We found that the signposting was not very clear. In one case, a sign for the department's clinical decision unit directed people in the wrong direction.

Complaints handling (for this service) and learning from feedback

- There was a central Patient Advice and Liaison Service (PALS). Patients had the opportunity to contact PALS via the telephone, by email or in person.
- We examined data provided by the trust which showed there had been a large reduction in complaints received regarding ED from twenty in July 2014 to eight in July 2015.
- We asked the trust to provide us with data that showed how quickly they responded to complaints made in ED. In the month prior to our inspection the department had responded to 27% of complaints within the agreed trust time frame of 30 working days. This meant in the majority of cases peoples complaints were not responded to in a timely way.
- We were told that complaints were communicated to staff at their daily handover meeting and/or to individual staff members as appropriate. Staff we spoke to confirmed that this happened.
- The ED patient experience report included a section on the action taken following complaints. One of these complaints had concerned a patient who had been clinically examined and had some of their clothes removed during the examination. Whilst on our inspection we saw that this practice was still occurring.
- The complaints log for the ED included a senior member of staff who was responsible for investigating and responding to the individual complaint. We saw that the names on this log included some of the ED matrons. We asked the ED matrons if they had received any training on how to manage complaints and they told us they had not. This meant we could not be sure that the investigation or response was adequate.
- Staff could not tell us of any examples of where feedback from patients and relatives had influenced service provision.

Are urgent and emergency services well-led?

Inadequate

The emergency department was not well led.

An escalation policy which aimed to improve the flow and service provided within ED was in place. However, staff told us they rarely saw tangible help from senior members of the trust when they escalated concerns such as capacity issues.

Senior medical leadership was visible and supportive. However, strategic nursing leadership was absent and it was not clear which areas of nursing care was managed by which member of the senior nursing team. Senior nurses felt unsupported in their role and one told us they had "been left to get on with it."

A governance committee structure was in place, and audit updates were presented at the committees although not all included action points and discussion. Performance reports showed data that did not correspond to figures produced elsewhere in the trust.

The risk register had identified the key risks in the department but were not dated, so it was not possible to see when they had been first identified. The register included actions undertaken, although these were brief and in places not specific.

Urgent and emergency services

The department did use a dashboard to monitor the activity in real time. Other data was collected by the trust information team. We saw that some of the data did not correspond and therefore could not be assured decisions were being made based on accurate data.

Patients and staff were given the opportunity to provide feedback about the service, although it was not clear how feedback was acted on.

Vision and strategy for this service

- Most staff understood the plans for a reconfigured ED, although junior staff had not been included in discussions.
- The department had developed a recovery plan for the ED with support from external experts. Objectives and outcomes had been defined along with the delivery and governance structure. Work streams and key milestones had been set out for ED transformation. This was monitored at department meetings.

Governance, risk management and quality measurement

- The ED held a monthly Clinical Governance meeting which was the main forum to discuss complaints, mortality, audits, incidents as well as the departments risk register.
- There was a divisional governance meeting which also received information on patient safety, audits, mortality and morbidity, new and changing guidance and policy updates. Meetings for these minutes were made available for staff to refer to.
- Managers within the department met regularly to discuss the progress of ED and issues that affected the department.
- Senior members of the ED team attended divisional meetings.
- We were told that nursing meetings took place. We reviewed the minutes from the previous meetings. The meeting for senior band 7 nurses were detailed and included action points assigned to individuals so that responsibility for these actions could be tracked. This was not the case in the band 6 and junior band 7 meeting which made it difficult to track actions to individuals.
- The department's quality and safety meetings included discussions around health and safety, serious incidents and pressure ulcer care. The minutes of the meeting were not detailed in all areas indicating items on the agenda had been discussed but not detailing the content of the discussion. This meant that anyone who wished to review the notes could not be sure of the content of the discussion or the person who had been assigned to investigate and provide feedback and recommendations to the group.
- From the minutes of a meeting in June 2015 we noted there was a discussion regarding a temporary shortage of administration staff which had left the department with no administration staff for a period, although the length of time was not clearly defined. This had been highlighted as a 'risk to patient safety'. There had been no discussion documented regarding the avoidance of this in the future. This demonstrated that issues were not sufficiently managed to fully understand the issues and to identify actions that would prevent recurrence.

Leadership of service

- Local medical leadership worked well. The clinical management from the medical lead was well established and the staff we spoke with reported that they had good relationships with their immediate manager and that they would feel comfortable in talking to more senior management within ED if they needed to.
- Nursing leadership in the department functioned on a day to day basis, but the strategic leadership of the nursing workforce was lacking. The trust had recruited four matrons to run the department and had initially also employed a senior nurse senior to them to provide overarching leadership. At the time of our inspection there was no-one in this post and so there was no one individual with overall nursing responsibility for the department.
- The matrons told us that they had areas of responsibility which they managed. Some of these areas were clearly defined, other areas such as incident investigation was not clear. Junior staff told us that they found the senior nursing structure confusing and the lack of an individual with overall responsibility meant they were not always sure who to approach with concerns.

- Junior medical staff reported to the on duty consultant or a senior registrar for advice and support, they told us this worked well.
- Previous inspections had highlighted a lack of visibility in the department for the nurse in charge and consultant. On this inspection we saw that both the nurse and consultant in charge were wearing badges identifying them. We saw them remain in the department throughout their shifts supporting junior staff.
- When we returned to the department in the evening we saw clear leadership, particularly from the nurse in charge.
- We were told by the senior ED team that consultants in department wore grey uniform to make them easily identifiable to staff. We returned to the department a week after the inspection and saw that this was not happening consistently, as the consultant was wearing their own clothes. This meant that they were not so easily identifiable.
- The department had an escalation policy available to staff. However, we found that there was a lack of support from senior managers of the trust. When we asked staff in the ED about the response from the senior team at times of high patient activity they told us that they rarely saw anyone from the senior management in the department to support them.

Culture within the department

- Staff told us that the department had been on under a lot of pressure for an extended period of time, though they did tell us that things had improved in the department in the last year.
- We saw very positive interactions between all staff groups.
- We were told that staff were able to raise issues as part of the daily handover or as part of their annual appraisal.
- Most of the staff we spoke with told us that they felt confident in raising concerns with management.

Public engagement

- Patients are given the opportunity to provide feedback via the 'Friends and Family Test'.
- There was no user group connected to the ED and there had been no public engagement regarding the design of the new ED.

Innovation, improvement and sustainability

- We did not see robust evidence of continuous learning, improvement and innovation throughout the ED.
- Staff told us they aspired to continually improve the quality of care but current staffing pressures impacted on the longer term planning for the ED.

Medical care (including older people's care)

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

Information about the service

At Medway Maritime Hospital, medical care services were managed by the Division of Acute and Emergency Medicine and Critical Care. Specialities included acute medicine, (including ambulatory care), gastroenterology, respiratory medicine, cardiology, endocrinology, geriatric medicine, clinical haematology and stroke. Endoscopy services were managed by the Division of Surgery and Anaesthetics.

Medical care services had a bed compliment of about 342 inpatient beds in 14 wards including the acute medical unit. There were 23,800 admissions to medical care services at Medway Maritime Hospital in 2014/15, of which 59% were emergency admissions, and 39% were day cases. By far the majority of admissions (50%) were in the speciality of general medicine with gastroenterology as the second most utilised (14%).

We inspected medical care services as part of our comprehensive inspection published in July 2014. At that inspection we judged that overall the service required improvement. All the domains we inspected were rated as requires improvement except caring which was rated as good.

During our announced inspection we visited all the medical care areas and wards managed by the division and endoscopy. We carried out an unannounced inspection on the 8 and 9 of September 2015, which included an evening visit.

To help us understand and judge the quality of care in medical care services at Medway Maritime Hospital we used a variety of methods to gather evidence. We spoke with 12 doctors including seven consultants, about 40 registered nurses including ward managers and matrons, and 10 healthcare assistants. We also spoke with about six allied health professionals and 16 other support staff. We also spoke with about 28 patients and about six patient's relatives. We interviewed the Divisional Management Team. We observed care and the environment and looked at records, including patient care records. We looked at a wide range of documents, including audit results, action plans, policies, and management information reports.

Medical care (including older people's care)

Summary of findings

We found the learning from some serious medicines incidents had not become embedded in practice. Rates of harm free care were worse than England averages. We observed medicines that were inappropriately stored. Clinical environments were not clean and hygienic and some needed refurbishment. Not all staff were completing their mandatory training. Nurse staffing levels showed frequent short-falls and there was an over reliance on agency nursing staff and medical locums.

We found patients' outcomes were worse than expected in some specialities with mortality rates higher than the national average. Practice did not always comply with the requirements of the Mental Capacity Act, Deprivation of Liberties Safeguards. We found staff were not always supported in their development through appraisal. However, services were generally available seven day a week. There were adequate arrangements to ensure patients received adequate pain relief and had enough to eat and drink.

Services were not responsive to people's needs as patients were unable to access the care they needed as a result of inadequate management of demand and patient flow through the hospital. The flow of patients through the service did not function as intended. Patients were frequently treated in mixed-sex wards. Discharge planning was inadequate and there were high levels of delayed transfers of care.

The vision and values of the organisation were not well developed or understood by staff. The leadership of the service was constantly changing which meant there was no clear focus on achieving objectives and management time was predominantly spent managing staffing and patient flow crises. Strategic planning and operational management were hindered at all levels by the availability of reliable, easily understood data. Staff satisfaction was mixed, and some staff reported feeling bullied. There was a limited approach to obtaining the views of patients.

We observed staff interactions and relationships with patients and those close to them as caring and supportive and they responded with compassion to pain, emotional distress and other fundamental needs. Staff treated patients with dignity and respect and people felt supported and cared for as a result.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

Although there was good reporting and identification of learning from safety incidents, we found examples where learning from serious incidents had not been implemented and there was an increased likelihood of recurrence as a result.

Nurse staffing levels showed frequent shortages which compromised safety or effectiveness. There was an over-reliance on agency nursing staff and medical locums which created potential safety risks.

Patients' safety was compromised by the inappropriate storage of medicines. Confidential patient records were not securely stored.

We found instances where clinical environments were not maintained in a clean or hygienic state which presented infection risks. We saw that the clinical environment needed refurbishment and derelict areas were used for storage. Fire exit arrangements were not always robust.

Rates of harm free care were consistently worse than the England average. Specifically, average rates for new venous thrombus embolism, pressure ulcers and catheter associated urinary tract infection were worse than England averages.

Mandatory training was not being consistently completed meaning staff may not have the necessary current skills to do their job.

Incidents

- Incidents were reported using a commercial software system that enabled incident reports to be submitted from wards and departments via an electronic reporting system. Managers told us that all staff, including support staff could access this system to report safety incidents. Staff we spoke with confirmed this and demonstrated its use.
- There were 1253 safety incidents reported during February - May 2015. Of these seven were reported as deaths (0.6%). Forty resulted in moderate harm (3.2%) and 737 resulted in no harm (59%). For incidents involving staff, seven were recorded as resulting in injury lasting more than three days, 435 caused temporary harm (35%), and 28 no harm. There were four causing permanent harm, and one with an unknown outcome. The high numbers of low and no harm incidents reported suggests a good reporting culture.
- There was one 'Never Event' for wrong site surgery reported in Dermatology. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- The top reporting wards were Acute Medical Unit (11% of total), and Milton and Will Adams wards (9% each of total).
- Between May 2014 – April 2015 there were 31 serious incidents requiring investigation reported to STEIS (Strategic Executive Information System); the national reporting system for serious incident. Of these, 14 were slips, trips and falls (45%) and five (16%) grade 2 pressure ulcers.
- All staff we spoke with were aware of the major safety concerns within medical care services. They told us they were patient falls, staffing issues and concerns regarding patient flow.
- There were arrangements to ensure that safety incidents were investigated. There y was a system of rapid safety reviews that ensured events were investigated promptly and actions taken. Serious incidents were subject to a root cause analysis. We saw examples of these investigations and noted that they were sufficiently thorough and identified lessons learnt and actions to be taken.
- One example was how the results of an RCA had identified that an ECG had been administeredrecorded incorrectly giving a false/ positive reading. Minutes of a Bronte ward meeting showed that the incident had been discussed at ward meeting. Emails showed how the learning had been escalated to the cardiac nurses for use at the teaching scenarios held for junior doctors. We saw that the agenda for the next junior doctors training showed the item was listed.
- However, we found there were two serious incidents in 2013 involving midazolam, a potent sedative. The

incidents resulted in the death of two patients. One of the actions following analysis of the incidents was to introduce a safe sedation policy. A policy was written in June 2014 but has since been removed from service. We did not see any evidence of a safe sedation policy in use.

- Another action was the restriction of the supply of midazolam to certain wards. The Acute Medical Unit should not hold midazolam injection as stock. However, on the inspection we found a box of midazolam in the CD cupboard that was not labelled. Harvey ward should not hold midazolam as stock. The controlled drug cupboard contained one box of midazolam for a patient that had passed away and one box of midazolam for a patient who was on the ward and had the medicine prescribed. This demonstrated that the learning from the midazolam incidents had not been fully embedded in practice and therefore the mitigation against recurrence was not realised.
- Staff we spoke with told us, and we saw from meeting minutes, that information regarding safety incidents was shared with staff. We saw that the outcomes of investigation were discussed in ward-based newsletters and handovers and at ward meetings. There was suitable discussion about the lessons learnt, and changes in practice needed to prevent recurrence.
- There was a system for each clinical speciality to hold monthly Mortality and Morbidity (M and M) meeting to review the care of patients who had died or had experienced complications in their treatment. We looked at the cardiology meeting minutes and found there were sufficiently detailed discussions of the care of patients, and that learning and action points were identified. The management team supplied us with a log that showed that although these meetings were occurring they were not being held at the frequency expected. In the period January – July 2015, four were held in acute medicine, four in respiratory medicine, three in haematology, two in care of the elderly and none in endocrinology, instead of the expected seven for each of the specialities.
- All staff we spoke with were aware of the need to be open and transparent when things went wrong. Senior staff were aware of their obligations relating to the duty of candour regulation but junior staff were less so. There were systems to ensure that the duty of candour was considered and followed in serious incidents. We saw clear prompts were included in the investigation templates that we saw completed to ensure that process was followed.

Safety thermometer

- Medical care services at Medway Maritime Hospital participated in the national safety thermometer scheme. The NHS Safety Thermometer is an improvement tool to measure patient 'harms' and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections. Ward managers collected monthly data.
- There were no arrangements for staff at ward or departmental level to be informed of their individual performance in the safety thermometer. This meant that they could not use this information to track trends in improvement or identify emerging concerns.
- A rate of harm free care was consistently worse than England average since May 2014 across the trust. For example in April 2015 the score was 86% compared to a national average of 94%. Average scores for new venous thrombus embolism, pressure ulcers and catheter associated urinary tract infection were worse than England averages. Rates were better than average in relation to falls with harm.
- The divisional Quality and Safety Report for June 2015 states that from June 14 – May 2015 there was a total of 827 falls. For individual wards, the range was from three to 136. For falls leading to fracture of a bone, there were 15 in same period with range from zero to four for individual wards.
- The divisional Quality and Safety Report for June 2015 also noted that 81 grade 2 pressure ulcers but no grade 3. There were 57 pressure ulcers that were reported as ungradable. For PU grade 2 have reported 81, grade 3 - 0 and 57 as upngradable.
- Key safety information such as days since the last fall, incidence of pressure damage or avoidable infection was displayed at the majority of at ward entrances in

a format that was easily understandable to patients and their families. However, some of this information related to the performance of the directorate, not the individual wards so was of less interest to patients and their families.

Cleanliness, infection control and hygiene

- We observed that cleaning schedules and the results of cleaning audits were displayed in clinical areas.
- The National Specifications of Cleanliness (NSC) requires hospitals to risk rate clinical areas, and sets out leaning standards, frequencies and monitoring arrangements for each risk category. We checked 25 high risk areas over the preceding five months (March 15 to July 2015. The trust was auditing these areas monthly, in line with the NSC auditing frequencies. The NSC requires trusts to achieve a percentage pass rate of 95% for this risk category. Out of the 125 audits checked 54 failed to meet the percentage required by the NSC, effectively 43.2% of audits, over this period failed to meet the requirements of the NSC audit. Keats ward did not achieve the standard required at all during this period.
- We inspected the cleaning standards on Gundulph ward in detail and found the environment was not in a clean and hygienic state. For example, we found the sanitary ware to be stained, and were told it was associated with the water treatment. In bathroom 38 we found the bath has ingrained grime and had been out of commission since February 2015. Internal window sills had dark coloured dust. The hoist was dusty and the integrated plumbing system (IPS) boarding had thick dark coloured dust at high level. There was paint flaking on walls which made cleaning difficult as walls should be sound and impervious. The bathroom at the end of the main ward had dark coloured dust high level throughout. Basins, shower base and toilets had ingrained scale deposits. The radiator in the corridor approaching the toilet had cobwebs within and flaking paint above. There was mould on the sealant around the shower base and sealant coming away from the wall. We saw black dust and debris secondary glazing. We observed dried faeces and toilet paper on the toilet brush.
- We carried out an unannounced inspection after 10 days and revisited Gundulph to check the cleaning standards. We found most of the issues we had found previously had yet to be addressed and that the clinical environment was not maintained in a clean and hygienic state.
- On Gundulph ward we checked 18 disposable curtains and six were undated, the 12 that were dated all were within the date expected. We were told that all curtains were changed every six months and the dates ones were within this time scale, there was no way of telling when the undated ones were due for change. We brought this to the attention of the Facilities Manager and there was no explanation for the error, there was also no evidence that records were kept elsewhere so as the date of the undated curtains could be established. We were told it was the trust's procedure to change curtains every six months however with the undated curtains it would be impossible to tell when they were due for changing. This potentially could lead to curtains being left beyond the six month change period.
- We checked the cleaning checklist and the cleaner told us they high dusted every day although on the checklist it was down to be completed on a Monday and checked on a Thursday. Given what we found it was very unlikely the high dusting was done every day. According to the checklist the high dusting was to be done on a Monday, but it was signed that the high dusting had been completed every day Monday through to Wednesday. The thickness and colour of the dust, showed the high dusting in the areas highlighted above had not been done in line with the cleaning checklist. This may show a lack of understanding by the cleaner and possibly indicates their training was insufficient. It could also bring into question the validity of the checklists.
- On Dickens ward we observed that one toilet bowel was dirty, and had lime-scale deposits. A shower base was stained and showed signs of mould. One male toilet on Keats ward was badly stained and visibly dirty under the rim indicating that it had not been cleaned.
- We saw that shower cubicles were badly stained and sealant areas were black with mould on Keats, Gundulph and Will Adams ward. On Keats ward the shower curtain in one bathroom was found to be of domestic quality and unsuitable for a hospital environment.

- On all wards we found toilet sanitary wear to be lime scale stained.
- We spoke with members of the specialist cleaning team who had been called to a ward to carry out a deep clean following a patient discharge. They told us they felt they had received adequate training and were well supported by their supervisors. They showed us the cleaning schedule they were required to complete and clearly understood the various components. They told us they had no difficulty obtaining the cleaning supplies they needed to do their job.
- In the year May 2014 – Apr 2015 there was one case of MRSA blood stream infection. There were 101 MRSA acquisitions after 48 hours of admission, (which suggests the colonisation occurred in hospital) averaging about eight a month. There were 23 SSA blood stream infections during this same year.
- We saw that patients with indwelling devices such as urinary catheters, had care planned as care bundles in line with Department of Health Guidance ('Saving Lives' 2011). We saw these care bundles in use and saw they were consistently completed by staff. We saw results of a 'Saving Lives Compliance' audit dated April – June 2015. Compliance rates for urinary catheters were 87%, for peripheral lines 91% and for central lines 87% which showed that care was being given in accordance with national guidance.
- During the year May 2014 to April 2015 there were 12 cases of C diff infection after 72 hours admission (suggesting infection in hospital). The divisional risk register of June 2015 noted increase in C Diff cases as a risk.
- We saw the results of 13 'Infection Control Audit Tool – Acute Ward' exercises. These were carried out March - May 2015. The results for individual wards ranged from 76 – 93% with an average of 82%. We saw that action plans had been developed to address both immediate and longer-term concerns.
- We saw 15 individual monthly hand hygiene results dated May 2014 - April 2015. The results ranged from 17% - 100%. The overall average was 92%. We saw that hand hygiene audit scores were displayed in ward areas. We noted that generally these were above 90%. We saw there were adequate hand washing facilities and supplies of soap and paper towels. Hand sanitizer was available by individual beds and at ward entrances with reminders for the staff and the public to use it. We observed staff and saw they generally washed their hands in line with the World Health Organisations guidance 'Five moments of Hand Hygiene'. We noted nurses used soap and water after contact with patients with C diff when hand sanitizer would have been ineffective.
- Equipment that was shared between patients, including commodes was cleaned after each use using disinfectant wipes. We observed staff doing this. Distinctive labels were in use to indicate that equipment was clean and ready for use. Staff consistently told us that if a label was not present then they would need to clean the piece of equipment before use and they would not be sure it had been adequately decontaminated since its last use. However, although the stickers were used they did not offer assurance that the item was clean. For example a clinical trolley located in the treatment room on Keats ward displayed a sticker with a cleaning date of 06/09/15 but it was visibly dirty with dried water marks, smears and hand marks.
- There were systems to ensure commodes were kept clean. In addition to the label system, we saw completed checklists which showed commodes were thoroughly cleaned each day irrespective of use and periodic checks by a senior nurse. There were commode cleaning audits and the results for April 2014 – Jan 2015 ranged from 0% to 100% with an average score of 91%. However this system was not infallible. We checked a number of commodes and they were generally visibly clean. However, on Gundulph we found one that had brown stains underneath despite being labelled as ready to use and a senior nurse check having been documented.
- On some wards we visited we found that some patients were isolated for infection control reasons. These patients were nursed in single rooms and we noted that necessary precautions were clearly displayed on the doors. We observed that staff followed these precautions although we did see that the room door was not always closed, for example of AMU and Bronte ward, despite the risks of the spread of gastro-intestinal infection such as C. Diff.

- We saw there were systems to segregate clinical and domestic waste. There were also arrangements for the separation of high-risk used linen. Mostly we observed that staff complied with these arrangements. However, on our unannounced visit we found domestic waste bins on Gundulph and Keats ward which contained clinical waste.
- We observed that sharps management generally complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw that sharps containers were used appropriately and they were dated and signed when brought into use and closed.
- We noted that in most storage areas including sluice rooms and stock cupboards, boxes and other items were stored on the floor which impeded proper cleaning and could damage the integrity of packaging. We found some derelict rooms being used as storage areas; the trust took immediate action to decommission these.
- We saw mandatory training records that indicated 9% of staff were categorised as red (i.e. not up to date) with infection control training.

Environment and equipment

- We found there were emergency trollies which contained all the equipment including a defibrillator, to manage a medical emergency such as a cardiac arrest. We saw that these trollies were fully stocked and ready for immediate use. There was a system for checking these daily, with a more thorough weekly check. We looked at the recording sheets for these checks and saw that generally they were checked, although we found odd days when the checks were not signed as completed. For example, on AMU the check sheet from 1 – 25 August 2015 showed checks were not recorded on the 6, 9 and 18 August.
- Staff were assessed as competent before they used any medical devices. Examples of these competency assessments of staff records were kept in ward areas. Agency nurses signed a disclaimer that they knew how to use equipment but there was no process for ward staff or managers to be assured of this.
- We saw that clinical equipment was maintained by the electrical medical equipment (EME) department and was labelled to show that it had been checked and maintained. There was an efficient system of twice-daily collections from the ward for equipment following use. Staff told us that they did not experience difficulties accessing equipment when needed. We checked three hoists on Gundulph wards and saw that they had all received their annual safety checks from the manufacturer.
- Hospital mattresses were fit for purpose and provided protection from infection and pressure damage. Where the risk of pressure damage was particularly high, staff could access specialist dynamic mattresses to ensure patients' needs were met and they were protected.
- We observed that the clinical environments in many wards in medical care services were cramped, old and in some cases were difficult to maintain. There was insufficient storage space which meant clinical areas were often cluttered making it difficult for staff to provide care and move around. We saw that the decorative state of ward areas was variable.
- We saw examples of chipped paintwork and plasterwork, stained ceiling tiles and flooring mended with tape. In bathrooms and toilets located in the corridors at the end of Gundulph, Keats and Will Adams wards we found that radiators were badly scratched exposing bare metal. Main corridors in ward areas on Will Adams ward and Keats ward were seen to be badly torn in places. Remedial actions had been taken including sealing the tears with protective tape but this was now dirty and lifting. This meant there was a risk of trips and falls.
- Exposed holes in top of protective radiator covers had prompted people to use it as a disposal bin. Used tissue and hand wipes were visible inside radiator cover on two wards.
- Staff told us that the maintenance department responded quickly to report of maintenance tasks. We saw that there was a system where work was reported by telephone and logged in a maintenance book. We saw examples of this book and saw that all maintenance requests were clearly documented. However, the sections to be completed by maintenance staff were not filled in which meant ward staff could not be assured if and when jobs were

completed. The estates manager told us that there was an audit trail however, as all jobs and their department recorded their outcomes were recorded centrally.

- Access to clinical areas was controlled by entry phone systems. We noted that all systems were working. We saw posters urging visitors not to let other visitors 'tailgate' on entry. We were asked to show our identification when we entered ward areas. This meant access of unauthorised people to ward areas, and access to patients was controlled to promote their safety.
- On Will Adams ward we found that the fire exit door was automatically activated when the fire system was engaged but the door could be manually opened using a key held by the nursing staff. We were told that this was to facilitate cleaning of the exit corridors. The Operational Estates Manager and the Building Manager who after 15 minutes trying to locate the key to this door, eventually disabled the mechanism to gain entry accompanied us. We found that the exit corridor was dirty and full of litter and rubble indicating that it had not been cleaned. A redundant medications trolley was obstructing the passage. When following this exit route we found two rooms dirty, unlocked and being used as an additional storage facility. One room contained large quantities of paint and painting equipment and the other was being used as additional storage for items of equipment to be used for patient personal care being stored on the floor. This included disposable curtains, slipper pan liners and hand washing towels.
- On Gundulph ward we found the fire exit route at the rear of the ward was obstructed with chairs. The fire exit door was automatically activated when the fire system was engaged but the door could be manually opened using a key held by the nursing staff. We were told that this was to facilitate cleaning of the exit corridors. We obtained the key and found that the exit corridor was dirty and full of litter and rubble indicating that it had not be cleaned. When following this exit route we found two rooms dirty, unlocked and being used as an additional storage facility. One room contained broken and redundant items of equipment and the other contained disposable items of equipment to be used for patient personal care being stored on the floor.

Medicines

- Medicines were stored securely to minimise unauthorised access. We observed that medicine cupboards and trolleys locked and key held by appropriate staff. Bedside medicines storage containers for patient's own medicines were also locked.
- d.Medicines trolleys and refrigerators were clean and tidy.
- We found all items in medicines trollies and refrigerators were within date with the exception of Sapphire ward where one expired item was found. Oral liquids did not have dates of opening on them which made it difficult to judge whether they were still fit for use. There was a system of expiry date checks by pharmacy, except on Sapphire where nurses did this.
- The Acute Medical Unit (AMU) managers noted a trend in incident reports about patient own drugs (PODs) being left behind when a patient is transferred between departments. AMU has implemented the practice of leaving POD lockers open when they are empty in response to this and prevent recurrence. We saw this happening on the ward.
- In ambulatory care community prescriptions were tracked to ensure that access to them was controlled and that no prescription forms were missing.
- We found that pharmacy staff completed medicines reconciliation. Medicines reconciliation is the process of confirming an accurate list of medicines that a patient is taking. We saw data that showed a pharmacist completed a medication review within 24 hours in 65% of admissions. This ensured that medicines treatment was accurate, effective and safe. Drug allergies were always recorded, including on prescription charts.
- Pharmacy staff completed Controlled Drug (CD) audits. Controlled drugs are medicines that are likely to be mis-used so have additional legal requirements regarding their storage, prescription and administration. On Sapphire ward we saw a CD audit

report that was dated April 2015; this audit had some amber sections of the red, amber, green (RAG) rating. There was a follow up audit in July 2015. The ward manager said that all RAG ratings were green although she could not find the audit report. When CDs were ordered it was unclear whether pharmacy staff were able to identify the member of staff who signed the order as staff told us they did not have to provide pharmacy with a specimen signature for identification purposes.

- We saw that ward staff completed controlled drug checks daily. We noted the occasional day when this was missed but overall they were consistently completed.
- We saw there were systems to ensure the secure management of medicines that were no longer required.
- Prescriptions generally met legal requirements and were legible and signed. However, bleep numbers were not always indicated in accordance with local policy.
- We observed that administration of medicines generally met the guidance issues by the Nursing and Midwifery Council (Standards of Medicines Management 2015).
- Nurses wore a red tabard when administering medicines to prevent unnecessary interruptions which could distract them and increase the potential for error.
- There were suitable arrangements for the management of chemotherapy medicines on Lawrence ward. Colour coded chemotherapy bags were used to identify whether chemotherapy was to be delivered to the ward or the day unit. Chemotherapy was stored in a designated refrigerator separate from other medicines. Extravasation kits were available so any extravasation events could be dealt with immediately to minimise the risk of harm to the patient.
- We judged there was an outstanding warfarin counselling service provided by a dedicated pharmacy team provided for newly started patients at discharge.
- We found an excellent system for self-administration of insulin which included an assessment of technique on at least two separate occasions by nursing staff. The wards had POD lockers and there was a self-administration policy but there was no evidence of patients self-administering any other medicines.
- The trust did not have a policy on monitoring the ambient (room) temperature where medicines were stored. Room temperatures were not being monitored on AMU, Sapphire ward, or Harvey ward. Room thermometers indicated a temperature of 27°C in AMU and Harvey treatment room areas. This meant medicines were being stored at above the manufacturers recommended temperatures which could make them less effective.
- The AMU medicine refrigerator temperatures were not being recorded in accordance with the updated policy. Only the current temperature was being recorded. Therefore there was no record of the range of temperature that the fridge had been running at over a 24 hour period. The refrigerators maximum temperature was reading 26.7°C. There was no record of any action taken and the thermometer had not been reset. On Lawrence ward the maximum refrigerator reading was 10°C, which is above the recommended temperature of between 2-8°C. Staff showed they did not understand the form as they were recording the minimum and maximum temperatures recommended, not actual, temperature. This showed that refrigerator medicines may have been exposed to temperatures that could reduce their efficacy and safety and that staff were unsure of the monitoring systems in place.
- We found Glucagon stored in discharge lounge medicines cupboard, not in refrigerators as it should be.
- On Lawrence ward we found Suxamethonium in the ward medicine refrigerator. This is a potent drug used in anaesthesia as a muscle relaxant and should only be available in specialised areas where its use is understood and defined.
- Missed drugs were reported at ward huddles and staff were advised to ensure drugs were available to avoid missed doses or to obtain drugs from the emergency pharmacy.
- We could not locate a critical medicines list. Therefore the hospital was not complying with NPSA/2010/

RRR009 (Reducing harm from omitted and delayed medicines in hospital 2010). A Critical Medicine list should reduce the chance of patients missing doses of important medicines.

- We found Chloramphenicol eye drops in a refrigerator with no discharge medication label. Nurses told us they gave these to patients which means that legal labelling requirements were not met.

Records

- Confidential patient records were not always stored securely. We saw numerous examples where medical records were stored in unlocked trolleys in corridors and waiting areas where they were left unattended. We saw a room containing many sets of patients' records on Gundulph ward which was unlocked and open despite being fitted with a digital lock. This meant there was a risk of unauthorised access.
- Patients' records were multi-disciplinary in that doctors, nurses and therapists contributed to a single unified document. Staff told us they found these helpful and they supported consistent approaches to patient care. We saw that nursing staff had developed the way in which they formatted their entries and used a systems-based recording method. This ensured that relevant information was not omitted and that the entry was easy to follow and understand.
- We saw that patients were risk assessed in key safety areas using nationally validated tools. For example we saw that the risk of falls was assessed and that the risk of pressure damage was assessed using the Braden score. We noted that generally when risks were identified relevant care plans which 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.
- Records were well maintained and easy to navigate. They were generally compliant with guidance issued by the General Medical Council and the Nursing and Midwifery Council, the professional regulatory bodies for doctors and nurses. The records we viewed were comprehensive, contemporaneous and reflected the care and treatment patients received. Patient records were readily accessible to those who needed them.
- However, we noted that records of 'intentional rounding' (whereby patients are attended at set intervals to ensure all their needs are met) were not consistently completed, often with an absence of recording for a whole day. We also noted that food charts were not always fully completed.
- Other records we requested in ward areas, such as duty rotas and safety information that were relevant to the running of the service could usually be produced without delay either in paper or electronic formats.
- We saw mandatory training records that indicated that 73% of staff were categorised as green (i.e. up to date) with information governance training.

Safeguarding

- We saw there were posters displayed in ward areas advising staff and the public of the steps to take if they felt a person in vulnerable circumstances was being abused, or at risk of abuse.
- We spoke with care support workers and registered nurses who were able to tell us the steps they would take if they suspected abuse. They knew where to find relevant safeguarding policies and contact numbers using the intranet system. We were given examples by both registered and unregistered staff of how they had recognised potentially abusive situations, and escalated concerns. They went on to tell us how investigations were undertaken and how they participated in these. They told us about the protection plans they introduce in these situations.
- Patients we spoke with told us they felt safe in the hospital.
- We saw mandatory training records that indicated that 25% of staff were categorised as red (i.e. not up to date) with level 1 safeguarding adults training, for those requiring level 2 training, 30% were not up to date. We also noted that 34% of staff were not current with level 2 safeguarding children training.

Mandatory training

- The trust had a programme of mandatory training that staff were required to undertake at specified frequencies. There was some variation in exact requirements depending on job role. We reviewed the programme and noted that it contained training that

covered statutory requirements, and the key major risk areas at appropriate frequencies. Much of the training was available as on-line learning packages. No staff we spoke with described difficulties accessing these electronic training packages. Staff we spoke with were aware of the mandatory training they were required to undertake.

- We spoke with ward mangers who monitored the completion of mandatory training for their teams. We saw that they had electronic systems which recorded the training that was required and its completion dates. We saw there was a Red/Amber/Green system in operation to alert them, and staff when training was due, or overdue.
- We looked at the mandatory training rates. We saw that 69% training requirements were categorised as green, 5% amber and 26% red. The trust target for mandatory training was 95% and this was not being met. This meant that over a quarter of mandatory training was not current and that staff may not have the essential skills to do their job.
- We spoke with a long-term locum consultant who reported they had completed their mandatory training through their agency.
- Agency staff, which represented a significant portion of the nursing workforce, were not included in mandatory training monitoring.
- On an elderly care ward, the ward manager had tracked the yearly changes in mandatory training rates and these had improved. One member of staff who had difficulty in achieving the pass mark for a particular module was given alternative learning modules to enable success.

Assessing and responding to patient risk

- We found that patients physiological parameters such as pulse and temperature were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' We watched observations being taken and noted that the technique used deterioration of their condition.
- We checked observation charts and saw that physiological parameters were conducted at appropriate frequencies.
- Medical care services utilised the National Early Warning Score (NEWS) to assist in the identification of patients at risk of deterioration. We noted on observation charts that these scores were calculated consistently and accurately. We tracked several instances of increased scoring, indicating a potential deterioration, and saw where escalation protocols were followed, or the rationale for not doing so was documented. This indicated that potential deterioration in a patient's condition was escalated.
- There were arrangements for staff to access a critical care outreach team to support and advise in the care of very sick or deteriorating patients twenty four hours day. We saw examples in patients' records where the outreach team had responded to requests to support staff in the care of acutely unwell or deteriorating patients. Ward staff we spoke with told us the outreach team was easy to contact and responded quickly to calls for assistance and they valued the support they provided
- .During our inspection we identified a room that was being used to facilitate cardiac procedures. Patients in this area were receiving sedative drugs which required appropriately skilled staff with advanced airway skills to ensure a safe environment for recovery. Guidance from the Royal College of Anaesthetists GPAS 2015 states "dedicated skilled assistance for anaesthetic must be provided in every situation where anaesthetic & sedation is administered." We found that the provision of this support was intermittent and dependant on who carried out the procedure. For instance, if the planned procedure list was being facilitated by theatres, an ODP (Operating Department Practitioner) was provided. However, if the list was being undertaken by an anaesthetist from the critical care unit, support was provided by a junior doctor and not a specialist ODP with advanced airway and recovery skills. We also found there was no formal clinical oversight of the service provided in this back room. There was also no quality control measures in place to monitor the service being provided.
- We saw mandatory training records that indicated 42% of staff were categorised as red (i.e. not up to date) with adult life support training.

- Risks, such as falls, were communicated to staff using symbol displayed on a magnetic whiteboard above each patient's bed.
- On Dickens ward we saw there was a comprehensive range of risk assessments that had been carried out using a standard trustwide format. For example, there were risk assessments for pregnant workers, manual handling and external contractors working on-site.
- We saw that ward areas had dedicated sepsis boxes to ensure that prompt treatment could be initiated if developing sepsis was identified.
- We noted that wards had introduced safety huddles at points through the day. We saw these huddles operating. On Sapphire ward these were held three times daily and we saw that topics such as deteriorating patients' condition, fall risks, pressure area care, mental capacity, medicines issues and infection risks (including sepsis) were covered. This meant that throughout the day risks to patients were being communicated and mitigated in real time.
- We checked a sample of fire extinguishers throughout all areas of the wards visited. Foam and dry powder extinguishers were mounted in accordance with current guidance and found to have labels confirming they had been checked as fit for use. They were recorded as tested September 2014 due for re-test September 2015.
- We saw mandatory training records that indicated 84% of staff were categorised as green (i.e. up to date) with health and safety training and 77% had current fire training.

Nursing staffing

- Overall we found that in medical care services the numbers of nurses on duty frequently fell below agreed templates based on their own an assessment of need, and that there was a huge reliance on temporary staff.
- We saw evidence which demonstrated there had been a comprehensive review of nursing establishments in March 2015 which used a nationally recognised methodology. This had led to an increase in 44 whole time equivalent (WTE) posts which were added to the establishment in June 2015. This review was based on a standard of registered nurse to patient ratios of 1:8 recommended by the National Institute for Health and Care Excellence (NICE) and a ratio of six to four registered nurses to support workers recommended by the Royal College of Nursing.
- All wards in medical care services used an electronic ward rostering system. Senior nurses told us that this enabled them to have a much clearer overview of current and future staffing issues.
- We studied the nursing staffing data submitted nationally for July 2015. We saw that the number of staff on duty against agreed staffing levels ranged from -13% to +14%. We were told the positive figures were because of additional staff providing one to one care to patients with complex needs. Ten of the seventeen clinical areas for which we were given data were showing a negative balance meaning that over the month there were fewer staff than assessed as necessary.
- During our inspection we noted that four of the five wards we visited on 26th August had staffing levels below the agreed templates. On our unannounced visit we checked the staff of five wards and found that four had fewer staff on duty than they should have.
- Staff and managers we spoke with said that they perceived that is was usual for clinical areas to work below the agreed nursing templates.
- We saw that nursing establishments allowed for nurses patient ratios of between 1.5 – 1.8 (except for step down wards which were not designated as acute areas and therefore outside the scope of the NICE guidance). . However, given that the agreed templates fell below the template this recommended ratio was not achieved. For instance on our unannounced visit to Gundulph ward the nurse patient ration exceeded 1:8 as they had a shift unfilled.
- We spoke with matrons and ward managers who told us that they continually risk assessed areas with decreased staffing and frequently moved staff to ensure the best use of resources across medical care services. However, we noted that this was based on agreed nurse-patient ratios with no formal assessment of patient need or acuity informing these decisions. It was acknowledged that this was a constant source of frustration for them, and for staff including agency workers. Junior nurses expressed this frustration to us.

Medical care (including older people's care)

- On Tennyson ward we saw documents that showed that there were five weeks since December 2014 when no substantive member of staff had not been seconded to another ward. In February 2015 there was a week where 23% of staff were seconded at some point during the week.
- Data provided by the trust showed vacancy rates in medical services to be 30% of establishment, worse than a trustwide rate of 11%. We noted that the divisional risk register included nurse recruitment as an extreme risk.
- The recruitment and retention of registered nurses to medical services was acknowledged as a major issue that had an impact on the operation of the service buy all grades of staff we spoke with. There had been oversees recruitment campaigns but these had not been wholly effective. A manager told us that they had recognised that they may have difficulty retaining oversees staff for longer than a year due to their proximity to London, but had made no contingency plans to manage this. Indeed a cohort of oversees staff recruited a year ago were now moving on but there had been no plans until now to consider how the vacancies this created would be covered.
- A manager told us they had found nurse recruitment process unduly protracted. This meant that staff, many of whom were also applying to other hospital trusts were offered and accepted other posts before offers could be made by Medway. This indicated that recruitment processes were not well managed.
- Staff from agencies filled gaps in nursing rotas. The hospital used NHS Professionals who also subcontracted to other agencies. There was a quality framework to ensure that agencies used met minimum standards in their operation and that staff had the necessary skills, qualifications and experience to do their job and were of good character. Agency usage rates across medical care services from September 2014 – May 2015 represented 41% of total pay spend. Individual ward rates ranged from 19 – 61%. On our unannounced visit we found the evening shift on Gundulph ward was staffed entirely by agency registered nurses. The ward manager told us that they were staying on as they did not feel it was fair to leave the staff unsupported and lacked confidence in the safe staffing of the ward that shift. This means there was a heavy reliance on temporary staff to provide adequate nursing cover and provide care to patients.
- We were told that as part of the framework agreement agencies were responsible for assessing the competency of their staff. There was no system whereby ward based staff would verify the registration status and competence levels of staff supplied to them. Agency staff were required to self-declare that they had current registration and were competent to undertake the administration of medicines, but there were no arrangements to check this. This meant there were no robust systems for ward staff to be assured of the quality of agency nurses and the safety of their practice.
- We saw there was a comprehensive induction booklet given to agency staff on arrival to the ward which set out operational arrangements, and expectations of how the nurse would work and report their actions. We saw these in use on ward areas. We spoke with two agency workers who confirmed they had completed their induction booklet. There was a system for recording electronically when induction books were completed which ward staff could access to check. This was demonstrated to us.
- In July 2015, 19% of agency nursing shifts were unfilled. A manager told us the non-fill rate for medicine was currently about 20%. This means that one in five shifts were not covered. Several matrons and ward managers told us the majority of these unfilled shifts were day shifts which meant that there was a higher number of shifts unfilled at the during the day when there was higher levels of activity.
- We observed that representatives from NHS professionals attended the bed-meeting. We noted that while the issue of unfilled nursing shifts was raised, there was no discussion as to how this should be managed. We detected a sense of acceptance that this was the norm and that no focussed action was required.
- There were arrangements to ensure that when patients required one-to-one care this was provided and that additional staff were hired to provide this. We saw examples of patients receiving 1:1 care. For

example a patient with dementia on Sapphire ward was being provided with 1:1 care by a mental health nurse, who was completing hourly records of their status and condition.

- There arrangements for nursing staff to hand over from one shift to the next. We attended a handover meeting and saw that all relevant information to allow staff to meet the immediate needs of patients safely was communicated.

Medical staffing

- Overall, we judged there was sufficient medical staff with an appropriate skill mix to meet the needs of patients on a day to day basis.
- We reviewed the medical staffing skill mix data. Consultants represented 36% of the medical workforce in line with a national average of 34%. Rates for junior doctors and registrars were similarly in line with national averages.
- Vacancy rates for medical staff showed rates for consultants were 30%. Locum rates across medical care services September 2015 – May 2015 were 39%. Locum staff, many of whom were employed on a long-term basis, which helped ensure continuity of care, generally covered vacancies in the medical rotas.
- The divisional risk register dated June 2015 identified "inadequate number of junior doctors inadequate to support patient care." The mitigating action was described as "gaps in junior cover rota covered where possible by locum staff."
- We saw that there were three consultants present on the Acute Medical Unit (AMU) each day between 8am to 5pm hours weekdays and between 8am and 8pm at weekends. The medical registrar was based predominately in the emergency department. Outside of these hours the consultant on call for the general internal medicine rota provided medical cover.
- We spoke with junior doctors who told us that there were always two registrars rostered both day and night. However, concern was expressed that because of staff vacancies that there were gaps in the rota that were covered by locum staff. In addition there were two senior house officers on duty at night.
- Speciality consultants, such as cardiologists, renal and respiratory medicine consultants provided an in-reach service to patients on AMU. This ensured that patients were seen and reviewed by consultants with relevant skills and expertise in their condition. They also saw patients who were waiting for a bed on their speciality wards daily.
- We noted that the medical high dependency unit and coronary care unit was covered by the medical registrars at night and not by cardiology specialists or doctors with training in intensive care medicine.
- We saw there were suitable systems for medical staff to hand over the care form one shift to the next. There was a handover meeting at 8am where the night team handed patients over to the AMU team, in-reach consultants and relevant junior doctors. There was also a handover meeting at 9pm between the specialist in-coming and out-going specialist registrars, the junior doctors, critical outreach team and the site practitioners. We attended both of these meetings and found that it was well-run and appropriate information was communicated to allow the safe care of patients causing concern.

Major Incident awareness and training

- We found that the major incident plans and business continuity policy were available on the trust intranet. We found that there was a variation in staff knowledge of these policies. Some staff knew what action was expected of them, while others felt that they could refer all issues to a senior person.
- We saw records of emergency simulation exercises including a major incident, Ebola presentation in ED, fire, and an incident involving medical gasses. We saw that there was adequate de-briefing following these exercises and that when necessary action plans were developed. This would ensure an accurate result.
- We saw results of the Vital Signs audit results for the period January – May 2015. Results across medical care services ranged from 85 – 100% compliance with an overall average of 97%. This suggests that patients are being adequately monitored.

Are medical care services effective?

Medical care (including older people's care)

Inadequate

There was inconsistency in the quality of care patients received and experienced demonstrated through national audits. Outcomes were below expected in some specialities with mortality rates higher than the national average. There was a lack of appreciation that this could be as a result of sub-optimal clinical care.

Staff were not always supported in their development through appraisal and there were no arrangements for clinical supervision.

Staff practice did not always comply with the requirements of the Mental Capacity Act, Deprivation of Liberties Safeguards and did not always show an appreciation of the obligations this legislation placed on them.

However, patients had access to a multidisciplinary team who worked collaboratively together to meet patients' needs. There were to consultant physician and other services available seven days a week and out-of-hours. There were adequate arrangements to ensure patients received adequate pain relief and had enough to eat and drink.

Evidence-based care and treatment

- We looked at the stroke pathway documentation. We judged that it followed guidance from NICE (Stroke Quality Standard QS2, 2010) and the Royal College of Physicians (National Clinical Guidelines for Stroke 2012).
- We were shown protocols that were used in the Ambulatory Care department. We noted that they referenced and were based on relevant NICE guidance.
- The latest Medicine Clinical Effectiveness report showed participation in 17 National Audits. The hospital did not participate in BTS Pleural procedures and National Diabetes Audit: Core Audit. The same report detailed 38 local projects on plan of which 16 (53%) were competed. This showed that medical care services were engaged in a programme of clinical audit as part of their governance arrangements.
- We found that in addition to national audits there was a range of local audit activity which was given due consideration and prompted changes to practice and other actions. For example we saw the results of an audit of admissions from Nursing Homes were reported in May 2015. We saw that a number of recommendations had been made that were now under consideration. We also saw that some audits were repeated so that the impact of actions could be evaluated. For example, we saw an audit of stage 1 - 3 acute kidney injury in the acute medical setting had been undertaken in 2014 and repeated in 2015. We saw that in some aspects the results had improved but had deteriorated in others. We noted that recommendations and an action plan had been developed.
- There was a system for local audits to be formally presented at the division's audit and governance meeting. We saw an agenda for a meeting held in September 2014 and noted a wide range of audit results was scheduled to be presented.
- The Acute Medical Unit was aware of the basic benchmarking measures recommended by the Society of Acute Medicine, but were not benchmarking their service against these. Therefore, they could not be assured that they were delivering care and treatment in the best way, and that patient outcomes were in line with other units.

Pain relief

- There was system of 'intentional-rounding' in place although records were inconsistently completed. This included checking that patients were comfortable and helping them to reposition if that was required.
- Staff told us they received no formal training in pain control. They could access a specialist pain team for advice and they told that the response was usually within the day. However there was only one pain specialist nurse for the whole hospital on-call Monday to Friday during working hours which had the potential to cause delays in their response. Outside those times, the on-call anaesthetist could be contacted.
- We reviewed the care of a patient on Will Adams ward who had challenges with chronic pain. We were told

that as she was known to the community chronic pain service and team the acute pain team would therefore not see her, even though adequate pain control was difficult to achieve for them.

- Patient pain scores were completed as part of routine observations and we saw these were completed. A system of scoring 1-10 was in use and this was also used to evaluate the effectiveness of pain relief given. We saw that there was a trial in progress of an observational pain tool for patients with cognitive difficulties (such as dementia) as this had been identified as an area for development.
- We tracked the notes of two patients who had been given 'as required' pain relief. We noted that apart from pain scores routinely assessed as part of routine monitoring there was no evaluation recorded of the effectiveness of the pain control given. This meant that staff could be sure that the pain relief medication that was prescribed was appropriate to meet the patients' needs.
- Patients reported they were given adequate pain relief and it was administered promptly when requested.
- In a Pain Management Audit dated May 2015 carried out on Keats ward, four patients (33%) felt staff definitely did all they could to help with pain, three (25%) felt to some extent staff did all they could to help with their pain, and five (42%) patients did not feel staff did all they could to help with their pain. In a similar audit on Nelson ward, 17 (89%) patients felt staff definitely did all they could to help the patient with pain, one (5%) patient felt to some extent staff did all they could to help with their pain, and one (5%) patient did not feel staff did all they could to help with their pain.

Nutrition and hydration

- Patients were risk assessed for nutritional problems using the Malnutrition Universal Screening Tool (MUST), which is a nationally recognised tool. Further assessment and support from a dietician was available for those assessed as at risk of malnutrition.
- We checked six records on Sapphire ward and found that all MUST scores had been recorded. We checked the records of patients on Tennyson ward who were identified as at risk and found they had appropriate nutrition care plans in place.
- We were provided with an undated trustwide re-audit which showed 87% of patients had MUST score showing an improvement of 30% on the previous audit. 66% had appropriate interventions implemented following assessment and 46% had been referred to dietician which was the same as previous audit.
- A Matron audit carried out May 2015 mainly in medical care services showed 54% had MUST scores recorded, 53% weight recorded within 48 hours and 75% had weight recorded weekly. 62% had appropriate intervention and 50% were referred to dietician appropriately. This demonstrated that trust policy in the management of patients at risk of malnutrition was not meeting the trust standards which were based on British Association of Parenteral and Enteral Nutrition (BPAEN) guidance.
- We reviewed patients' records and found that food and fluid charts had generally been adequately completed although we found some examples where they had not.
- There was a 'red-tray' system in operation so all staff could easily identify patients who needed help with meals. A ward hostess demonstrated an understanding of this system and was adamant that she could not remove a red tray as nursing staff needed to be aware how much food had been taken. We observed patients being fed or helped to eat at mealtimes.
- A red jug system was in use for identifying patients who needed to be encouraged and helped with hydration and we observed staff regularly topping up jugs and encouraging patients to drink. On Keats ward we checked the fluid charts for two patients with red jugs and found that appropriate records were being kept to monitor their fluid intake.
- We saw that signs above patient beds indicating when a patient required assistance with eating or drinking were seen to be unobtrusive and non-judgemental.

- Patients reported that they were given dietary supplements when they were clinically indicated. We observed patients with these supplements.
- We saw that patients had drinks left within reach and the system of intentional-rounding ensured this happened although these records were inconsistently completed.
- On the stroke ward we saw that some patients who could not swallow were fed using a PEG (Percutaneous Endoscopic Gastroscopy) feeding tube. We saw that these patients had their nutritional needs assessed and monitored by a dietician. We spoke with ward staff who demonstrated a sound knowledge of the risks of these feeding tubes and the care patients with such feeding tubes required. However, we noted there was no policy to guide staff in this aspect of nutritional care although we were told that one was in preparation.

Patient outcomes

- The CQC Intelligent Monitoring report of May 2015 identified increased mortality risks in the specialities of endocrine medicine, respiratory, cardiology and infectious diseases (Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators 01-Jul-13 to 30-Jun-14). The trust mortality indicators for the previous two years were increased.
- We discussed these increased risks with the divisional management team. They were convinced that these results were a consequence of mis-coding of records. They had undertaken look-back exercises in gastro-enterology and respiratory medicine (for patients who had died of chronic obstructive pulmonary disease) and felt that co-morbidities had not been sufficiently recorded which had produced results worse that then should have been. We were concerned as during these conversations there was no acknowledgement that the data could indicate increased mortality as a result of sub-optimal care. We were not told of any exercises undertaken to explore this possibility. We were further concerned at the apparent lack of progress in addressing the issues of increased mortality which had been known for at least two years.
- In the Diabetes (adult) inpatient audit (NaDIA) published September 2013, the trust was worse than England average in 11 out of 21 indicators. Performance had deteriorated in 14 indicators compared with 2012 results, and was better in one. However we were told the poor performance was due to most of the standards needing to take place in the community and the trust was unable to get the information to demonstrate their performance against the audit standards.
- In the Acute Myocardial Infarction audit (MINAP) 2012-14 the trust scored worse than England average for the items 'seen by cardiologist' (88 v 94%), and 'admitted to cardiac ward' (33 v 56%). It scored better than average for patients having angiography (79 v 78%). There was some improvement since the previous year in the last two indicators but the first indicator was worse.
- In the national Sentinel Stroke National Audit Programme (SSNAP) results for January – March 2015, the hospital achieved and overall rating of Band D (where band A in the highest and band E the lowest). 46% of teams in England achieve band D making it the largest England cohort in March 2015. This meant the trust is performing in line with its peers. This performance was an improvement in the previous two quarters where the trust achieved E scores.
- The smoking cessation service achieved good quit rates. These were measured at four weeks, at six months and at one year and reported quit rates were 62%, 46% and 50% respectively.
- The lung cancer audit data suggested that 98% of patients were discussed at an MDT. The national England average was reported as 96%. 94% of these patients received a CT before surgery. This is better than the national average of 91%.
- The Joint Advisory Group on GI Endoscopy (JAG) ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced. The hospital had current accreditation, but the latest visit from JAG had raised a multitude of concerns ranging from the overall leadership of the department, to the lack of expected audit practice and the lack of appropriate environment. The department was also struggling to cope with the increased demand for their service as it was currently only running lists five days a week

(morning and afternoon). A recently qualified nurse endoscopist was only performing one list per fortnight. The unit was due to be re-visited again later in 2015 when a decision would be made regarding reaccreditation of the department. We saw minutes of meetings and an entry in the risk register which showed there was internal concern that further accreditation may not be granted.

- Patients in medical care services were as likely or less than likely than average to be re-admitted to hospital. The overall standardised relative risk of admission for medical emergency admissions was better than the England average at 98 (any score below 100 shows a reduction in risk). The standardised average for general medicine was at the average, was well below average for geriatrics (62), and slightly above average for cardiology (107).

Competent staff

- We saw mandatory training records that indicated 44% of staff were categorised as red (i.e. not up to date) with their appraisal. We saw other data that suggested all consultant staff had received an appraisal in the last year.
- We spoke with staff who told that they had participated in an appraisal in the last year. They told us they found the process helpful and had a personal development plan with objectives for them to achieve and outlining the support and training they required to achieve these.
- There were no arrangements to provide clinical supervision to nursing staff.
- We spoke with a consultant who was a consultant appraiser. They appraised at least five consultant colleagues a year using an on-line system. Individual performance data was up-loaded annually, along with reflections and evidence professional development activities. Competency was assessed through compliance with mandatory training, review of complaints, compliments and information from the electronic incident reporting system. This system supported the revalidation of consultants' competence for registration purposes.
- The 2014-2015 End of Year Questionnaire 'Framework of Quality Assurance for Responsible Officers and Revalidation' Annual Organisational Audit (concerning the duties of the Responsible Officer with regard to appraisal of medical staff) demonstrated adequate effectiveness of the systems overseen by the responsible officer including the monitoring of performance and responding to concerns. There were high levels of completion of appraisal amongst all levels of medical staff including middle grade staff and temporary staff. We noted there were no unapproved or missed consultant appraisals.
- Junior doctors told us they received adequate teaching and supervision. They received two days induction training and had a named clinical supervisor. There was scheduled teaching on AMU weekly and the foundation year 1 junior doctors had dedicated teaching each Wednesday. AMU teaching included discussion of the case of the week and a journal review.
- There was a system to ensure that nurses remained registered with the Nursing and Midwifery Council (NMC) which was necessary for them to practice. A ward manager explained, and showed us, how they received an email from the Human Resources department that a nurse's registration was due to expire. They then checked the NMC website to ensure the nurse had re-registered and kept evidence of this on their ward based personal file. We saw a letter from the chief nurse advising nurses of impending changes to registration rules made by the NMC. This meant there was assurance that nurses in medical care services remained registered.
- We saw posters displayed informing registered nurses of the new revalidation requirements currently being introduced by the NMC. These included key headlines and sources of further information so nurses were prepared for the changes and could maintain their registration.
- Nursing staff told us they could access training higher and further education qualifications. For example, a nurse told us how they were just commencing degree level studies supported by the trust.
- We spoke with a member of support staff who had been in post for eight months. They described in detail their induction programme which they felt had been useful and effective in preparing them to do their job.

They described a corporate induction day, and periods of job shadowing and supervised work. They told us they received the specialist training on IT systems they required. A ward manager told us they received a three week induction and that they had been allocated a 'buddy' to support them through the early stages of their appointment. They too felt the induction arrangement had been effective.

- We saw there was a wide range of specialist nurses, for example the frail elderly team, palliative care team, safeguarding leads and discharge co-ordinators and noted their presence on the wards. Staff told us they felt supported by these specialists and valued their input in ensuring they were delivering competent care.

Multidisciplinary working

- We found that patients had access to the full range of therapy services. We spoke with therapy staff who told us that they considered there to be insufficient therapy resource to meet the needs of patients. One therapist told us that they covered two wards, and felt that their work was mainly concerned with expediting discharges that were already delayed or poorly planned. They felt they had little scope to offer any other meaningful aspects of therapy. The stroke unit reported a lack of Speech and Language Therapy resource and this had been reflected in their performance in the national stroke audit.
- All ward staff we spoke with were happy with pharmacy support available but made the comment that there was insufficient numbers of pharmacists.
- Ward staff told us that there was a weekly multidisciplinary team meeting with the whole team. We attended a multidisciplinary ward meeting on Will Adams ward. The meeting included a member of IDT, physio, senior nurse and other members of nursing team. We observed a good exchange of patient information between the members present. This included the medical and nursing needs and personal circumstances for the 26 patients on the ward. The member of Integrated Discharge Team (MDT) described how information was then disseminated to the social care team to assist with expediting discharges.
- On Keats ward there appeared to be little proactive or joined-up working with the therapy teams to provide care to patients or plan discharge.
- We spoke with staff on AMU who told us that they could access support from mental health services easily. They gave us of an example of a suicidal patient who had been seen within an hour by the psychiatric liaison nurse.
- There were arrangements for patients to be reviewed by specialist consultants within medical care services, for example through the in-reach activities on AMU. There were also arrangements to obtain specialist opinions from other divisions, for example surgeons.

Seven-day services

- There were arrangements for patients to be seen on a ward round daily, including weekends. Patients on AMU received a consultant review daily. We saw records that conformed this.
- A stroke thrombolysis service was provided seven days a week. There was a rota of medical staff with the relevant skills who provided this service at Medway, Monday – Friday. There were alternative arrangements at weekends using tele-medicine facilities with medical cover provided by a West Kent-wide rota. This meant that stroke thrombolysis was available seven days a week.
- Staff an AMU told us that they had access to specialised mental health services seven days a week, 24 hours a day.
- We found there was a rota to provide emergency endoscopy services in the case of gastro-intestinal bleed at all times including weekends. However, routine endoscopy services were only available Monday – Friday.
- The Integrated Discharge Team were available at weekends but offered a reduced service consisting of assessment rounds to identify priority patients for discharge.
- Pharmacy was open at weekends to support seven day working. An emergency drug cupboard provided for out of hours use. All nursing staff we spoke with knew about the facility and how to access it. There was an on-call pharmacy service which staff told us

was effective at providing service when required. Pharmacists provided a ward service at the weekends so that discharge medications could be authorised at ward level decreasing dispensing times and waits for patients.

- We saw there were arrangements to ensure key diagnostic services, such as imaging and CT scanning were available at all times. We saw a poster displayed which set out clearly the access and referral and reporting timescales and arrangements for each diagnostic service. Medical staff told us they could access services when they needed them.
- We noted that the Ambulatory Care Unit was not open at weekends. We were told this was due to staffing issues and no patient demand. However, this lead to a build of referrals on a Monday, for example on the Monday of the week of our inspection there were 22 referrals at the beginning of the day.
- We found that there was no therapy service provided on the stroke ward at weekends. This meant patients undergoing intensive rehabilitation plans had no access to specialist therapy staff two days out of seven.

Access to information

- We attended handover meetings and operational meetings and found that there was adequate communication of patients' on-going needs and of any risks to their well-being. Operational issues relevant to the immediate running of the hospital were also discussed.
- We saw that there were ward based hand-over sheets for staff to reference. These were regularly updated and contained current and accurate information about patients' needs, treatment plans and relevant risks and their management.
- There was a system of handover when patients were transferred between wards and departments. There was a verbal handover which was documented on a pro-forma using the SBAR (situation, background, assessment, recommendations) format. We saw records of these handover fully completed and retained in patient notes. Patients discharged to care homes had these forms completed also, but there were none available for us to view.
- We saw that GP's received discharge summaries for patients who had been treated at the hospital.
- We saw there was system for nurses and others to communicate non-urgent patient related takes to medical staff via a doctors' book. We saw an example of this book on Dickens ward and saw it was used effectively although not all jobs were marked as completed when they had been done.
- We spoke to a ward clerk who told us that accessing old medical notes was not an issue and that there was an effective tracking system in operation. They told us that sometimes patients had temporary notes, but that the main file could be obtained within 48 hours, but in practice this was usually much quicker.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw mandatory training records that indicated 49% of staff were categorised as red (i.e. not up to date) with training in consent. 31% were not up to date with training in the Mental Capacity Act 2005 (MCA).
- Staff were generally able to demonstrate an understanding of the principles of the MC such as need for assessments of capacity, how they should be performed and the concept of best interests.
- Staff knew the name of the trust lead for the MCA and how they could be contacted. They told us that the lead provided valuable support and co-ordinated Deprivation of Liberty Safeguards (DoLS) applications and other assessments for those who lacked capacity. However, we noted that there was a single person undertaking this role. The post-holder managers told us this resource was insufficient to meet demand. On the day of our unannounced inspection we requested to track some specific DoLS but were unable to do so as the lead was not available and one other person had access to the electronic records they held. This meant vital records were not always available to staff who needed them.
- We saw that assessments of capacity were carried out using a standardised template that ensured the requirements of the MCA Code of Practice issued by the Department of Health were met.

Medical care (including older people's care)

- We saw records of best interests meeting held with all key stakeholders when major decisions were being considered for those who lacked capacity.
- We saw that a specific consent form was used for those undergoing major procedures who lacked the capacity to consent. We checked two of these consent forms and found they demonstrated the reason for the treatment, why it was in the patient's best interests and was the least restrictive option.
- There were 44 DoLS applications during the period February - June 2015.
- Generally speaking, nursing staff showed a variable understanding of the concept of DoLS and associated processes. However, we spoke with junior doctors who were much less sure. One suggested to us that this was a role for nursing staff.
- Ward managers signed-off urgent authorisations. We were told that they had undergone specific training to undertake this. Following our discussions, we were concerned that authorisations may be scrutinised by staff with insufficient understanding to adequately assess the appropriateness of the authorisation and to establish if the least restrictive option was proposed and used despite undergoing training. We were also concerned, that staff may not be or of sufficient seniority to challenge requests for authorisation that may not be appropriate. adequately assess the appropriateness of the authorisation and to establish if the least restrictive option was being used. We saw that applications for urgent authorisations were not refused.
- There were no systems to alert staff when DoLS were due to expire. We checked a DoLS application on Nelson ward, and found that the authorisation had not been returned to the ward and that the nurse in charge was not aware of the expiry date, or of the conditions the authorisation stipulated.
- On Milton ward we found that an authorisation had expired on the 8th August 2015 but had not been reapplied for no reapplication had been made to the supervisory body until the 22nd August 2015. This meant the patient was unlawfully deprived of their liberty during this period.
- SWard staff told us that they did not routinely receive copies authorisations when they were returned to the trust by the supervisory body. . There was a widespread notion that the application alone provided the authority to deprive liberty. Staff were generally unclear about the 2014 supreme court judgement of a deprivation of liberty. Staff were not clear that an authorisation may contain conditions which they were obliged to ensure were met.
- We reviewed patients on Will Adams ward and identified four who we judged should be considered for a DoLS authorisation to their cognitive state. Patient records indicated that neither medical or nursing staff had identified such an authorisation should be considered. This meant patients might have had their liberty restricted without appropriate authorisation or statutory safeguards of their human rights.

Are medical care services caring?

Good

Feedback from patients and those close to them was positive.

We observed staff interactions and relationships with patients and those close to them as caring and supportive and they responded with compassion to pain, emotional distress and other fundamental needs. Staff treated patients with dignity and respect and people felt supported and cared for as a result.

Staff involved patients as partners in their own care and were supported to cope emotionally with their care and treatment.

Compassionate care

- Medical care services participated in the national friends and family test scheme to gather patient feedback. For the period March 2014 February 2015 the response rate was worse than the England average (26 v 36%). Monthly scores ranged 33 -100 with an overall average score of 76. Average monthly scores for individual wards ranged from 64 – 83**.** A score above 50 is considered a positive indication that patients would recommend the hospital to family and friends.

Medical care (including older people's care)

- Despite staff facing the challenges of lack of capacity, shortages of staff and reliance on temporary staffinguring our inspection we observed that patients were alwaysgenerally 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 before they entered. We observed that staff were kind and patient in their approach and we saw numerous examples of difficult situations being sensitively managed.
- Patients told us that they received care in a way that preserved their privacy and dignity. A typical comment was, "They close the screens so it is just you and the nurse; you never ever feel embarrassed."
- Patients told us, and we observed that call-bells were answered promptly and well as requests for assistance.
- We saw the results from a 'Patient Satisfaction Questionnaire November 2014 – Cardiac Catheter Suite' 100% of patients surveyed were very satisfied or satisfied that their privacy and dignity was maintained. In a similar survey carried out in the Rapid Access Chest Pain Clinic, 98% felt that their privacy and dignity were completely respected..

Understanding and involvement of patients and those close to them

- Patients told us that they were kept informed of their care plans, and were involved in developing these. Where appropriate, they told us they were given choices about the care and treatment options available.
- We found patients were given information to help them understand their disease and its treatment. On Bronte ward we observed a member of staff patiently explaining to a patient their medicines to take home. The medications were laid out on the bed. The member of staff was illustrating with a pictorial chart to assist the patient in remembering when to take each one.
- We saw the results of a 'Patient Satisfaction Questionnaire – Cardiac Catheter Suite November 2014' and noted 98% of patients surveyed were very satisfied or satisfied with the explanation of their diagnosis and procedure. 100% of patients were very satisfied or satisfied with the written and verbal information provided. In a similar audit carried out in the Rapid Access Chest Pain Clinic 98% felt they were given enough time to discuss their health or medical problem. 90% felt their questions were answered adequately, with 7% feeling that the answers were 'to some extent' adequate. 80% that their medication had been changed felt that the reason for change was explained adequately, with 10% feeling that the explanation was adequate 'to some extent'. 90% felt the explanation of the tests was very good or good.

Emotional support

- Patients reported that they felt able to discuss their emotional state with staff. A typical comment was, "If you are upset you can talk to them and they do everything to help. I've never had a cross word here at all."
- We saw the chaplain visiting the wards and providing emotional support and spiritual care to those patients who wanted it.
- The Dementia and Delirium team organised a monthly 'Carers Coffee Break' to provide those caring for someone living with dementia with support and information.
- There was a 'Dementia Buddy' scheme where volunteers came to the ward to carry out activities such as hand massage, or listening to music. We saw posters in ward areas advising the availability of this scheme and spoke with the scheme co-ordinator. Staff who had used it told us that it provided welcome support to those living with dementia.

Are medical care services responsive?

Inadequate

Patients were unable to access the care they need because of inadequate management of demand and flow through the service which did not function as intended. Patients were cared for in non-speciality and escalation areas and were frequently treated in mixed-sex wards.

Discharge planning was inadequate, there were high levels of delayed transfers of care. This meant patients

experienced unnecessary waits or lack of appropriate care as they moved between services both within the hospital and the local health system. We were not assured of the effectiveness of the service's response to current flow issues and the predicted season surge in Winter 2015.

Services were not adequately responsive to the needs of those living with dementia with inappropriate environments and a lack of stimulation, despite the introduction of positive initiatives such as dementia buddies and the 'butterfly scheme'.

The time taken to respond to patients' complaints was too long, although complaints were taken seriously, investigated appropriately and learning from them shared.

Service planning and delivery to meet the needs of local people

- We discussed capacity plans with key personnel. The local Clinical Commissioning Group had requested an updated plan to deal with anticipated surge in demand caused by seasonal pressures. A draft plan had been rejected as more individual accountability of actions was thought necessary. This plan was being revised. We noted that this revision had limited clinical input, with the only sign off coming from a single member of the emergency department. We heard the trust had experienced a lull in demand a few weeks previously and had declared their bed status as 'green'. The status was red at the time of our inspection. We asked what was done differently when the status escalated from green to red and were categorically told nothing. We believed there was no real experience of what was needed, and no senior support to provide the required clinical leadership to achieve a realistic plan to effectively manage any increase in activity. We believed that the current struggles to meet demand has normalised the responses we would expect to see in times of capacity crisis such that they were now usual business.
- Sapphire and Dickens wards were being utilised as 'step-down' wards who were awaiting discharge arrangements or for community-based care to be finalised. During our inspection there was confusion on Sapphire ward as the ward was being emptied in preparation for closure, despite the numbers of delayed transfers of care remaining problematic. During our inspection staff were told there had been a change of plan and that the ward would remain operational.
- The stroke unit offered a thrombolysis (clot-busting) service as part of the treatment of acute stroke. We spoke with a consultant who described the on-call arrangements that ensured this treatment was available at all times. However, we noted the service was not provided at the weekend at Medway although there were alternative arrangements.
- Medway is an area with above the national average number of smokers. We saw there was a smoking cessation service which worked with inpatients in medical care services. We were told that the respiratory specialist nurses and the lung cancer multi-disciplinary team referred patients to the service. We also health education materials about smoking cessation displayed in the main reception and refreshment areas. Training was provided to junior doctors on the management of smoking cessation with patients.
- We saw that the Ambulatory Care Unit (ACU) worked closely with the local community nursing service, 'Hospital @ Home' scheme to enable care to be delivered as close to home as possible whenever it was clinically safe to do so. GP's could contact the consultants at the unit for immediate advice to prevent unnecessary admission.
- However, we spoke with senior staff on the ACU. We found there was no real understanding of what the actual demand for the service was, and might be in the future.
- There were rapid access clinics where GP's could refer patients for urgent consultant opinion. For example rapid access cardiac clinics or endoscopy appointments. This enabled patients to access specialist care quickly and avoided the need for attendance at the emergency department. Two junior doctors told us that they had no concerns about the cardiology rapid access clinic and that it worked well.
- We saw mandatory training records that indicated 83% of staff were categorised as green (i.e. up to date) with training in equality and diversity.

Medical care (including older people's care)

Access and flow

- Bed Occupancy was in excess of 99% across the trust between January - March 2015. This is in excess of the generally accepted ideal rate of 85%.
- The average length of stay (AVLOS) in 2014 for emergency admissions to medical care services was eight days, higher than the England average of 6.8 days. In particular the AVLOS was higher than average in the specialities of general medicine, geriatrics and cardiology.
- We spoke with staff on the Acute Medical Unit. They told us that the aim was for patients to receive a rapid review of their condition, to have any necessary diagnostic tests and to commence treatment. If indicated, they were transferred to relevant speciality wards for on-going care otherwise they would be discharged. We were told the staff were aiming for a 12 hour length of stay on the unit. However, this was not achieved and the unit was generally operating as a medical ward with much longer stays. This impeded the ability of the unit to respond promptly to patients' needs, and to streamline flow through medical care services. We reviewed the length of stay of patients on the ward at the time, and the length of stay ranged from zero to six days. Out of 21 patients, eight had a length of stay greater than three days.
- Junior doctors we spoke with told us that when the AMU was full, patients went straight to medical wards which exacerbated flow issues in medical care services.
- There were three bed meetings per day to assist in the effective operational management of the hospital. We attended two meetings. We saw that all the relevant stakeholders attended and we considered them well run and focussed.
- We found that the management of medical patients in non-speciality beds was variable. We reviewed a sample records of medical patients cared for in non-speciality areas. We found there was no documentation of the reasons why those patients had been selected to transfer to non-speciality beds. On McCullogh ward we reviewed medical patients and found an outlying patient who had no named consultant. There had been no consultant review over the weekend and registrar reviews three of the four previous days. No referrals for therapy had been made. On Nelson ward we reviewed a medical outlier where there was confusion as to the responsible consultant and who had not been reviewed by a consultant that day. Staff on this ward gave us anecdotal evidence that this was not an isolated example.
- However we reviewed the care of medical patients outlying on Victory ward. Staff told us, and records confirmed there was a designated consultant for each of these patients and a junior doctor provided in-hours cover 08:00 – 17:00 Monday to Friday. Patients were reviewed every day, including weekends.
- We were told that extra-capacity beds were opened to manage surges in demand. We asked for further information and data to scope the scale of the issue. The trust responded, "No central record kept. Additional capacity remaining in the trust are the eight beds on the admission and discharge lounge opened on a regular basis one – five nights per week." We saw these extra capacity beds were used on the evening of our unannounced inspection.
- There were 14 bed moves for patients occurring out of hours (22:00 – 06:00) between February – July 2015. The reason for all bar one was recorded as clinical need with the remaining move attributed to a patient request.
- There were no real changes in the numbers of overall bed moves between 2014/15 and the previous year. We noted 62% of patients were not moved at all, 38% were moved at least once, and only 13% moved more than this. Only 2% of patients moved more than four times.
- We were told that medical patients who were treated on surgical wards should not have acute care needs. We judged there were some inappropriate medical patients on surgical wards due to the complexity of their medical condition.
- There was an Integrated Discharge Team (IDT) which included nurses, therapists and social care staff funded and employed by Medway Community Health Trust. They supported medical care services in the management of patient discharge, especially those patients with complex needs. They visited the wards daily Monday – Friday. They attended a daily board

round to discuss the discharge plans of individual patients. We saw these happening and noted that although there was good representation from nursing and therapy services, medical staff were not engaged in these meetings. However, we noted that on Keats ward board rounds were not embedded in practice and a regular occurrence.

- We were shown data which showed for the 12 weeks between 4th June – 20th August 2015, there were an average of 37 delayed transfers of care reported with a range of 21 – 45. By far the most common reasons for delay were recorded as completion of assessment or patient or family choice. The number of delayed bed days for the same period ranged from 293 – 974 during the same period. The average delayed days ranged from 10 – 16.5. The trajectory for this data showed no discernible trends.
- We saw that Delayed Transfer of Care database had been established. Patients who had a length of stay greater than 10 days were identified from the patient administration system. These patients were discussed weekly at a forum with the intention of identifying any blocks to their individual care pathway so they could be managed. These meetings were followed up with a meeting at which the Clinical Commissioning Groups and Social Care Departments were represented to ensure a whole system approach to these management plans.
- We reviewed records and spoke with staff and found there was no clear, proactive approach to discharge by medical teams. For example, on Gundulph ward we noted that only nine out of 16 patients had an estimated discharge date assigned on admission. On Keats ward we found no estimated discharge dates were documented and on Will Adams estimated discharge dates had not been reviewed.
- There were relatively few discharges over the weekend. The trust supplied us with data that showed that in the period May – July 2015, weekend discharges accounted for only about 15% of total discharges.
- We heard examples from patients and the Integrated Discharge Team of patient discharges being delayed as ward staff, especially agency nursing staff, did not understand the process sufficiently and failed to complete necessary assessments and other paperwork in a timely fashion. We heard one example of a nurse who could not discharge patients because she did not have the required login in to the appropriate IT system.
- We reviewed the notes of two patients out of 16 who needed a speciality review. One had waited seven days for a review by the gastro-enterology team, and one six days for a respiratory review. We noted that both patients were discharged shortly after. This demonstrates that patients' discharges were not well managed in medical care services.
- We reviewed the notes of patients on a short stay unit and saw that 50% were not short stay patients. On Wakely ward was designated a short stay unit but we were told the average length of stay was 15 days.
- On the internal bed occupancy system (BOC) we saw that patients who had multiple bed moves were identified. We were told this was to prevent further bed moves which may cause deterioration in their condition or provide a poor experience.
- There were two wards identified as 'step down' wards where patients who were medically fit to leave hospital, but required community services that were not yet available could wait for discharge. We spoke with a bed manager who explained the system for identifying and transferring patients to these beds. The system was difficult to manage effectively as the demand was variable. For example, some days there were step-down beds available but no medically-fit patients to transfer, or on other occasions demand outstripped supply.
- We found problems with discharge processes and waiting times for medicines for discharge. The discharge lounge were particularly experienced challenges and told us they had to send patients home and then have their medicines delivered by taxi on more than one occasion. There was no specific contact in pharmacy for the discharge lounge to liaise with over the problems they have with getting discharge medicines being done in a timely fashion. This meant the difficulties were difficult to resolve on both a short or medium term basis.
- Staff members on Sapphire ward and the discharge lounge expressed dissatisfaction with the time it takes

for some patients to receive their discharge medicine (TTO's). When TTOs were not authorised at ward level the patient was transferred to the discharge lounge without their drug chart. The staff told us that this meant patients sometimes missed doses of their medicines.

- Staff told us the discharge letter should be written before the patient is transferred to the discharge lounge, but this does not always happen. They told us that there were not enough pharmacists to check discharge prescriptions on the ward and there can be delays in taking the drug chart to the dispensary.
- The dispensary sets a maximum turnaround time for TTOs of two hours. The pharmacy audit indicates that 90% of TTOs are processed with the two hour window once the TTO had been written and the pharmacy had been informed about the discharge.
- We saw on a tracking system that for June and July 2015 approximately 70% of TTOs were pre-validated (authorised) on the ward by a pharmacist; the remaining 30% of TTOs were authorised in the dispensary. The average turnaround time for the July TTOs that were authorised at ward level was 57 minutes. When the drug chart and PODs were sent to the dispensary the turnaround time was 104 minutes (that is 47 minutes slower). However, we did not see any audit data for the total amount of time that it takes to discharge a patient; that is, from the time that the patient was told they can go home to the patient leaving the hospital with their medicines.
- The stroke ward had designed a system to ensure that there was always a free bed on the unit to ensure there were no delays in 'door to needle' time for patients who required thrombolysis (clot-busting) treatment for stroke. We spoke with ward staff who confirmed that this system was working.
- All GP urgent referrals to medical care services were seen on the ambulatory care unit, unless the seriousness of their condition prevented this. This meant they were seen and reviewed by a consultant who was able to make a decision about the need for admission or community management. This had the potential to decrease the numbers of inappropriate admissions.
- Staff on the ambulatory care unit told us they could usually access imaging services the same day, and often within an hour.
- Medical care services were not meeting national standards for referral to treatment times. The trust suspended referral to treatment (RTT) reporting in December 2014, and recommenced in June 2015. In June 2015, of the eight medical specialties reporting, none met the standard that 92% of incomplete pathways should have been waiting for less than 18 weeks. The specialty with the largest number of patients on waiting to start treatment at the end of June, dermatology (6,556 patients), had 68% patients waiting within 18 weeks. General medicine was worst, performing with 63% of patients waiting within 18 weeks and rheumatology the best performing, with 88%. The performance against the incomplete pathway standard in in England was 93% for June 2015.

Meeting people's individual needs

- There were multiple breaches of mixed sex accommodation rules on a daily basis. This meant that males and female were sharing sleeping accommodation and bathroom facilities. We noted that on the divisional risk register dated June 2015, it was stated that AMU was breaching same sex accommodation guidelines daily. Trustwide figures for mixed sex accommodation breaches (which we noted were mostly occurring in most AMU) for the period May 2014 – April 2015 totalled 367.
- On Nelson ward we found there was a female patient in a male bed. This was not recognised as a mixed sex accommodation breach by staff as the patient was not concerned by this. The situation was not identified in the bed meeting we attended at the relevant time.
- There was a system for identifying those with sensory impairments or other risk factors (such as falls) by the use of discrete symbols. We saw these were used on Milton ward.
- On Gundulph ward we reviewed care records for a patient in bay five who was partially sighted. We found that care rounds had not been recorded as being undertaken since 20:00 the preceding day. The patient was unable to verbally communicate and records clearly stated that he was not able to use the call bell.

The nurse in charge told us that they would have expected these checks to have been completed and recorded due to the complexity of the patient's needs. This meant that staff might not have been able to respond to this patient's care needs.

- On the internal bed occupancy system (BOC) and ward handover sheets we saw that patients with dementia were identified. We were told this was to prevent these patients being moved as this could lead to deterioration in their mental state.
- We saw that on Milton ward the 'butterfly scheme' was used to identify patients with dementia and guide the staff in communication strategies. This is a commercial scheme widely used nationally for this purpose. Information about the scheme and the services of the Alzheimer's Society were displayed on the ward noticeboard. In addition patients with dementia had a 'This is Me' booklet completed. This a document designed by the Alzheimer's Society which enables key personal and biographical information and care preferences to be recorded for staff to reference.
- We saw that Milton ward had a designated memory room for family and friend to spend time with those patients living with dementia. We saw that puzzles, games, books and crayons were provided for diversional activities.
- Staff we spoke with on Milton ward told us that they received no accredited training in dementia, even though they were working on a specialised ward. They told us that they felt this was required.
- On Keats ward we saw a patient who was disturbed and confused. When checking their medical records we found that they had not received a dementia screening test despite being above the age of 75 years. A member of staff said that because they had come in with dementia they considered there was no requirement to do the assessment. We checked six sets of patient records were checked on Will Adams ward to identify if the policy for screening patients over the age of 75 for dementia were being followed. Of the six records that we checked we found that four were aged above 75 and none had been screened.
- However, data supplied by the trust showed that they met the national target (CQUIN) of 90% for all stages of dementia case finding and screening.
- We saw that the principles of dementia friendly design had not been implemented on the majority of ward in medical care services. For example, there was no pictorial signage indicating toilet facilities and lavatory seats and other fittings were not of contrasting colours.
- Ward areas had day rooms that patients could use, although staff told us they were not always fully utilised. On Tennyson we saw the dayroom had books, and CD's and player for patients to use but we did not notice any patients using the facility. Staff on this ward told us that they were too busy to get patients to use this facility.
- We saw a learning disability resource folder. Staff told us they could bleep the learning disabilities team for support and advice regarding the care of any patient with a learning disability. They told us how they had been supported to care for a patient by the use of an individual communication folder.
- We saw that bathrooms and lavatories were suitable for those with limited mobility. There were adequate supplies of mobility aids and lifting equipment such as hoist to enable staff to care for patients.
- There were arrangements to secure translation services for those for whom English was not their first language. We saw data that confirmed translation services were used about 10 times in medicine from February - July 2015. We saw information regarding translation services and their access was displayed on ward noticeboards. We spoke with a ward clerk who told us she was aware there was a translation service, and knew where she could find details should this be required.
- However we observed the care of a patient who was unable to communicate in English. They were given a meal without establishing whether he had any dietary preferences or special requirements. When we asked the Senior Nurse in Charge if any interpreter services had been engaged we were told that this had not been done but would be sought the following day.

- Patients we spoke with were positive about the quality and range of food that was available to them. A typical comment received was, "Food is lovely; I always get enough to eat."
- We spoke with two patients and their carers who fully understood the changes in their medication that had been made. They knew why changes had been made and felt well supported with information regarding their treatment.
- We observed that clinical areas displayed printed health-education literature produced by national bodies. Some of this information was general in nature whilst some was specific to the speciality of the ward such as information about liver disease on Keats ward.
- Ward areas displayed photo-boards of staff so patients and their relatives could identify them and their job role. We noted that these were generally kept up to date.

Learning from complaints and concerns

- The division had produced a clear process for the management of complaints in July 2015 and we saw a copy of this.
- We saw that any following executive sign-off, the divisional management team were made aware all complaints that were up-held. The management team then wrote to the relevant ward and medical staff to ensure they were aware of the outcome and lessons to be learnt. Further discussion then took place at departmental level. Staff we spoke with told us that complaints were discussed in ward safety huddles and at ward meetings. We saw records that confirmed this.
- We saw evidence of how the timeliness of complaints responses were managed. We were told that staff felt the process was administration heavy and that this caused delays in the process. There were delays in responding to complaints within policy timescale of 25 days. Response times for the trust were a mean average of 65 days. The median average was 33 days suggesting some complaints were delayed significantly in excess of the mean average figure.
- Patients we spoke with were aware of how to raise a concern or complaint, including the role of the Patient Advice and Liaison Service (PALS). We found that the PALS office was poorly signposted and experienced difficulty locating it. We saw that information on how to complain was displayed in ward areas.
- Nursing staff we spoke with demonstrated understanding of the complaints process and were able to discuss how they dealt with complaints. They were aware of the role of PALS and how to contact them.
- We saw that wards displayed 'You Said, We Did' posters on ward noticeboards which detailed how they had response to both positive and negative feedback.
- During discussion with the matron and ward manager on Will Adams ward we were told how the complaints department monitored all complaints. We discussed the process and the timeline monitoring system which ensured that complaints are dealt with in line with the appropriate timescales. Each complaint was issued with a nominated handler who remained responsible for investigating the complaint, drafting the response and returning it to the complaints department for scrutiny and dispatch.
- The ward manager kept copies of complaints they received and the responses to them on the ward for staff to use as a learning tool. We saw their responses demonstrated a thorough investigation of the concerns raised and that explanations were given, apologies made and any remedial actions communicated. Complaints were discussed at ward meetings. We saw examples of ward meeting minutes dated June 2015 which contained reference to this.
- We asked for an example of action or change of practice resulting from a complaint. We were told of how a complaint from a relative about not all staff knowing each patients care needs had resulted in a change in the format of ward bedside handovers. Now all clinical support workers attend handover and are aware of each patient's specific needs.
- During the period July 2014 - July 2015, five complaints were escalated to the Parliamentary and Health Services Ombudsman for adjudication. One

complaint was upheld, one was not upheld, two were partly upheld and one was pending a decision. This suggests the trust was managing complaints effectively.

Are medical care services well-led?

Inadequate

There was no clear statement of vision and values of the organisationservice that was were not well developed orunderstood by staff. TThere was no leadership strategy with the leadership of the service was constantly changing which meant there was no clear focus on setting or achieving objectives.

The approach to service delivery and improvement was focussed on the short term because management time was predominantly spent managing staffing and patient flow crises. Strategic planning and operational management were hindered at all levels by the availability of reliable, easily understood data.

Staff satisfaction was mixed, and some staff reported feeling bullied. We found there were high levels of stress, workload and some conflict with the trust.There was a limited approach to obtaining the views of patients and there were no arrangements to involve them in the design of the services they used.

However, we saw some examples of innovative practice that had been introduced.

Vision and strategy for this service

- Staff we spoke with at all levels were aware there was an 18-month recovery plan. However, staff were unable to articulate clearly what this plan involved, what its specific objectives were or their responsibilities in achieving the plan. This lack of clarity was more marked as staff became more junior in their role.
- We judged the trust recovery plan was not tailored to medicine and therefore did not specifically address some of the challenges the service experienced.
- We saw that some, but not all, wards, such as Milton and Tennyson, had developed unit philosophies which were displayed. We were told that staff had contributed to the development of these to ensure there was a sense of shared ownership.
- The manager on Dickens ward showed us their ward development plan for the next three months and we saw evidence that work was in progress to revise the current ward vision and mission.

Governance, risk management and quality measurement

- There was a system of governance which staff generally understood and could explain. There was a monthly Adult Medicine Quality and Safety meeting. We looked at the minutes of a meeting held in June 2015. We saw that key staff were in attendance and that the agenda items covered all the main areas of concern and that actions were identified for individuals. However, we noted meeting in March and April 2015, and the May meeting delayed as it was not possible to attain the necessary quorum for the meeting to proceed. We also noted that monthly mortality and morbidity meetings were not held consistently in all specialities. This suggests that there may have been competing operational priorities and that the ability to commit to a vital forum was compromised.
- We also saw minutes of a divisional 'Clinical Risk and Incident Group' held in August 2015. These showed that there was discussion about incident trends, reviews of progress of incidents under investigation and an analysis of overdue incidents,
- We saw that each ward and department maintained a risk register which was an integral part of the electronic reporting system. The division maintained a risk register that was based on the common themes and elevated risks from departmental registers. The divisional register informed the corporate risk register. We looked at these registers and saw that risks were clearly identified and that mitigating actions were identified. A ward manager told us that risks were reviewed weekly with the matron to ensure the risk remained the controls were still appropriate.
- We spoke with the management team who acknowledged that the availability of data, and the

quality of that data, was a major limiting factor on their ability to plan strategically and manage operationally. They gave us the example of data regarding bed flows which was not routinely available to them.

- We saw a 'Quality and Safety Report' for adult medicine dated June 2015. We were told these were produced monthly. This contained some statistical information on infection control topics, falls and pressure ulcers in table form for the previous year. They also contained narrative on the outcome of RCA investigations. Whilst this information was comprehensive it was difficult to navigate and comprehend and there was no analysis of the data presented.
- The division did not produce performance reports which summarised performance across clinical, operational and financial domains in the form of dashboards or balanced score-cards. This meant it was not possible to correlate performance across these key areas, to understand the inter-relationships between to plan meaningful actions.
- Performance information at ward level was not available to managers and matrons, for example, safety thermometer returns. This meant departmental managers did not have the data readily available to help them identify emerging concerns, or give them and their staff assurance that they were performing well or improving. Ward managers and matrons we spoke with viewed this as a missed opportunity.
- We saw there was a quality monitoring initiative called 'Better Care Together.' We saw reports of reviews carried out by senior staff from spring 2015. We saw these identified areas of good practice and areas requiring improvement across the five inspection domains we use. It was difficult to be sure how these improvements were planned, carried out and monitored although each ward manager maintained a file of evidence in their areas which we saw.
- We saw reports from matron reviews of wards. However, these were poorly completed and it was difficult to be assured how these would identify and address issues of quality and safety.

Leadership of service

- Since our last inspection, there has not been consistent management and leadership within medical care services. Many key leadership roles had been vacant or held by managers in an interim capacity. Staff we spoke with at all levels told us they found this unsettling. They described a service in a state of constant flux, where with each new manager there was a change of focus and emphasis with shifting priorities objectives, and manner in which they would be achieved. This meant staff felt rudderless and unaware of how the key challenges facing the service wold be approached.
- Staff told us that the constant leadership changes had resulted in work projects not being completed/ embedded in practice as leaders with key responsibility for driving these projects moved on.
- Staff we spoke with articulated a sense of frustration with senior managers not progressing issues. A ward manager told us they escalated issues to mangers and felt that then things were removed from their control but no action ensued. They described it as "everything gets stuck in the middle."
- One staff member talked of "change fatigue," they went on to tell us that they felt there were remnants of the previous management style at middle manager and executive level. Change was not perceived as joined up with matrons and ward managers implementing changes after through research which were then "squashed" by middle managers.
- We saw an example where a nurse had been informally performance managed rather than using the relevant trust policy. They felt they were not supported, were not given adequate feedback and were left feeling "used and deflated." They felt they should have been formally managed. This meant that by not using the formal policy, there was a negative impact on the well-being of the staff member involved.

Culture within the service

- We found that there was a system for patients to nominate staff for an award for exceptional service. We saw that these 'Wow' awards were prominently

displayed which meant that the staff achievements were recognised and publicised. We also saw that Dickens and Sapphire had one Team of the Month in June 2015 and that this had been publicised.

- In the staff survey results Quarter 2, 2014/15, 51% of staff responded they would be likely or extremely likely to recommend the hospital as a place to work
- We spoke with three members of staff who told us that they perceived that an historic culture of bullying had much improved since the CQC's first inspection. However, three other staff members felt that there remained a bullying culture and said they had direct experience of this but felt intimidated and unable to use the relevant personnel policies.
- Staff we found frequently reported feeling stressed. Excessive workloads were frequently cited as a cause of this stress.
- We noted that staff felt comfortable to challenge when they had concerns. We were appropriately challenged in matters of dress code, identification and access to confidential information. This demonstrated that staff felt empowered to ensure standards were maintained.
- We noted that the matrons within medical care services were well respected by ward staff and doctors. We found them to be a cohesive group who were committed to improving standards of quality and safety and patient experience. However, we found that the vast majority of their time was spent dealing with urgent operational matters such as staffing and flow, which greatly decreased the time available devote to developmental projects. An example of this would be the poor cleaning standards on Gundulph ward where the matron had not had the time available to monitor the cleaning and the effect of remedial actions.

Public engagement

- We asked ward managers and the management team about arrangements for including the public in service developments or re-design. We were told there were currently no arrangements to do this, and that there were no user-groups in existence for specialities or any other patient participation forum.
- The trust participated in the national patient survey, and we saw reports of patients satisfaction surveys carried out in the cardiac ward areas.

Staff engagement

- We saw examples of communications issued by the division to keep staff informed of changes, developments and learning across the service. We saw an example of the Acute and Emergency Medicine News Summer 2015.
- We saw examples of the Associate Chief Nurse's 'Weekly Round-up' email that was sent to all wards and departments and covered current topics of interest and actions required.
- We saw minutes that showed individual ward held meetings for staff, on about a monthly basis. Staff told us they could add agenda items to these meetings although there were some items always covered such as reviews of incidents and complaints. Staff told us they found these meeting useful for finding out information, and discussing and resolving ward-based issues.
- We spoke to a ward manager staff who told us that it was sometimes difficult to get staff to the meeting so they also produced a ward newsletter which we were shown.

Innovation, improvement and sustainability

- Despite the trust being financially challenged, the divisional management team had not agreed any cost improvement programmes. They were able to explain the process by which they risk-assessed any future plans to consider potential impacts on quality and safety.
- We saw that registered nurses in mental health had been recruited to wards where the clinical mix suggested this. For example, on the dementia ward and on a gastro-enterology ward where there were high numbers of patients with behaviour which challenged staff. Staff told us they felt this was an innovative solution to their staffing recruitment challenges, and that the skill sets these nurses possessed enhanced patient care.
- We saw that ward establishments contained non-clinical support workers who carried out a wide range of tasks they were not directly related to patient care, such as re-stocking supplies. This freed up the clinical staff to spend time on direct care activities.

Surgery

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

Information about the service

The surgical department at Medway Maritime Hospital provides a range of surgical services to a population of 409,000 approximately. It delivers surgical specialties including colorectal, vascular, breast, gynaecology, urology, ear nose and throat and trauma and orthopaedics. It also offers a range of laparoscopic (keyhole surgery) procedures as well as a 24-hour emergency and trauma service. In order to carry out this inspection, CQC reviewed information from a range of sources to get a balanced and proportionate view of the service. We reviewed data supplied by the trust, other external stakeholders, and held a listening event where members of the public were invited to share their experiences. We visited the surgical wards and observed care being delivered by staff. We reviewed online patient feedback and took the information we received before, during and after the inspection from members of the public. CQC held a number of focus groups and drop-in sessions where staff could talk to inspectors and share their experiences of working at Medway Maritime Hospital.

During this inspection, the surgical inspectors reviewed a total of 9 ward areas and the theatre department. We spoke with 55 staff, 25 patients and 15 relatives.

Summary of findings

We found evidence that the concerns raised following the CQC's last inspection had not been addressed. Our main concerns related to staffing levels, discharge processes, access and flow, ineffective management and leadership, governance and risk board effectiveness's and quality of care and patient experience.

Whilst we acknowledge that incident reporting had improved in the department we remain concerned that not all incidents were being reported. We were also concerned that senior staff responsible for reviewing and investigating incidents did not have the time to carry out these duties due to the impact of staffing levels. We identified a high tolerance to incident reporting in the department. Staff told inspectors that they tried to report all of the incidents however, it was not always possible because of the time and staffing constraints. Agency staff were not consistently reporting incidents.

The trust was not meeting referral to treatment times (RTT) in surgery.

Staffing levels throughout the department were found to be insufficient to meet people's needs. This was also identified at the last inspection. The trust remained heavily reliant on staff good will to undertake extra shifts, and temporary agency and bank staff in the interim to ease the pressures. There was a lack of robust induction procedures and records for these staff.

Surgery

Cleanliness data for the surgical unit was reviewed as part of the inspection process. Our observations identified the areas we visited as being clean and tidy. However, when we reviewed the cleanliness data it highlighted a significant failing in achieving the national standards of cleanliness, and major shortfalls in the audit processes used to measure compliance.

There is a concern that the surgical clinical unit is not learning from, or improving quality, from complaints and comments made. Staff remained unaware of complaints at a directorate levels which had influenced change, except from the ones made directly to them regarding noise, lights at nights, or communication problems.

Staff morale had been left in a poor state as a result of ineffective engagement, management and constant changes to directorate teams. The results of the most recent staff survey continued to raise concerns about staff welfare, moral and organisational culture at the trust.

Are surgery services safe?

Inadequate

Staffing levels across the service fell below both national and locally set levels and posed a risk to the quality and safety of patient care, as well as to staff welfare. We identified these risks as a significant concern at our last inspection. Whilst we were told that steps had been taken to address the staffing levels, we found little evidence that the situation had been managed effectively. Following our last inspection the trust completed a staffing review which demonstrated that all areas were understaffed. Clinical areas had their funded establishment increased. This meant that on paper, staffing establishments were increased but the exercise had little impact on the reality of the staffing levels in clinical areas. The trust did successfully recruit from abroad, however, retention of these staff was poor.

Incident reporting in the department had improved since our last inspection. However, we remain concerned that not all incidents are being reported. Staff told us they tried to report all incidents however, there were times where they were unable to do so. They told us that this was due to time constraints. Some staff described working in excess of 12 hours, sometimes without a break just to meet patient's care needs which left little time for incident reporting. We asked senior staff how frequently they review reported incidents and they told us that it was not as regular as they would like. They described having to work clinically to ensure ward areas were safe rather doing management tasks like incident reviews.

Mortality and Morbidity reviews were in place in the trust. However, the minutes we reviewed demonstrated a variance in the quality of the meetings.

Whilst the ward area appeared to be clean and tidy, audit data showed us that the department was not meeting the national a standards of cleanliness. The frequency of the audit process was not increased as a result of the failures.

The department was not compliant with NPSA/2010/RRR009 as there was a lack of a critical medicines list. We found surgical wards stored Suxamethonium (a drug used to induce muscle relaxation and short-term paralysis) in their refrigerators. This drug should only be available in

controlled areas where an anaesthetist is present. Kingfisher ward did not track FP10s (Medication prescriptions). NHS Protect guidance states that “As a matter of best practice, prescribers should keep a record of the serial numbers of prescription forms issued to them."

Mandatory training compliance was low in the department. For example the compliance rates varied between 75% and 85% across the department.

Staff thermometer data was displayed in all clinical areas..

There was a major incident policy in place and staff were aware of their roles should an incident occur.

Incidents

- The surgical department had a total of thirteen STEIS (National Framework for Reporting and Learning from Serious Incidents Requiring Investigation) between May 2014 and Apr 2015. These incidents attributed to slips, trips and falls, sub-optimal care of the deteriorating patient, grade 3 pressure ulcers and surgical error.
- All thirteen incidents had a root cause analysis (RCA) investigation completed and the reports were submitted to CQC for review.
- The department reported one 'Never Event' between May 14 – Apr 15. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Incident reporting and learning from these incidents had improved since our last inspection. However, we continue to have concerns about the service capturing all the incidents within the department. For example, agency staff gave inspectors mixed feedback when asked about incident reporting. Some stated they reported incidents and others told us they had never reported an incident despite being aware of occasions where an incidents should have been reported. They told us they did not know how to use the electronic reporting tool used in the trust.
- Senior staff responsible for reviewing incidents told us they did not have adequate time to go through the reports. They told us that this was because clinical duties took priority, especially when due to staff shortages. Senior staff were therefore not always able to carry out their management roles including reviewing incidents. This meant that there was a risk if incidents were not always being reviewed, this could have impacted on learning from events in a timely way.
- Further, there was significant disparity regarding whether agency staff could access the electronic incident reporting system. This was because as not all staff had access to the username and password protected computer system. Senior staff reported that agency staff could complete paper based incident forms however these forms were not always available on the wards we visited.
- Mortality and Morbidity (M&M, a key component of workplace-based learning where clinicians discuss errors and adverse events in an open manner, review care standards, and make changes if required) meetings were in place in the department. The documentation we reviewed from these meetings demonstrated a variance in M&M quality between surgical disciplines. The quality of the urology M&M meeting was of a much higher quality than that of general surgery. The data was presented in a chronological order, which took account of the number of elective and emergency cases and the number of admissions for each surgeon. The number of cases were broken down at procedure level and indicated the mortality and morbidity of each surgeon's case load for the specific time period. Patient information was presented in a way that took account of the initial presentation, background, clinical management and discharge. General surgical M&M notes were of poor quality which may suggest the process lacks structure which may have an impact on learning, quality, and the clinical value of these meetings. It is worth noting that CQC only received evidence of M&M’s from urology and general surgery which is not a fair representation of all the surgical disciplines in the trust.
- The trust had a Duty of Candour policy in place. Senior management were aware of their role in adhering to the Duty of Candour regulations. However, we found clinical staff at band two to six, and the temporary workforce were not aware of the new regulation or its implications.

Safety thermometer

- Safety thermometer data was collected and displayed in areas accessible to the public to view. This meant that data was visible to those who wish to view it.
- Safety thermometer data for the department showed a persistent prevalence of level 2-4 pressure ulcers, and C.UTIs (Catheter Urinary Tract Infections) between June 2014 and June 2015.

Cleanliness, infection control and hygiene

- The areas we visited appeared to be clean and tidy. However, we requested the NCS (National Standards of Cleanliness) environmental audit data to demonstrate compliance with the national standards of cleanliness. The data we reviewed showed us that wards in the surgical department were failing to meet the national standards for high risk areas. The records we viewed between March 15 and July 15 showed very poor performance in three surgical wards; Arethusa, Pembroke and Phoenix, all of which only achieved the national standard once in the identified period. The NSC states that if there are concerns over cleaning standards and areas are not meeting the requirements in their risk category then the auditing should be increase to the next level of auditing frequency. For example if high risk areas (audited monthly) did not meet the requirement consistently the next level of auditing (weekly) should be actioned, until such times the areas are consistently meeting the percentage required. We saw no evidence of this having taken place.
- Data we reviewed for April and March 2015 showed 3 cases of MRSA (Methicillin-resistant Staphylococcus Aureus) had been identified on the surgical wards.
- The trust provided us with hand hygiene audit data for all clinical areas for April 2015. We noted that with the exception of the day surgery procedures suite, the maxilo-facial service, pre-assessment, Sunderland Day unit and Victory ward, all other surgical wards, including theatres (7 wards and theatres) had failed to return a completed hand hygiene audit. The Surgery, Anasethetics and Theatres Performance dashboard however reported an overall hand hygiene compliance rate of 83% for the month of April 2015.
- Nursing staff raised a concern that intravenous cannulas were not always dated on insertion in line with trust policy. This resulted in cannulas being changed unnecessarily. Audit data revealed mixed compliance with the trusts "Saving Lives" audit in relation to the management of peripheral intravenous cannulas. In April 2015, Victory ward attained 89% compliance; Arethusa and McCulloch attained 92% and Kingfisher and the Sunderland Day unit 100%.
- Staff were observed wearing and using PPE (Personal Protective Equipment) appropriately during the inspection. Patients and their relatives confirmed compliance with key trust policies. However, on Victory ward we identified a medical professional conducting a wound review on an MRSA positive patient with no apron. There was ample PPE available outside the side room. We intervened and requested the individual adhered to infection control policy and wear an apron before taking down the wound dressing.
- We inspected a selection of equipment store rooms. Room H in theatres, was noted to have products on the ground as well as an unidentifiable fluid on the floor. This area was also being used to store sterile and non-sterile equipment.
- Patients were isolated appropriately to minimise the spread of infections.

Environment and equipment

- Our last inspection identified concerns with resuscitation and emergency equipment. We found improvements across the department. However, it is worth noting that when we carried out the unannounced inspection we found the checks had lapsed. For example, check lists on one ward demonstrated that emergency equipment was only checked on six occasions out of a possible twelve (between the 29 August 2015 and 8 September 2015). This meant that the trust policy, which states daily checks are necessary, was not being followed.
- During our inspection we noted the temperature on the surgical wards to be excessive. One ward area in particular was of great concern. The bay areas in McCullough ward was found to measure twenty nine degrees. It is worth noting that the weather outside was cool, so the temperature would be in excess of the twenty nine degrees had we measured it on a hot day. We found the temperature around the nurses station

and kitchen area to be noticeably much higher. However, we were unable to measure the actual temperature in these areas without the aid of a thermometer.

- The ward bay areas housed frail elderly and patients experiencing high temperatures. Patients told us the heat was just “unbearable.” They also told us that they were very distressed that the windows could not be opened and the glass doors had been closed. We asked staff why the doors had been closed and they told us that it was the result of feedback from a mock inspection. Staff were instructed to keep the door closed during the CQC inspection for infection control and dignity and privacy reasons. However, there was no infection control risk identified during the inspection and the doors were in fact, clear glass, which did not provide any dignity protection to patients. Inspectors asked staff to open the doors with immediate effect to ensure the health, safety and welfare of the patients in these bay areas. We are aware that there is no upper temperature level that providers are legally required to act upon. However, the health, safety, welfare and safety of patients, visitors and staff may be affected by being cared for, and working in, such intolerable temperatures. Staff told us they have reported their concerns over and over again and have not seen any action taken to address these concerns.

Medicines

- During our inspection we found that all the surgical wards stored Suxamethonium (a drug used to induce muscle relaxation and short-term paralysis) in their refrigerators. This drug should only be available in controlled areas where an anaesthetist is present. Ward staff we talked with were unaware of what this drug was used for, or the clinical implications if administered. One ward had returned it to pharmacy but the pharmacy department sent it back to the ward without question. We brought this to the attention of hospital management and the pharmacy department during our inspection and the drug was swiftly removed from these inappropriate areas. We carried out random refrigerator checks on our unannounced inspection which demonstrated the drug had been permanently removed.
- Kingfisher ward did not track FP10s (Medication prescriptions). NHS Protect guidance states that “As a matter of best practice, prescribers should keep a record of the serial numbers of prescription forms issued to them. The first and last serial numbers of pads should be recorded. It is also good practice to record the number of the first remaining prescription form in an in-use pad at the end of the working day. This will help to identify any prescriptions lost or stolen overnight.”
- We also found a lack of a signature list for the ordering of Controlled drugs on Kingfisher ward. This meant that trust policy was not being followed.
- An audit into the disposal of controlled drugs within theatres was conducted as part of the departments routine audit programme. The conclusion of the audit stated that "Anaesthetists failed to meet AAGBI Standards." 90% of anasethetic staff were aware of the need to empty syringes of unused controlled drugs however only 67% of staff practised this. 53% of staff were aware of the need to dispose of unused controlled drugs on absorbent material however only 23% of staff did so. The performance of Operating Department Practitioners (ODP's) was markedly better in the same audit with 100% of staff emptying syringes of controlled drugs. Whilst 95% of ODP's were aware of the need to empty the syringe on to absorbent materials, only 75% practicsed this.
- We found out of date Flumazenil on Arethusa ward, which expired in June 2015.
- Midazolam found in the CD (Controlled Drugs) cupboard on Arethusa, was not labelled for specific patient use. This did not follow with the trust midazolam policy which stated that only a limited number of named wards could hold a stock of midazolam following two never events associated with midazolam. This stock had been checked 4 times in the CD check and not returned to pharmacy as per policy.
- There were problems identified with refrigerator monitoring on Arethusa ward. Staff had little understanding of the maximum and minimum recordings; records reviewed by the inspection team demonstrated that staff routinely reported refridgerator temperatures of as "2°C" for the minimum temperature and "8°C" as the maximum; these readings were pre-programmed alarm limit temperatures and were not the actual minimum and maximum temperatures which the refridergator had been exposed too in the

preceding 24 hours. On Kingfisher ward we found a checklist which recorded that a refrigerator maximum temperature of 10.1°C for six days however no action was taken. This meant that the medication may not have been stored within its recommended temperatures.

- VTE (Venous thromboembolism) assessments were being completed. However, we found one example on Kingfisher ward where although a patient was identified as needing Dalteparin (a drug used is used for prophylaxis or treatment of deep vein thrombosis and pulmonary embolism) on 25 August 2015 it had still not been prescribed as of the 27 August 2015.
- Medical prescriptions were found to be legible and signed, but the doctors bleep number was not always included as per trust policy.
- There was a lack of systems in operation for self-administration of anything other than insulin. We found one patient who was self-administering Solpadol and keeping it in her handbag as she was anxious about receiving it on time.
- We found no room temperature monitoring in place on wards where medication was stored.
- The surgery department was non-compliant with NPSA/2010/RRR009 (Reducing harm from omitted and delayed medicines in hospital) as there was a lack of a critical medicines list.
- Surgical wards that were not routinely utilising transdermal patch site application records. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medication through the skin. Patch site application records are recommended so as to ensure previously applied patches are removed from the patient before new patches are applied so as to reduce the risk of accidental overdose.
- We found a lack of opening dates on liquid medication including Oramorph (oral morphine) which has a 3 month expiry from the date of opening.
- Ward staff reported delays in producing the EDN (Electronic Discharge Note); these were required in order that the pharmacy department could prepare medicines for patients to take home. During the inspection, patients raised concerns about the timeliness of obtaining discharge medication.
- Evidence suggests that if nursing staff are interrupted whilst on their drug round errors are more likely and can lead to patient harm. We found that medication rounds were not protected (i.e staff are allocated the role of conducting a medication round during which time other staff must not interrupt that individual). The NHS Medication Safety Thermometer results for April 2015 identified that the following surgical wards had high proportions of patients who expereinced omitted doses of medicines during a 24 hour period (medicines omitted for clinical reasons or where the patient refused have been excluded): Arethusa (20.8%), Victory (30.8%), Phoenix (26.9%) and Trafalgar (28.6%).
- The department operated an excellent system for self-administration of insulin which included an assessment of technique on at least two separate occasions by nursing staff.
- Epidurals infusions were stored separately in line with national guidance.
- PCA (Patient Controlled Analgesia) was prescribed on a separate drug chart and patients had a pre-programmed pump for standard infusion. This reduced the risk of errors associated with PCA's.

Records

- We reviewed a selection of patient records during our announced inspection and found that they contained the relevant risk assessments which demonstrated that patients were having their care needs risk assessed.
- However, when we returned on our unannounced inspection the selection of records we viewed varied in quality.
- We reviewed note folders that had lots of loose pages just pushed inside. This meant it was difficult to see a chronology to the care patients had received. It also posed a risk to the care, if important records were lost due to poor administration standards.
- We also found patient notes scattered across a desk in the discharge lounge on McCullough ward. We asked

the agency nurse why medical records were left in an unsecure and unattended area. We were told that there was, “no place to put them.” This meant that medical records were not kept confidential or stored securely.

- We identified some room for improvement in the nursing documentation we viewed. For example, times, dates, staff designation was not always recorded. We also saw entries from medical staff in the medical records that were unreadable.

Safeguarding

- There was a safeguarding policy in place which staff were aware of.
- Staff could explain what safeguarding was and the processes they would use to raise a concern.
- There was evidence that staff recognised and reported safeguarding concerns in the department.
- Safeguarding training compliance data suggested the surgical and anaesthetics department achieved 78% for level 1 and 68% for level 2. adults. Compliance rates for safeguarding children was reported as 93% for level 1, 75% for level 2 training and 17% for level 3.

Mandatory training

- Mandatory training compliance was low in the department. For example, the compliance rates varied between 75% and 85% across the department for the various mandatory training modules including health and safety, manual handling and fire safety. There was an expectation that mandatory training compliance should be between ninety five and one hundred percent.
- Staff told us the low staffing levels impacted their ability to attend training.
- Online training was also provided for staff. However, there was an expectation that staff would complete this training in their own time from home. Staff told us that accessing this training portal was difficult which meant they were unable to complete the training.

Assessing and responding to patient risk

- The trust used a NEWS (National Early Warning Score) to identify deteriorating patients.
- During the inspection the records we reviewed showed that these scores were being recorded and acted upon. However, we were aware of reported incidents where clinical observations were not recorded; NEWS scores were not completed and medical reviews did not take place in a timely manner in line with trust policies. This resulted in deteriorating patients not receiving the medical reviews they needed.
- The main theatres department was using the WHO (World Health Organisation) surgical safety checklist. Compliance with the documentary requirements of the checklist were seen to be good, with the theatre department attaining 97% compliance in July 2015; 98% in May 2015 and 98% in April 2015. A further observational audit of how staff performed the various non-documented components of the process had also been conducted; overall satisfactory compliance with the 'Time in, time out and sign out' process across nine surgical areas was 89%.
- We were told that the department had a system where a dedicated medical team would liaise with surgical wards to ensure specific patients had regular reviews. We found a high proportion of medical outliers located on surgical wards (outliers in this sense, refers to patients who are receiving care on a ward which does not specialise in the condition attributed to the patient). Staff provided mixed feedback on the quality of the care these patients received. Some reported no concerns with obtaining medical reviews and care consistency. However, other staff told us that getting medical input and reviews was occasionally problematic and required several phone calls and reminders before patients were seen.

Nursing staffing

- CQC observed a dedicated, but exhausted workforce across the surgical department. All the staff we talked with (including temporary staff) expressed concerns about the standard of patient care they could physically provide due to the impact of the staffing levels.
- The department used an acuity tool. However, its use had little impact on the staffing levels in the department.
- Staff told us that even if they managed to have all of their full quota of staff attend work, they were soon moved to other areas to assist with staffing levels

elsewhere, leaving their own areas short. This was consistent with what we observed during the site meetings which were held daily; senior staff discussed each of the clinical areas to determine where there were shortfalls in staffing numbers which were likely to impact on the quality of care provided. As a result of these reviews, staff were reallocated to areas of high priority accordingly.

- One relative told us, “the nurses are run off their feet and don’t have the necessary resources or time to do their jobs properly."
- We asked senior management what steps had been taken to address the staffing concerns. They told us they moved staff around to manage the situation and requested bank and agency staff. International recruitment was also used as an improvement tool. Recruitment was somewhat successful but the retention of the staff proved inadequate to manage the situation. A Manager told us that international staff moved to London areas as the wage was more attractive. However, staff had a different perception on why retention was poor. They told us that a minority left for the prospect of higher wages. However, more often than not, they left because of the high stress levels, lack of clinical support, daily ward moves, and lack of job satisfaction and development opportunities.
- We attended handovers in ward areas during our announced and unannounced inspection. Handovers were undertaken round the beds of patients. Staff told us that they were carried out like this for two reasons. The first being that was “what we were told to do” and “so that staff can see the patients they were talking about.” The handovers we witnessed did not maintain patient confidentiality, respect or promote patient dignity. We noted that patients could hear confidential information about fellow patients. We also noted that visitors were present in bay areas during one of the handovers.
- The quality of the handovers was variable. A handover sheet was made available to staff, however, it was not always updated with the most relevant information. We also noted the detail in which patients were handed over varied, with some discussing past medical history and admission and others just focusing on the previous 12 hours. It was apparent there was no clear structure to the process which posed a risk to care continuity and caused fragmented communications with nursing teams, some of which were entirely agency staff.
- We asked staff if they considered their clinical areas to be safe. They told us they did not think their areas were always safe because of the staffing levels. One staff member told us “I wouldn’t be happy to have my family here because there are not enough staff."
- Additional comments we received from staff during the inspection included; "it’s totally not safe and the other wards are the same” and “we just don’t have the time to do things properly” and “some patients feel like they can’t bleep us for help because they know we're busy.”
- Arethusa ward reported a 4.5 WTE shifts vacant for a shift on the 27th August 2015. Pembroke ward was found to have a vacancy rate of 11 WTE nursing staff. The theatre department reported a deficit of 20 wte staff, an overall vacancy rate of 16%.
- McCullough ward had a WTE qualified nurse planned budgeted establishment of 20.7; the actual establishment was 12.5wte. We noted that two of the 12 staff should not have been included in the actual staffing numbers as they both should have had supernumerary status due to their personal circumstances.
- We found the skill mix on all ward areas to be insufficient to meet peoples' care or safety needs. Staff we talked with told us that there was little clinical support provided in their clinical areas. They told us that this was because of high staffing vacancy levels on shifts and the time constraints place on more experience staff. They also told us that high levels of agency staff was also an obstacle to ensuring patients received adequate support. CSW (clinical support workers) told us they were frequently the only permanent staff on duty with a team of agency nurses at night. We found this was substantiated during our unannounced inspection where one ward was staffed entirely by agency nurses.
- The surgical department relied on agency and bank to cover the staffing vacancies. However, we were told that not all the shifts were covered because, “even the agency staff are fed up of the workload and the lack of support.” The trust told us that they had an induction programme in place for temporary staff. This induction

included an induction leaflet with basic information for temporary workers and a self-assessment competency. We were told that temporary staff had a formal introduction into their clinical area when they worked there for the first time. We asked to see evidence of these inductions.

- We were told that the trust was in the process of merging paper based records onto an electronic system. We reviewed a selection of the records that were already on the electric system. However, the agency staff we talked with provided mixed feedback about the induction process. Some temporary staff told us that they had received an induction and some had not. A selection of those who claimed they had an induction were unable to produce a record to demonstrate this. We found confusion at ward level about what the induction process should be and how it was being documented. Permanent staff told us they didn't always carry out an induction because of time restraints placed upon them. They described working over their hours without a break. One comment received was, "there is only so much extra time you can work in one day."
- We were concerned about heavy reliance on temporary staff across the surgery department and the reliance on self-assessment competencies for medication administration. This coincided with our concerns about the under reporting of incidents from this staff group. The trust had no assurance that agency staff were competent to administer medication safely as they have not had the same standard of competency assessments permanent staff had received. This posed a moderate risk to patients being cared for across the service.
- Concerns were also raised about staff being moved from the theatre department to work in ward areas. Staff were asked to work on wards without management ensuring there was appropriate support in place for staff. The skill-set of a theatre nurse was vastly different to that of a ward nurse and redeployment without adequate support not only posed a risk to patients but to the registered staff who were redeployed. There was no evidence that staff had their competency levels assessed for cross department working. Staff told us they had raised concerns about this with management.
- We were aware that a clinical support worker was asked to leave a training day to undertake ward clerking duties despite never having performed the role before. Information received from staff said that this was because of the CQC inspection.
- We identified one staff member whose working arrangements had been reviewed by the trust occupational health department due to recent health issues. The review stated that this staff member was not to undertake clinical duties to ensure a safe recovery. However, due to staffing pressures, this person was forced to work clinically to ensure patient care was delivered and their team was supported in times of great pressure. However, this meant that the organisation was failing in its duty to ensure the health, safety and welfare of this staff member.
- One ward area we visited told us that they operated a fast track recruitment system. This meant that prospective staff could be interviewed and obtain occupational health appointments in one day in an attempt to speed up the recruitment process. However, this was not mentioned elsewhere in the department.

Surgical staffing

- Medical staffing numbers in surgery identified 180 WTE staff employed across the service. 17% of these staff were junior doctors (5% higher than the England average), 37% registrars and 12% middle grades (both within the England average). The trust reported consultant staffing at 34% which was below the England average of 41%.
- We attended medical handovers during the inspection. We found a conflict in terms of handover timings and a risk to the quality of the handovers. For example, the registrar and consultant handovers occurred at the same time limiting attendance and affecting communication.
- Locum staff were used to ensure the service would be delivered in times of staff shortages. Locum staff were employed on a long-term basis which helped ensure continuity of care.

- There was consultant presence between 08:00 and 17:00. Out of hours a consultant on call service was provided. Medical staff we talked with told us that this worked well and that they felt well supported by their colleagues out of hours.
- Consultant led ward rounds were standard practice at weekends.

Major incident awareness and training

- The trust had a major incident and business continuity policy in place which provided the necessary guidance for staff.
- We found evidence of appropriate protocols for deferring elective activity to prioritise unscheduled emergency procedures
- Staff were aware of their roles should a major incident arise.

Are surgery services effective?

Requires improvement

Whilst the data we reviewed showed good performance when compared to other trusts nationally, we are concerned about the quality and validity of the data.

Staff were identifying the need for DoLs (Deprivation of Liberty Safeguards) assessments in the department. However, we found that applications were not complete and there was no system in place to monitor when the application had expired. This meant that patients may have their liberty deprived illegally.

Trust policies reflected NICE (National Institute for Health and Care Excellence) Royal College and other national guidance.

Patients we talked with during our unannounced inspection did not have access to water. We asked staff how the low staffing levels impacted on patients who required assistance at meal times. They told us that patients sometime experienced long waits for assistance. However, documentation reviewed demonstrated that patients had their nutritional needs risk assessed. Where a risk was identified a referral was made to the dietician for input and review.

Medical records and conversations with patients and staff demonstrated a multidisciplinary approach to care. For example patients had referrals to physiotherapists, dieticians, speech and language and occupational therapists.

The department had appropriate access to screening and diagnostic services seven days a week. Consultant ward rounds were conducted at the weekend and theatres had appropriate emergency theatre access to ensure that patients needs could be met twenty four hours a day. Patients were cared for by competent staff that had the necessary skills to meet their care needs. Data suggested that patient outcomes were within the England averages.

Evidence-based care and treatment

- We found systems in place which meant that the service took account of published research and national guidance.
- Policies and guidelines reflected NICE and Royal College of Surgeons guidelines. Care was also being delivered in-line with NCEPOD (National Confidential Enquiry into Patient Outcome and Death).
- Care was provided in line with NICE CG50 (Acutely ill Patients in Hospital) and CG83 (Rehabilitation after Critical Illness).
- There was a clinical audit lead in post who had over sight of the departments formal audit plan.
- The trust had a consultant geriatrician who provided specialist medical cover Monday to Friday.

Pain relief

- There was a pain assessment tool being used in the department. Records demonstrated that this was being used to aid pain assessments.
- MAR (Medication Administration Records) evidenced that pain relief was prescribed and administered to patients.
- Where PCA (Patient Controlled Analgesia) and epidural analgesia was being used the appropriate safety protocols were in place. For example, anti-emetic medication (effective against nausea and vomiting), reversal agent and fluids were also prescribed for use in the unlikely event of an emergency.

- There was a dedicated acute and chronic pain service provided in the trust. However, the acute pain team consisted of a lead consultant and one specialist nurse to deliver a service to the entire trust. The chronic pain service was also delivered by just one nurse. Both services worked independently and did not interact with the other.
- The acute pain service was provided Monday to Friday, between the hours of 9am to 5pm and outside of this, support was available from the outreach team with assistance from the on call anaesthetist.
- Ward areas did not have a pain link person to support learning and training around pain management.
- The feedback we obtained from staff about the acute service was positive, however, concerns were continuously raised about the unsustainable workload on just one person.

Nutrition and hydration

- Staffing numbers had an impact on the patients who required assistance at meal times. Staff told us they,"did their best" but, “there was only so much you could do at one time.” This meant that patients had to wait a long time before staff could help them at meal times which frequently resulted in the meals getting cold.
- Feedback from patients told us the quality of the food was “poor.”
- During our unannounced inspection we visited the discharge lounge where patients asked inspectors to fill their water jugs. We noted all the jugs in that area were empty. They told us they had asked several times for water but the staff did not have time to get it. This meant that patients did not have access to water to stay hydrated for extended periods. It is important to note that this ward was continuously affected by unpleasantly high temperatures.
- The surgical department audited performance against the trust pre-operative fasting policy. 100% of audited patients were fasted for the minimum recommended time period however it was noted that the average fasting time was 7.9 hours with a range of between 2.75 hours and 20.5 hours. 28% of patients attending for elective surgery were fluid fasted for between 7 and 10 hours; and 24% of patients were fluid fasted for between 10 and 20.5 hours which suggested that patients were being fluid fasted for excessive periods of time. The average food fasting time for patients attending for elective surgery was 13.6 hours with a range of between 5.75 hours and 20.5 hours. This range of fasting would again suggest that some patients expereinced excessive fasting times and went against the trust fasting policy.
- Patients had their nutritional needs risk assessed. The department used a MUST (Malnutrition Screening Tool) to determine the extent of the risk.
- Those identified as being at risk had their weight recorded, and a referral to the dietician team was made.
- Food charts were in operation and there was a choice of food available to meet individual dietary needs.
- Fluid charts were also being used, however, they varied in quality and completeness from ward to ward.
- Protected meal times were in use across the service which meant patients were not interrupted by health care professionals during set times, to enable patients to eat their meals.

Patient outcomes

- Data demonstrated that the risk of readmission for patients who attended for elective general surgery and urology was higher than expected (risk ratio of 156 (general surgery) and 114 f(urology) versus 100); those undergoing non-elective (emergency) general surgery or urology were less likely to be readmitted (risk ratio of 95 for general surgery and 85 for urology, versus an expected 100).
- The department participated in national audit programmes including the national hip fracture audit, bowel cancer audit, CEPOD (Confidential Enquiry into Patient Outcomes and Death) and emergency laparotomy audit.
- Emergency laparotomy data demonstrated a fully staffed emergency theatre, intensivist and outreach cover, interventional radiology and CT (Computed tomography) provision twenty four hours a day. There was a sepsis management, enhanced recovery and single surgical pathway for patients. The Emergency laparotomy 2014 audit identified the need to undertake a formal calculation of risk associated with perioperative mortality. Since May 2015 formal calculations were in place with the P-Possum risk score

entered for every emergency laparotomy case which meant booking an appropriate senior consultant surgeon and anaesthetist in theatre as per Trust policy which stated if the risk was >5% then the consultant surgeon and anaesthetist should be present.

- Hip Fracture audit shows mixed performance year on year, and compared to the England average. The trust did better than the England average when it came to patients having surgery on the day of or day after admission: patients having a bone health assessment, falls assessment and pressure ulcer prevention. In 2014 41% of patients were reviewed by a geriatrician, which was lower than the 51% national benchmark. However, it is worth noting that this had increased from 20% in 2013. The trust performance for ensuring patients were admitted to ward areas within four hours had worsened since 2013 when it achieved 51%. In 2014 it reported 47% of patients were admitted within the recommended time frame, which is only just below the national average of 48%.
- Bowel audit results demonstrated performance similar to the England average. The bowel cancer audit demonstrated that 100% of the patients were discussed at an MDT (Multidisciplinary Team Meeting). 80% of patients had major surgery and 71% had laparoscopic surgery attempted or carried out. However, 79% of patients were seen by a clinical nurse specialist opposed to the national average of 88%. 80% of patients had their CT scan reported. The England average for CT scan reporting was 89%.
- The department operated to the RCS (Royal College of Surgeons) standards for unscheduled care.
- Average length of stay was similar to the national average for elective and non-elective pathways.
- We found a good enhanced recovery pathway embedded in the department. The trust had recently recruited a new matron to the post of enhanced recovery lead practitioner. This post brought the prospect of further service development as well as improved support for patients and staff.

Competent staff

- All substantive nursing staff were subject to nursing registration checks and the unit was in preparation for the new Nursing and Midwifery Council (NMC) nursing revalidation processes.
- Evidence demonstrated that revalidation for medical staff was carried out in line with Royal College recommendations.
- Surgery and anaesthetics reported 67% of staff had received level 1 adult basic life support training.
- Data showed us that Infection control training had been received by 96% at leve l1, 84% at level 2 and 82% at level 3 training.
- 79% of staff in the department had received consent training.
- Staff had undertaken annual appraisals. The department reported a compliance rate of 95%. However, the staff we talked with described the appraisal system at Medway as a "paper exercise" rather than a meaningful and productive process.
- Clinical supervision was not widely practiced. Clinical supervision can be defined as a process that identifies solutions to problems, improve practice and increase understanding of professional issues. This meant that the services was missing an opportunity to improve the service and to strengthen, learn and share clinical expertise and skills.
- Manual handling training rates were reported as 85% for the two yearly theory update, 71% for two yearly practical and 74% for the five year update.
- Mandatory training in the department was not meeting the set 95% standard.
- Comparative outcomes by clinician were reported nationally.
- A practice development facilitator on the orthopaedic wards provided support to permanent and temporary staff.
- We found good career development pathways for band 2 clinical support workers.

Multidisciplinary working

Surgery

- There was evidence in the medical records we reviewed, and the conversations we had with staff and relatives, that the unit took a multidisciplinary approach to the care.
- During the inspection we spoke to a range of staff who had a professional input into the care delivered.
- Entries in the medical records demonstrated a wide range of professional input into care. For example physiotherapist, dietician, microbiologist, speech and language therapist, pharmacist, surgical and medical team input.
- All patients discharged from the surgical high dependancy unit were followed up by the outreach team and the physiotherapists involved in the rehabilitation service.
- The critical care outreach team provided a service seven days a week, twenty four hours a day cover.
- The orthopaedic wards held an integrated discharge meeting each day. This was attended by a senior sister, occupational therapist, physiotherapist and the integrated discharge facilitator.

Seven-day services

- The department provided consultant-led care seven days a week.
- Consultant led ward rounds were provided at the weekends with registrar and junior doctor on site cover.
- An on call physiotherapy service was also provided at the weekends.
- There was also an on call pharmacist available to provide support to the unit out of hours.
- We found suitable access to imaging, and pathology, but we noted that there was no OT (Occupational Therapy) service provision.
- There was appropriate access to diagnostic, screening and emergency theatre provisions out of hours.

Access to information

- The clinical areas we visited had a wide range of conditions specific information available for patients and their relatives.
- Each ward area provided information which supported patients and their relatives to make decisions about their care and treatment and the services available to them.
- Information for relatives was displayed in the waiting room and display boards in ward corridors.
- Patients and relatives we spoke to told us they felt they could approach staff to ask for additional information if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We visited Victory ward where the staff were identifying and recognising the need for DoLS applications for their patients. The Deprivation of Liberty Safeguards(DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in hospitals are looked after in a way that does not inappropriately restrict their freedom. Capacity assessments were in place, best interest meetings had occurred and urgent authorisations had been signed off and agreed which we recognised as good practice. However, on closer inspection of the documentation it appeared that extensions to the applications were not signed off. We noted applications that had expired. There was no documentary record of application extensions, only the original applications were present.
- We found the IMCA (Independent Mental Capacity Advocate) section of the applications were filled in incorrectly. Sections E,F,G,H on the forms we reviewed were not completed. One form we viewed had conflicting information about the patients power of attorney.
- Ward staff were not aware of the application expiry dates, nor was there a system in place that would flag up the expiry dates.
- There were no records of when assessments were completed, and no way to formally track an application. Inspectors contacted the safeguarding office but they were unable to provide the relevant information about individual applications. There was also no formal way of checking if there were conditions attached to individual applications. This was identified as a significant risk to the organisation. This also demonstrates a disconnect between the safeguarding team and clinical staff.

Surgery

- Staff told us they did not received feedback on authorisations and acknowledged that their understanding of trust processes was not clear.
- The surgical risk registers noted that surgery teams do not get sufficient support from the safeguarding team with respect to Deprivation of Liberty Safeguards (DoLS). However, no specific actions were noted, other than "better working collaboration."
- We found consent was obtained in line with national guidance.
- Patients told us they had enough time and information to be able to give informed consent.

Are surgery services caring?

Good

We observed staff delivering compassionate care to patients during our inspection. The patients and staff we talked with told us they were well cared for by kind staff. Patients described staff as "very dedicated" and as "delivering impressive care" despite the "noticeable lack of staff." Staff worked in a way that demonstrated genuine commitment to their patients and staff teams. Comments received from relatives included "the staff deserve a pat on the back," " they don't have the time or resources to do their jobs," "but the care is good, you just don't hear about it."

The patients and relatives we talked with told us that they received good care from "fantastic" staff. They told us that staff were responsive to their needs when they called for help. Some told us that responses during the night were somewhat slower than during the day, but they felt their care needs were met regardless. Patients felt their needs were understood and met by the staff in the department.

Emotional support was provided from a range of sources, including ward staff, specialised nurses, members of the multidisciplinary teams and the chaplaincy services. Patients and their relatives felt their emotional needs were taken into account during their admissions. They also told us that they were involved in planning their care, given enough time to discuss concerns with the relevant medical staff. Patients felt able to ask questions about their care and contribute to discussions and make decisions about care. Documentation demonstrates that people's individual needs were taken into account when care planning, for example, communication, religious needs, and personal preferences. Despite high levels of patient satisfaction during the inspection, all of those we talked with raised concerns about their perception of low staffing levels and the great pressures placed upon the staff.

Data from the 'Friends and Family Test' demonstrated low response rates that depicted average and low levels of satisfaction in the surgical department. For example, satisfaction scores for June 2015 ranged between 50% and 98%.

It is worth noting that during our unannounced inspection patients expressed their dissatisfaction with the care they received. This feedback was obtained from patients who were being cared for in the surgical discharge lounge. Patient experience in this area was found to be very low at the time of our inspection.

Staff told us they did their very best for patients but were extremely dissatisfied delivering what they perceived as "task oriented care." They felt that care was driven not by patients' needs and not individualised or holistic in nature. Staff told us that they felt unable to always care for patients in a way that they themselves would like to be cared for.

Compassionate care

- Patients told us that they felt cared for by compassionate and kind staff.
- 'Friends and Family Test' results demonstrated mixed satisfaction levels across the surgical department. Results were found to range between average and poor with a moderate response rate. For example one ward we visited (Victory) reported a 50% satisfaction rate for June 2015 with the majority of those surveyed saying they would not recommend the ward. Response rates for individual areas was found to be low between March 2014 and February 2015. The lowest being Kingfisher ward with only 208 responses area in the given time frame.

Understanding and involvement of patients and those close to them

- Staff demonstrated a good knowledge of how to involve patients and their relatives in the planning of their care.

- Documents we viewed during the inspection demonstrated that patients were involved in their care planning. For example people's individual preferences were recorded and acted upon.
- We observed staff interacting with patients and their relatives in a positive and proactive way. We saw staff trying to ensure patients were as involved as possible in making decisions about the care they received.
- The patients and relatives we talked with told us they felt very involved in their care planning and were kept regularly informed by staff.
- It is worth noting that some patients we talked with told us communication between the nursing and medical teams could be improved upon.

Emotional support

- Emotional support was firstly provided by the nursing staff in ward areas. The trust had specialist nurses and member of the multidisciplinary team who provided specialist knowledge and support to families for example, cancer, bowel and learning difficulties specialist nurses as well as the palliative care team.
- There was a chaplaincy service available to provide emotional and spiritual support for patients and their loved ones.
- We did not see any evidence of assessments for anxiety and depression. However, staff assured us that referrals could be, and were made to the mental health support team when necessary.
- Staff were acutely aware of the importance of ensuring that they not only supported patients, but also their families. The relatives we talked with told us that their emotional needs were being met.

Are surgery services responsive?

Requires improvement

We have rated the services in the surgical department as requires improvement.

The service was not managing to meet the needs of local people. We continue to have significant concerns about referral to treatment times (RTT), access and flow throughout the department and what appears to be the lack of effective action to the staffing concerns raised by CQC in March 2013.

We found evidence that peoples individual needs were not continuously being met during their admissions. Patients were being cared for in inappropriate clinical areas for example, the recovery area, the discharge lounge on McCullough and for extended times in the surgical assessment unit. During our unannounced inspection we identified an entire bay of patients (in the discharge lounge) who did not have access to drinking water. One patient told us that their bed was broken and therefore had to sit in a chair all day. This patient had raised a concern about the bed with staff and did not have the matter resolved.

The orthopaedic ward which cared for the majority of older patients with fractured hips (a category of patients which is also a high risk group for dementia) had several patients with a dementia diagnosis but only one nurse who had received dementia training. This was insufficient to meet the needs of patients with dementia in this particular ward area.

We found a lack of quality monitoring on McCullough ward relating to the length of stay in the discharge lounge and poor discharge processes across the department. Data was not being collected in a formal way which would ensure it could be used as a service improvement tool.

Staff were aware of their role in assisting patients to raise concerns or complaints. Ward areas had PALS (Patients Advise Liaison Service) information leaflets available. Feedback from staff varied about the quality of learning from complaints.

Service planning and delivery to meet the needs of local people

- Our last inspection identified the struggle of the surgical department to meet the needs of local people. We did not see any improvements to how the service was responding to the demands placed upon it. Whilst we recognise that work had taken place in some areas to respect patient's dignity and privacy, and improve patients experience, the overall the improvements were limited. We found patients were being cared for in

inappropriate areas for example extended stays on the day surgical unit, recovery, POCU (Post-Operative Care Unit) and the discharge lounge on McCullough ward being used to as an escalation area.

- Referral to treatment time (RTT) data had been poor for patients on admitted pathways until August 2014 the Trust was performing on Average at 70-75% which was below the national standard of 90%. In November 2014 the trust stopped submitting RTT data so we are unable to comment on the trusts performance after this date.

Access and flow

- Our last inspection identified concerns with flow in the department. We found no evidence of improvements during this inspection. The department was failing to meet the demands of the service.
- The management team told us the discharge lounge in McCullough ward was used as a second stage recovery area. However, staff told us this area was frequently being used as an inpatient area when demand exceeded capacity. There were no overnight patients in this area during our announced inspection. However, when we returned to do an unannounced inspection this area was being used to provide overnight care. The ward kept a written log of the patients in this area. However, the data was not always complete. There was no easy way to identify patient admission or discharges to this area. Staff told us that this information was only recorded in patient's notes. We asked to see the electronic admission data for this area and we were told that patients in this area were recorded as being elsewhere in the hospital. The lack of electronic tracking and accurate admission/discharge data made it difficult to determine the frequency of this area's use as an inpatient area. It also made identifying the average length of stay near on impossible without reviewing large volumes of patients notes.
- The surgical assessment unit would normally have an expected length of stay of twenty three/twenty four hours. However, we found patients were exceeding this by several days. This meant the area was not functioning as a surgical assessment area.
- Other patients we spoke to told us they were subjected to several ward moves in the middle of the night. We requested data from the trust to demonstrate the time and frequency of patient's bed moves. At the time of writing the report this information was not available.
- The recovery area was still being used as a ward when demand exceeded capacity and there was a shortage of surgical beds. This area was also being used by the A&E department to avoid breeches. Whilst we acknowledge the lengths staff went to ensure patients received a good quality of care, it was still an inappropriate area to provide inpatient care with extended stays also resulting in relatives visiting this area whilst post-operative patients were in recovery. It also had an impact on the delivery and effectiveness of surgical lists. We heard of occasions where patients had to be recovered in anaesthetic rooms which resulted in poor patient experience and delays in the efficiency of operating lists.
- We continue to have concerns about theatre efficiency. We reviewed several theatres registered and found that the average surgical start time was after 9am, despite the area being staffed from 8am. Several reasons were given for this, including ward staff shortages, porter provision and theatre teams not being ready to send for patients in a timely manner.
- Bed occupancy was reported to be 99.1% between January 2015 and March 2015. This was marginally worse when compared to the same previous the previous year (96.6%).
- We found discharges are not as well managed as they could be. Staff gave us reasons why this was the case. For example, they described long waits for medical staff to complete discharge letters and medication prescriptions, delays in obtaining medication, and the "abysmal performance of the new transport provider."
- Poor cross site community working had also resulted in patients expereincing delays in being discharged to third party community services.
- The department had implemented a new process to monitor and control surgical cancelations. This meant that patients could not be cancelled without the agreement of the medical director.

- Data reviewed between February and July 2015 showed 95 cancelations because of the lack of availability of surgical beds.
- Data also demonstrated that cancellations were reducing over this time periods. However, it is worth noting that in the same time period 527 day surgery cases were cancelled.
- The percentage of patients whose operation was cancelled and were not treated within 28 days was 0% for 14 of 16 previous quarters, although the most recent quarter was 7%.
- 76% of Fractured Neck of Femur patients were seen within 48 hours which was better than the England average of 73.8%.
- The average length of stay was similar to national averages for elective and non-elective cases.
- Poor performance was reported against the latest Fractured Neck of Femur audit which noted a consistently high unplanned re-attendance rate.
- We did not find any surgical outliers in medical wards during the inspection. However, we noted high numbers of medical outliers on surgical wards.

Meeting people's individual needs

- We talked with a patient who told us that the bed management team had requested that they undertake a ward move at 1:30am. This patient told us that he was very grateful to the nurse who "was kind and compassionate but not afraid to stand her ground" and "treated me with dignity" and prevented the move from taking place in the middle of the night. However, this was not the experience of many of the patients we talked with.
- Translation services were available in the department. Multilingual staff were also used to provide translation services when available.
- The trust had a learning difficulties team to support patients and ward staff. Feedback obtained about this team was positive and staff told us they utilised the service as and when they needed to.
- Each area had a dementia champion in place. However, the staffing levels impacted their visibility and function on the ward. This in turn, had an impact on the available support for these patients and staff who cared for them. The department had implemented the national 'butterfly scheme' to improve care for this patient group.

Learning from complaints and concerns

- The department had a complaints policy that reflected national guidance.
- Staff were aware of the policy, its contents and their role in supporting patients and relative to raise a concerns.
- There was PALS (Patients Advice and Liaison Service) which provided additional information and advice to those who wish to make a complaint.
- A patient told us "I made a complaint and they took it seriously and resolved it to my satisfaction."
- Ward meeting minutes demonstrated that complaints were discussed with teams to aid learning.
- Staff were able to tell us about local complaints about their clinical areas, however, they were unable to identify trends and themes in the department or at a trust level.
- The department operated a 'you said we did' initiative. Actions to concerns were displayed in ward areas. We found some of the examples of actions taken by staff to be weak responses to the concerns raised. For example we noted feedback given by a patient that said "appalling treatment and arrogance of staff, especially the day staff." The documented action to this comment was "advised all staff to ensure they treat everybody with respect." The staff we talked with were unable to talk about the feedback and we were told that the patient had not been contacted with an explanation or apology.

Are surgery services well-led?

Inadequate

There was no clinical lead for the surgical department. This position had been unfilled for some time. The leadership from senior nurses upwards was not effective or proactive. Staff did not know who was in charge of their department and had lost touch with senior management because of the constant management churn. Staff told us they were

tired of the changes and only concentrated on their own individual roles and their immediate teams. Junior and temporary staff were not provided with adequate support they needed to do their jobs.

Governance and risk management in the department was not effective. Meeting minutes demonstrated that essential staff were not attending meetings and that actions were not agreed and implemented in a timely manner. Staff at ground level were unaware of the recent improvements from the boards and were unable to give any examples of how the boards worked or influenced changes, or drove improvements in the service.

Morale in the department was extremely low. The department was being run on the good will of an exhausted and undervalued work force. Staff engagement was poor and public engagement was non-existent except for 'Friends and Family Tests'.

Vision and strategy for this service

- There was a vision and strategy for the department. However, it was not known to the staff who work at ward level. Staff felt disconnected from the vision, strategy and goals of the surgical service.

Governance, risk management and quality measurement

- We found evidence of a weak governance, risk and quality management structure and processes in the department.
- We reviewed a selection of governance minutes which identified concerns about the governance structure and quality of the processes. For example, we noted the governance manager and governance and risk leads did not attend several meetings as one would expect. Minutes revealed that “it was discussed and noted that there was again lack of senior management in attendance.” Meetings were not quorate therefore unable to make decisions and take action.
- Actions and risks were not addressed or resolved in a proactive manner. For example, the lack of paediatric trained nurses, or the pregnancy testing policy and guidelines.
- The anaesthetics governance group and the surgical governance group were held separately which in effect meant that actions were continuously regurgitated in two separate forums.
- Audit lead updates, incident and complaint reports were not submitted regularly.
- Ward level staff were not aware of the governance and risk structure, processes or outcomes.
- Infection control concerns were not regularly discussed at these meetings.

Leadership of service

- We found poor dashboards in place in the department. This meant that quality measurement and department performance would not be monitored effectively.
- Staff told us they were “worn out” and “exhausted” by the management churn in the department.
- Some staff told us they were not aware of who their middle managers were because it changes so frequently. Comments we received were “I’ve just given up with trying to know who’s who” and “I’ve no idea who’s in charge.”
- We received comments like "I’m sick of raising concerns with managers only to find they have left 3 weeks later,” and “I’m continuously telling them some thing’s and nothing ever changes as a result because they keep leaving.”
- We found there was no time for staff to undertake management duties: this was severely impacted by the consistent low staffing levels. For example this affected performance, sickness and incident reviews.
- No time was set aside for staff to undertake mandatory training.
- When we asked staff what was the one change that would make the most impact on the service we got a unanimous response of “more staff” and “every problem here is down to staffing.”
- “Ward meetings are opportunities for us to raise concerns, but nothing happens.”
- “We get told off by management because things are not done, but there just isn’t enough time to do it.”

- Staff were not receiving appropriate support or advice from the HR (Human Resources) department. Staff were unaware of their employment rights and trust employment policies and procedures. Managers were providing advice to staff that which did not reflect trust policy.

Culture within the service

- Morale across the service was found to be very low. This in turn has had an impact on the department's ability to recruit and retain staff.
- The staff group have been exposed to so much change and leadership churn that they have become disconnected from the senior management team and trust board.
- We were told that senior management were not visible at ward levels. Staff expressed their concerns about the lack of visibility and interactions with the senior team.
- Staff felt valued by their immediate team members (band 6 & 7).
- “Most staff adjust to not being able to recognise the CEO or head of nursing due to constant changes at the top.”
- Staff could not name any members of the executive team and did not know who the director of nursing was. Staff told us they had never seen senior management in their clinical areas.
- “There is good team working amongst us as nurses, we just get on with it, but we are exhausted.”
- We were told that staff frequently raised concerns that went unaddressed. Faith in senior management’s capability was damaged as a result.
- We found evidence of silo working in the department. This meant that best practice and learning was not shared.
- We were approached by staff who wished to raise concerns about bullying and harassment and inappropriate behaviour in the theatre department. We noted that the anaesthetic governance meeting minutes from April 2015 noted that electronic incident records were completed on attitudes and language used in theatre. The minutes also noted that the way staff were treated needed to be improved. During the inspection we received whistleblowing concerns related to the inappropriate behaviour in the theatre department. We reported these concerns to the HR department who commenced an investigation with immediate effect.

Public and staff engagement

- Staff told us they did not feel engaged with the board or the senior management team.
- They also told us that they were “worn out by the constant management churn” that they had just given up trying to stay abreast of the changes.
- We found no evidence of engagement with the public other than 'Friends and Family Tests'. This meant the service did not take account of the public’s view.

Innovation, improvement and sustainability

- The department operated an excellent system for self-administration of insulin which included an assessment of technique on at least two separate occasions by nursing staff.
- The surgical pre-assessment service was offered a good quality of service to its patients.

Critical care

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

Information about the service

Critical care services for adults at Medway Maritime Hospital account for 67% of the critical care activity within the hospital; the remaining services are for children and for neonates, and will be reported separately. The trust has three critical care units (CCU) for adults: the Intensive Care Unit (ICU) of nine beds for people requiring advanced respiratory support (ventilation) and other complex therapies (described as level three care), and two high dependency units (HDUs) providing level two care for people who require higher levels of care and more detailed observation than provided on a general ward. The medical HDU (MHDU) has six beds, and the surgical HDU (SHDU) has ten beds.

There is a critical care outreach service available 24 hours each day to assist staff throughout the hospital with the assessment and management of deteriorating patients on general wards. There is also a trust wide resuscitation team who provide clinical expertise, leadership and education during and after emergency calls.

An intensive care medical consultant is available 24 hours a day, seven days a week for ICU and SHDU ensuring out of hour and weekend cover is provided. Intensive care medical consultant cover for MHDU is only available on weekday mornings. Afternoon, night and weekend cover is provided by a medical consultant who is not exclusively available for critical care duties. Patients are supported by pharmacy services and therapy services including physiotherapy, dietetics, occupational therapy and speech and language therapy.

Trust staff are members of the South East Critical Care Network (SECCN) and have contributed data to the network's quality report, and to the Intensive Care National Audit and Research Centre (ICNARC) - an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland. Data submitted by the trust to ICNARC for 2013-2014 was made available to us as the data for 2014-2015 was not published at the time of writing this report. However, the most recent (unpublished) data made available to us was March 2015 and this has been considered and reflected in some of the statistical data in this report. This does not include data about the HDUs.

Mortality between January 2014 and December 2014 was above the national expected rate but within predicted limits, and comparable to other similar units. Between January and March 2015 local reports demonstrate a slightly improved mortality ratio than 2014.

We visited ICU, MHDU and SHDU during our announced inspection. We spoke with 34 staff including junior and senior doctors, nursing staff, health care support workers, allied health professionals, chaplains, and members of the administration team. We also spoke with nine patients, and four relatives. We observed care and treatment patients received, and viewed care records. We reviewed performance data submitted by the trust, and gathered information from staff at focus groups.

Critical care

Summary of findings

Improvements are needed in the safety of MHDU in particular, responsiveness to patient needs, and leadership across the critical care services. The services were found to be caring and effective.

Whilst we saw many examples of safe practice, there were inconsistencies across the services. Safety on ICU and the Surgical HDU was judged to be good, however we were concerned about medical staffing and cramped conditions on MHDU. Since our last inspection medical staffing of MHDU continues to be under-resourced, with periods of inappropriate medical skill mix. This meant that medical staffing was not always in accordance with Core Standards for Intensive Care Units, 2013 (the core standards) published by the Intensive Care Society in partnership with the Faculty of Intensive Care Medicine and Royal Colleges.

The environment in MHDU did not comply with Department of Health best practice guidance: Health Building Note HBN-04.01 or core standards. Bed spaces were significantly under the recommended 3.6m, and bathroom facilities were only accessible through circulation routes. The close proximity of patients not only presented difficulties with privacy and dignity, and risks to infection prevention and control, but also to safe use of equipment located around the beds. There was no documentary evidence that regular checks were carried out on equipment provided for difficult airway management on SHDU. This poses a risk that equipment would not be ready for use in an emergency.

Generally occupancy rates within the trust and within the critical care service exceeded the national average. Of a total 55,898 in-patient admissions to the trust in 2014-2015, in excess of 2000 patients were admitted to the three critical care units. This is higher than peer groups. In spite of a recovery (improvement) plan designed to address flow and capacity within the organisation, there was insufficient bed capacity throughout the hospital. This meant that a significant amount of patients experienced delayed discharge or transfer to other wards, and that patients were being discharged out of hours, at a rate that was higher than similar units, and that was not meeting the core standards.

Whilst the trust had stated vision and values, we saw no evidence of a comprehensive plan guiding the improvement and sustainability of the critical care services. Risks, issues and poor performance were not always dealt with appropriately or in a timely way. For example, it was unclear what specific actions were in place to mitigate long standing extreme risks. In addition, medical staffing, delays admitting people from recovery and delayed admission to MHDU, both identified as risks prior to our April 2014 inspection, were not shown to have sufficiently improved since at least July 2013.

We also found areas of good practice :

Medical staffing in ICU and SHDU met the core standards. There were sufficient numbers of appropriately trained and supervised nursing staff available within the services. There were effective systems in place to: safeguard people from abuse, ensure safe medicines management, and for infection prevention and control. Staff were up to date with mandatory training.

Care and treatment was delivered in accordance with best practice and recognised guidance and standards. We saw that patient outcomes for ICU were monitored and measured, and submitted to ICNARC. Data submitted by the trust to ICNARC for 2013-2014 was made available to us as the data for 2014-2015 was not published at the time of writing this report. However, the most recent (unpublished) data subsequently made available to us was March 2015 and this has been considered and reflected in some of the statistical data in this report.

There was collaborative working amongst the multi-disciplinary team. There had been improvements in recording mortality and morbidity.

Verbal feedback from patients and those close to them was generally positive. We saw people were supported in decisions about care, where appropriate, and they told us staff were kind and helpful.

Staff were generally positive about improvements to the culture and leadership within the trust and at departmental level, following recent management changes. Staff reported that leaders were supportive and supported innovation.

Critical care

Are critical care services safe?

Requires improvement

We found that there was scope for improvement in MHDU where medical staffing levels were not in line with the core standards. There were periods of inappropriate medical skill mix, which were not addressed. Whilst an intensive care consultant was available 24 hours a day, seven days a week for ICU and SHDU, intensive care consultant cover for MHDU was only available on weekday mornings. Afternoon, night and weekend cover was provided by a separate on-call rota exclusively for MHDU 24 hours a day 7 days a week and was provided by Medical Consultants with critical care training. Some actions relating to safe staffing were recorded on the risk register, however they were not always responded to in a timely way, and we saw little or no improvement since July 2013.

The environment in MHDU was congested and did not comply with the core standards and Department of Health best practice guidance: Health Building Note HBN-04.01. MHDU was only accessible through another ward, and signage to MHDU was unclear. The space between beds was inadequate which created risks to infection prevention and control, safe use of extra-large medical devices or equipment and maintaining privacy and dignity. These risks had not been recorded on the risk register, and we saw no indication of when the facilities may be upgraded.

The availability and use of equipment was found to be appropriate to meet patients' needs. However, there was no documentary evidence that regular checks were carried out on the tracheostomy equipment trolley in SHDU. This posed a risk that it was not ready to be used in an emergency. There was a lack of facilities available to monitor temperatures in clinical rooms and storage areas. This meant that manufacturers' recommendations concerning storage of medicinal products may not always have been observed, and that their quality and integrity may not always be assured.

Safety data was clearly displayed on notice boards within each unit. This included key safety indicators and incidents reported to the Health and Social Care Information Centre (HSCIC) Safety Thermometer. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety thermometer indicators had a low incidence in all categories. Unit-acquired infections, including methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. Diff) incidence remained very low. In addition, re-admission to the critical care units, a marker of premature discharge was also low.

Nurse staffing levels were in accordance with national standards. Medicines were generally stored in line with good practice guidance. Records were complete and related to care and treatment plans and observations. Good practice was identified in infection prevention and control with low rates of infection. Staff demonstrated a clear understanding of the systems in place to safeguard adults from harm. Critical care outreach services were available 24 hours each day to assist staff throughout the hospital with the assessment and management of deteriorating patients.

Incidents

- The services were part of the local critical care network. Incidents were reviewed at network meetings and changes agreed to prevent similar incidents happening in the future. We saw evidence that medical and nursing staff from the services had consistently attended the meetings.
- Incident reporting rates were similar to the England average.
- Mortality ratios between January 2014 and December 2014 were above the expected rate but within predicted limits and were comparable to other similar units. Between January and March 2015 local data demonstrated a slightly improved mortality ratio than 2014.
- Staff told us they understood how to use the trust's electronic reporting system (DATIX) to report near misses and patient safety incidents and we saw this happened.
- There were no 'Never Events' or Strategic Executive Information System (STEIS) incidents reported between May 2014 and 2015. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented.

Critical care

- All reported incidents were adequately investigated and learning points identified. Actions and lessons learnt from incidents were shared through staff meetings, one to one meetings with line managers, emails and newsletters, as well as verbally at staff handover reports.
- Recent examples of changes to practice following near misses or no-harm safety incidents were: changes to feeding regimes, management of tracheostomy tubes and additional training around safe management of intravenous pumps. We also saw examples of training and discussions recorded in response to medication errors.
- A process was in place to review mortality and morbidity information in line with Hospital Standardised Mortality Ratios (HMSR) and Standardised Mortality Index (SHMI). Feedback from mortality and morbidity meetings was discussed with staff when relevant. Monthly mortality meetings were attended by consultants and action points were documented and implemented.
- Safety data was clearly displayed on notice boards within each unit. This included key safety indicators and incidents reported to HSCIC Safety Thermometer, such as infection rates.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient and any other 'relevant person' within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. The principle aim is to improve openness and transparency within the NHS. Most staff were aware of the duty of candour.
- None of the staff we spoke with could recall a situation where it was thought necessary to apply the duty of candour. We saw no evidence that any training on candour was provided for staff, or that there was information available for patient and the public. However some nursing staff showed us the jointly published information by the Nursing and Midwifery Council and General Medical Council which was made available to them.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The most recent safety thermometer data available to us was reported over a 13 month period between June 2014 and June 2015. The data we reviewed demonstrated consistent harm free care to patients.
- Only one catheter associated urinary tract infection (C. UTI) was reported between June 2014 and June 2015. This was better than comparable units. Staff were made aware of the contributory factors.
- A nationally recognised grading system was used to determine the severity of pressure ulcers. There were four pressure ulcers in categories 2 – 4 reported over a 13 month period. Nursing staff had worked in a collaborative way with the trust tissue viability services to minimise further risk. There was, however, little evidence of analysis of trends.
- No falls with harm had been reported between June 2014 and June 2105 or at the time of our inspection. Staff confirmed there had been none.
- Staff were able to describe the contributory factors to patients acquiring infections and pressure damage. Staff told us they found the tissue viability nurse specialist and infection control nurse specialist nurse accessible and informative in supporting staff to manage associated risks. Records we looked at confirmed that specialist expertise and advice had been sought and provided in a timely manner, and acted upon.

Cleanliness, infection control and hygiene

- The three units we visited were visibly clean and odour free. Staff, patients, and relatives told us they were very satisfied with the cleaning services provided and had no concerns. Infection rates were very low within the service.
- Throughout our inspection we saw that staff complied with the trust's infection prevention and control policies. This included being 'bare below the elbow', hand washing, correct wearing of disposable gloves and aprons. Staff had received training about infection prevention and control at their induction and as part of in-house and mandatory training. 90% compliance with mandatory infection prevention and control training was reported across the trust.

- Each unit had a designated domestic team with responsibility for cleanliness and cleaning products, who were available throughout the day. There were written instructions and audits in place to indicate when the premises were cleaned. Deep cleans were undertaken every time a patient was transferred.
- We saw a patient with a known infection being nursed in the shared bay in the MHDU, as there was no side room available. The staff sought advice from the infection control nurse specialist and moved the patient into a side room at the earliest opportunity. However, in light of the congested environment, this posed a significant risk of cross infection. We saw no record of this on the risk register.
- There were clear signs on the doors to alert staff and visitors to the increased precautions they must take when entering and leaving isolation rooms. We saw that the instructions were generally complied with throughout our visit.
- A microbiology consultant attended the ICU at least weekly, and with other members of the infection prevention and control team was available by telephone to advise the daily multidisciplinary ward round. We observed the infection control nurse specialist visited patients in response to laboratory results across the services, and documented patient specific instructions for staff to follow.
- We looked at ICNARC data for 2013- 2014, and saw that rates for unit-acquired infections were low. There was no incidence of Clostridium Difficile (C Diff) or of unit-acquired infections in blood. This demonstrated comparable rates to other units.
- Staff cared for people with infections and those with a specific risk of infection in side rooms used as isolation rooms, for example people with MRSA and those with low immunity.
- Disposable curtains were used in patient areas, were clean, and dates for changing them were visible.
- Hand washing facilities and hand wash gels with instructions were readily available for patients, staff and visitors in all areas and were being used consistently.
- We saw that monthly audits of infection prevention and control took place and were reported to the trust's Patient Safety Committee in May 2015. Results of the audits between April 2014 and March 2015 generally demonstrated good levels of compliance, with no areas of concern.
- We saw that staff were generally compliant with the disposal of clinical waste, however we observed one bin for the disposal of sharp objects on SHDU was not secured, and brought this to the immediate attention of the nurse in charge.

Environment and equipment

- We saw that the services failed to meet environmental requirements of the intensive care core standards and Department of Health guidance: Health Building Note HBN 04-01, specifically in MHDU.
- In MHDU there was one single room and a 5 bed bay with bed spaces at 2.7m. This is significantly under the 3.6m bed centres recommended by Health Building Note HBN 04-01. The close proximity of patients presented difficulties with the risk of cross infection and the safe use of equipment located around the beds.
- MHDU was not located centrally within the hospital site. It was not adjacent to imaging facilities, the operating theatre or urgent care.
- There were not always facilities to monitor temperature parameters in clinical treatment and storage areas across the services. This meant that that the manufacturers' recommended storage requirements may not always be met or the quality and integrity of medicinal products always assured.
- None of the risks relating to the environment were reported on the local or corporate risk register, or were brought to our attention by staff.
- The core standards were, however, met in the following ways: ICU was spacious, well lit and free from obstruction. The main operating theatre complex was located close to ICU and SHDU. There were designated areas for storage of medical gas cylinders, linen and furniture.
- Staff had access to sufficient equipment for monitoring and treating patients to meet their needs. Records showed that regular and consistent equipment checks,

maintenance, and stock controls were in place to ensure patients were not at risk of harm from unsuitable or unsafe equipment. All consumables and equipment we looked at were in date

- Resuscitation equipment was accessible and was checked daily to ensure it was in good working order and ready to use. However, there was an absence of documentary evidence to demonstrate that regular checks of emergency tracheostomy equipment were carried out in SHDU. This meant that equipment may not be ready for use. We brought this to the attention of the senior nurse.
- All patients were visible from the central nurses' station(s) and had monitoring equipment in place.
- There were designated areas for storage of medical gas cylinders, linen and furniture. However, in MHDU we saw equipment storage in a seating area for visitors outside the ward sister's office.
- There were separate call bells for patients to summon assistance and for staff to summon emergency assistance. We saw these were responded to in a timely manner.
- Security to the units was good. Entry to the three units was controlled by an intercom and visitors were asked to confirm their identity prior to entry.
- Safety alerts relating to equipment were received, communicated, and acted upon in a timely manner.
- Staff we spoke with were able to demonstrate the use of equipment and were trained and competent to use it.
- We saw a good supply of moving and handling equipment and condition-specific equipment being used to assist and support patients. This included bariatric equipment.

Medicines

- The pharmacy service provided to the critical care services met the requirements of the intensive care core standards. Staff and patients we spoke with told us they received a good service, and they could access advice and support from the pharmacist as necessary.
- We observed face to face advice and support from pharmacy staff. This was consistently provided across the services throughout our visit, and they recorded interventions and changes to medicines regimes on the patient medication administration record in a timely manner.
- Medicines were generally stored safely in locked cabinets and in accordance with the trust policy. During our visit we saw some medicines that were not stored according to policy in the SHDU and MHDU and brought this to the immediate attention of the senior nurse(s), who took corrective action.
- Medicines that required refrigeration were kept in designated refrigerators. We saw evidence that the refrigerator temperatures were recorded at least daily. Staff were aware of the action to take if the temperature fell outside of expected parameters.
- Staff accessed up to date medicines information such as formularies, safety alerts and guidance on the safe administration of medicines.
- Nursing staff confirmed there was a sepsis protocol for doctors to follow when prescribing antibiotics. There was on call access to the microbiologist and infection prevention and control team for further advice if needed.
- We observed staff giving and recording the administration of medicines and medicinal gases in a person cent stated that daily stock checks were also carried out correctly.
- We observed staff giving and recording the administration of medicines and medicinal gases in a person centred way, with the appropriate safety checks carried out.
- The medicines administration records we reviewed demonstrated that patients were prescribed and administered medicines as instructed.
- Controlled drugs (CDs) are medicines which require additional security. These were stored, received, administered and disposed of in accordance with trust policy. The CD registers we looked at demonstrated that daily stock checks were also carried out correctly.

Records

- Patient records were in electronic and paper form. Electronic records required individual passwords in order for staff to gain access to them. Records were stored securely to ensure confidentiality and safety.
- Staff spoke positively about the work in progress to fully implement electronic patient records and prescribing, using the electronic records management system. They felt it had helped improve accuracy of data entry and storage and audit data, for example.
- We reviewed nine sets of nursing and medical records across the service and saw that they were generally completed, dated and signed in accordance with trust policy, and that there was co-ordination between electronic and paper based systems.
- Patients' vital signs were documented along with cardiac and respiratory indicators. Fluid intake and output was recorded and acted upon in a timely manner.
- Records were designed in a way that allowed essential information to be documented, for example, allergies, medical history and current medication. The records contained up to date treatment and care plans and evidence of discussions with the patient, their relatives or those appointed to act in their best interest, where applicable.
- We saw safety goals and risk assessments had been documented and acted upon and evaluated in accordance with national and local requirements.
- Records were stored securely to ensure confidentiality and safety.

Safeguarding

- Staff had relevant knowledge of the safeguarding systems in place, and were clear about their role in raising and escalating any concerns.
- As part of the trust's mandatory training programme 80% of staff working in critical care services had completed level one safeguarding training to enable them to report and record abuse of vulnerable adults. We saw an example of a safeguarding concern raised about a patient in MHDU. This showed timely reporting and action, and that there was collaborative multi-professional working.
- The trust safeguarding team was undergoing restructure at the time of our visit. Staff we spoke with found the interim arrangements satisfactory and did not report any negative impact. However, the trust has identified that reliability of safeguarding data is questionable due to the lack of administrative support to keep the performance figures updated.

Mandatory training

- There were arrangements in place for staff to complete mandatory training that covered a range of agreed topics, and was provided either face to face or through online learning.
- Staff told us there was 100% compliance with mandatory training in the critical care services and provided documentary evidence of this.
- The trust demonstrated 81% compliance with mandatory training overall, which was below their target of 95%.
- Staff told us that completion of mandatory training was their responsibility and that managers would monitor attendance and report on any gaps. There were arrangements in place to ensure that corrective action was taken.

Assessing and responding to patient risk

- We saw that patients were assessed on admission and during their stay for the risk of harm. There were assessments in place for: observation of vital signs, pressure ulcers, venous thromboembolism (blood clots) and sepsis (infection). We observed some minor gaps in record keeping which we brought to the attention of the nurse in charge.
- Each patient's progress was reviewed by nurses and doctors at a handover between each shift.
- Nursing staff showed us the sepsis protocol for doctors to follow when prescribing antibiotics. Nurses we spoke with confirmed they had completed recent training in this area and were able to describe the protocol to follow.
- A risk register was completed to identify and manage patient risks in each unit. We saw a number of risks that had been on the risk register for more than a year. Although we saw evidence that some mitigating action had been taken, the risks were mostly unresolved.

Critical care

- There was a 24 hour, seven day a week nurse led outreach service to support all aspects of the acutely and critically ill patient, including acting on early warning scores used to assess and manage deteriorating patients.

Nursing staffing

- A lead nurse (Matron) with overall responsibility for the nursing service was supported by Band 7 nurses (senior sisters) to oversee the staffing requirements.
- The core standards for intensive care units, 2013, were used to establish staffing requirements. During our inspection we saw these standards were met.
- All nursing staff wore a name badge with a separate badge to denote the nurse in charge.
- There were some nursing vacancies within the service, for which there was ongoing recruitment. A recent appointment had been made for an advanced nurse practitioner.
- There was no evidence that agency nursing staff were used on a regular basis. Managers described retention of nursing staff as good. The senior nurse for each shift did not have a case load of patients. This meant they were acting as a clinical co-ordinator. However nursing staff on MHDU and SHDU told us they did not always meet the national standard for ensuring that a supernumerary charge nurse was available for all shifts.
- There had previously been a link nurse system to ensure two way communication with specialist nurses; however this was no longer fully operational. Staff told us the change to the arrangements had not had any negative impact, and that they felt supported by specialist nurses who were accessible and responsive. This was confirmed in patient records.
- Ward receptionists were employed for non-clinical duties such as obtaining medical records and responding to visitors to the unit. Receptionists we spoke with described their role and responsibilities accurately and said they felt well supported by managers and other staff.

Medical staffing

- Medical staffing of ICU and SHDU was compliant with intensive care core standards. A critical care consultant with general anaesthetic experience was available on site from 8am hours until 6pm and on call by telephone out of hours. Continuity of care was provided by the use of an on call rota.
- The arrangements for medical staffing were different in MHDU and did not meet the core standards. Intensive care consultant cover for MHDU was only available on weekday mornings. Afternoon, night and weekend cover was provided using a separate and dedicated on-call rota exclusively for MHDU 24 hours a day 7 days a week and was provided by Medical Consultants with critical care training.
- Since our previous inspection, a rota had been introduced to ensure there was a dedicated medical registrar to provide medical care out of hours in MHDU. The medical registrar could telephone an on call intensive care consultant for specialist advice as needed.
- The medical registrar may or may not have HDU experience. MHDU did not always have direct access to a doctor with advanced airway training. This meant that the intensive care core standards were not met.
- There was a consultant with a lead responsibility for facilitating ongoing learning and development of doctors. Junior doctors we spoke with could not provide evidence of an individualised learning and development plan.

Major incident awareness and training

- The trust had a major incident plan which provided instruction about emergency preparedness and business continuity. Staff correctly described their roles and responsibilities in the event of a major incident.

Are critical care services effective?

Good

Patients' needs were assessed and care and treatment were generally delivered in line with legislation, standards and evidence based practice, and consistent with national benchmarks. For example, information produced by NICE (National Institute for Clinical and Health Excellence), Faculty of Intensive Care Medicine, and the Royal Colleges.

Critical care

The service was part of the local critical care network and participated in their quality reporting system and reported patient outcomes to the Intensive Care National Audit and Research Centre (ICNARC). Data submitted by the trust to ICNARC for 2013-2014 was made available to us as the data for 2014-2015 was not published at the time of writing this report. However, the most recent (unpublished) data subsequently made available to us was March 2015 and this has been considered and reflected in some of the statistical data in this report. This does not include data about the HDUs. Generally patient outcomes were within expected ranges when compared to other similar critical care services.

There was collaborative multidisciplinary work, with support provided to the services by a range of professionals. The services were supported by a multidisciplinary critical care outreach team.

Staff we spoke with demonstrated up to date knowledge of the Mental Capacity Act (MCA) and were clear about the procedures to follow when reaching decisions in a persons' best interest.

Pain management, nutrition and hydration needs were met. Generally patient outcomes were within expected ranges when compared to other similar critical care services.

The service provided a supportive learning environment for staff to learn and develop their skills and competencies. There was a practice development nurse appointed to ICU, but not to HDUs. University links and mentors were available to facilitate individual learning. Staff were encouraged to acquire new skills and share best practice within the trust and at external networks. 68% of nurses held a post registration award in critical care nursing, which is above the required standard set out in the core standards.

Evidence-based care and treatment

- We observed a range of evidence based best practice guidance from recognised national and specialist organisations used to deliver care. For example, National Institute for Health and Care Excellence (NICE), Intensive Care Society, Faculty of Intensive Care Medicine, British Thoracic Society and the Royal Colleges. The Matching Michigan assessment and documentation was used to reduce blood stream infections from central venous catheters.
- Pathways were consistently followed, and there was evidence that patients were receiving appropriate care by doctors, nurses and allied health professionals. This included rehabilitation of patients with restricted mobility.
- The hospital was part of the National Organ Donation programme led by NHS Blood and Transplant (NHSBT) and followed NICE guideline CG135 to ensure their criteria were met.
- Each unit had an identified person to collect and collate audit data to ensure it could be presented in a timely manner to internal and external forums.

Pain relief

- There were arrangements in place to ensure that patients had their pain assessed and managed in an appropriate way.
- Pain scores were documented in patient records, using recognised techniques and measures. Records we looked at showed there were clear links between patients' pain scores and the pain relief medication given.
- Pain relief medicines were reviewed regularly with patients by nurses, doctors, and pharmacists.
- Medicines for pain relief were administered only when prescribed by a doctor, and were recorded in the medicines administration record and clinical notes.
- Staff had access to the trust pain team that included an anaesthetist and a specialist nurse.

Nutrition and hydration

- Access to dietician support was available Monday to Friday. Dietician's were not always available to attend the multi-professional ward round because of other responsibilities. Staff told us their work load had been affected by changes in the arrangements for specialist nursing support for nutrition.
- Speech and language therapists (SALT) were accessible to support and advise people with swallowing difficulties. Those we spoke with told us they felt they had all the necessary resources to provide an effective

service. Patients had their nutritional needs assessed, documented and acted upon, including their weight and their risk of malnutrition and dehydration using the Malnutrition Universal Screening Tool (MUST).

- We saw that there were protected meal times to allow staff to assist patients with eating and drinking where needed.
- Records showed fluid monitoring was in place for patients, demonstrating fluid intake and output was measured, recorded and analysed.
- National and local guidelines for the provision and assessment of nutrition were provided for staff. The records we looked at confirmed that these were being followed.

Patient outcomes

- Staff carried out a number of local, regional and national audits to monitor the effectiveness of the service. The trust contributed to ICNARC data: average occupancy, mortality rates, discharges and readmission to the ICU within 48 hours of transfer.
- We looked at ICNARC data for 2013/4, which showed that the services had poor performance against four indicators: risk-adjusted hospital mortality, delayed discharges (12-hour delays); and delayed discharges (24-hour delays). These had all occurred in MHDU. The two delayed discharge indicators were worse than the national performance, but not classed as 'outliers'. Outlier is the term given to results that are significantly outside of the expected comparator.
- ICNARC data showed that infection rates were very low, as were unplanned re-admissions within 48 hours.

Competent staff

- The critical care service operated a competency based learning and development programme for doctors, nurses, health care assistants and allied health professionals.
- The service had guidelines and an induction package for newly appointed nurses, doctors and doctors in training. Although the services did not use temporary (agency or locum) staff on a regular basis, staff provided evidence that temporary staff would be expected to complete an orientation and induction programme.
- All staff we spoke with reported they were up to date with their annual appraisal. All staff knew who was responsible for their appraisal and staff in lead roles knew who was in their team and due an appraisal. This was recorded and available from the electronic staff system.
- Critical care services did not have an amalgamated training record. For training outside of mandatory requirements each member of staff had a competency booklet which they were required to keep up to date. Staff confirmed this to be the case; however we were unable to see evidence of individual completed booklets during our inspection.
- Staff had access to a training room to complete eLearning and other courses.
- All staff in the critical care services were given an annual review of their competencies and performance.
- A practice development nurse supported nursing staff to complete induction programmes when new to the unit(s), and helped staff to achieve and maintain the necessary skills, knowledge and competencies required for their role in the critical care environment.
- Clinical staff were trained in Immediate Life Support to ensure that they could act as first responders and treat patients in cardiac arrest until the arrival of a cardiac arrest team.
- 68% of nursing staff held a post registration award in critical care nursing, which is above the minimum standard of 50% set out in the intensive care core standards.
- 70% of registered (qualified) nurses had successfully completed a degree in nursing.
- 73% of nurses had a mentorship qualification meaning that they could support learning and assessment in practice. Nursing staff were prepared for the changes in the Nursing ad Midwifery Council (NMC) revalidation processes.

Multidisciplinary working

- Patients had access to a full range of allied health professionals, and all staff we spoke with described good collaborative working practices. We saw this occurred.

Critical care

- A multidisciplinary team, known as the outreach team worked closely with the nursing and anaesthetic staff within the trust to support ward staff in the detection and management of critically ill patients. The service was led by a consultant nurse with support from the matron for critical care.
- The critical care outreach team also provided a follow up service to support the continued recovery of patients when they leave the HDU /ICU areas and return to other wards. The trust's learning disability nurse resigned in February 2015 and had not been replaced at the time of our visit. Staff said they could not recall any negative impact as a result of this change and were fully satisfied with the interim arrangements, which included access to other nurses with a learning disability qualification. We saw that a learning disability nurse had been consulted for advice relating to a patient on MHDU.
- There was an identified medical clinical lead and a specialist nurse for organ donation. There were 75 referrals for organ donation between April 2014 and March 2015. This had resulted in 16 donations.

Seven-day services

- Medical consultants worked on rotation and were responsible for ensuring the unit had adequate clinical cover from junior doctors at all times when the consultant was not on the unit.
- There were on call arrangements for most services out of hours such as imaging, pharmacy, physiotherapy and the outreach team.

Access to information

- The service provided a range of written information to support patients and those close to them, including specific information for children.
- Patients and relatives told us they felt they could ask for information.
- Staff had timely access to patients' records where relevant. The units employed administrative staff to co-ordinate requests for information.
- We saw a range of useful information such as education resources, manufacturers' product guidance, and text books.

Consent, Mental Capacity and Deprivation of Liberty Safeguards

- Trust safeguarding policies were linked with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood the principles of the MCA and DoLS and were aware of their role to assess mental capacity and the processes required to escalate any concerns or seek specialist advice.
- We saw in records that mental capacity assessments were undertaken at least daily and that consent to care and treatment was obtained from patients. Where people lacked mental capacity, best interest decisions had been made by designated professionals, following correct processes.
- We observed patients being asked by a range of staff for their agreement to care and treatment.

Are critical care services caring?

Good

We found that critical care services were caring. However, there was a lack of documentary evidence that patient satisfaction was consistently measured and acted upon across the services.

The critical care services had previously participated in the NHS 'Friends and Family Test' (FFT) to obtain feedback from patients; however, there was no available FFT data for the past 12 months. Staff told us that during 2014 the service had not participated in FFT, but that 725 family members of patients in ICU had taken part in the national Family Reported Experiences Evaluation (FREE) study. The outcomes of the study were generally positive and compared well with similar units.

Patients and those close to them provided us with verbal feedback. All of the people we spoke with were satisfied with the care they received, and many described staff as kind, calm, professional, helpful and encouraging. Observation of care in ICU and SHDU showed that people's privacy and dignity were upheld. However the congested environment in MHDU meant that people's visual and auditory privacy were sometimes compromised.

Critical care

Patients' nursing and medical records were up to date and individual in describing patient needs. We saw many examples of personalised care and emotional support being provided by staff from different professions.

Compassionate care

- The critical care services had previously participated in the NHS 'Friends and Family Test' (FFT) to obtain feedback from patients, however there was no available FFT data for the past 12 months.
- During 2014, ICU participated in a national research project known as FREE designed to evaluate family and relatives' experiences. 725 family members of patients in ICU at Medway had participated in the study with the majority providing positive feedback about their experiences, and described the staff as kind and supportive.
- Relatives had given examples of where staff had met individual needs, for example taking a patient from ICU to a family wedding and taking patients from ICU and HDU for walks in the grounds of the hospital when their clinical condition allowed.
- Verbal feedback from patients and relatives that we spoke with was generally positive. They told us they were supported in decisions about care, where appropriate. Staff were kind and helpful.
- We saw that staff generally communicated with patients and those close to them in a calm and professional manner.
- One patient we spoke with on MHDU told us she was dissatisfied with the abrupt manner of the nurse looking after them. We brought this to the attention of the nurse in charge who investigated this further and took corrective action.
- We observed staff supported patient's mobility and repositioning in an unrushed way, and that they gave them encouragement and praise.
- We saw staff protecting people's dignity and privacy, drawing curtains around bed areas securely, and lowering their voice to discuss personal information.
- In MHDU auditory and visual privacy was not always achievable due to the close proximity of bed spaces. We overheard a nurse in MHDU discussing a patient's details over the phone at the nurses' station within earshot of other patients, rather than in the ward office. We brought this to the attention of the ward sister who took corrective action.
- People close to the patients were encouraged to visit. There were effective arrangements for flexible visiting when required.
- A calm, quiet relaxed atmosphere was maintained. We saw that staff dimmed lights during some set rest periods to ensure patients were not disturbed or deprived of sleep.

Understanding and involvement of patients and those close to them

- We observed staff interacting with patients and those close to them. Staff explained what they were going to do, checked people's understanding, and asked for their agreement. For example, when administering medicines, or using equipment to monitor vital signs.
- Patients and those close to them told us that they were encouraged by nurses to be as independent as possible.
- Records we looked at showed that telephone conversations between staff and patients' relatives were documented.
- Patients and relatives told us they felt aware of what was happening and involved with their care.
- One relative on SHDU told us "I have been kept totally informed on this ward."

Emotional support

- Nurses, doctors, chaplains and a range of allied health professionals were actively involved in supporting peoples' emotional needs.
- The ward receptionists managed visitors and telephone calls in a quiet and reassuring manner.
- Patients who were restless and confused were observed to be provided with one to one support and given appropriate information and reassurance by staff.
- Patients and relatives told us staff were approachable and accessible and they felt able to talk to them if they needed to.

Critical care

- Emotional support was also provided by the critical care outreach team, including after discharge from ICU and the HDUs.
- Multi-faith chaplaincy services were available seven days a week. We saw chaplains visit all three units regularly throughout our visit. They provided emotional support to patients and those close to them. This included for patients who were at the end of their life.
- We saw a range of clinical nurse specialists were accessible and provided emotional support to patients. For example, the palliative care team, pain nurse specialist, infection control nurse and tissue viability nurse.
- A bereavement project was established in ICU where staff helped relatives in compiling a memory box, keep a diary and send a bereavement card.

Are critical care services responsive?

Requires improvement

We rated responsiveness as requires improvement. The critical care services were not always able to respond to patients' needs. Access to the units was based on clinical need, including people who needed planned critical care following surgery. There were consistently high levels of bed occupancy that were above the NHS average. This was due to pressures on patient flow within the trust. Site meetings were held three times a day to monitor and manage bed flow.

During 2013-2014 ICNARC data showed incidence of delayed discharge was above the NHS national average for similar units. Bed pressures in the rest of the hospital meant patients sometimes experienced delayed discharge from the critical care units to other wards. Some patients were discharged onto wards at night, which was not the most appropriate time for the patient, although this was below (that is better than) the national average for night time discharge for similar units. Delayed discharges were also resulting in mixed sex accommodation breaches. This also adversely impacted on financial Commissioning for Quality and Innovation (CQUIN) payment. Poor performance in this area had been reported for a considerable period of time in spite of a recovery (improvement) plan. It was unclear what specific actions were in place to mitigate the risks.

There was no evidence that elective surgical operations had been cancelled due to unavailability of a critical care bed. However, managers told us that on occasion, patients who required critical care services were nursed in the post-operative recovery area due to lack of bed capacity in HDU and ICU. Data made available to us indicated that no improvements had been made to this situation since at least July 2013.

There were low numbers of complaints in critical care services. There was a well-publicised complaints system that was understood by staff and patients.

Service planning and delivery to meet the needs of local people

- The trust reported that healthcare needs in the region were greater than in most other parts of Kent. The area is undergoing a steady year on year increase in population which is anticipated to continue.
- Critical services for adults within the trust account for 67.4% of all the critical care service, which is below the national critical care bed capacity of 68.7%.
- The volume of patients admitted to the three critical care units exceeded 2000 patients in 2013-2014 and was higher than peer groups. The bed occupancy in level three beds was consistently higher. The medical staffing in MHDU continues to be under-resourced with and required a dedicated on-call rota for junior doctors. Recruitment to medical roles was underway but has proven difficult. A consultant on-call rota for MHDU had now commenced. Managers told us that service planning was linked to the surgical services project to support the review of processes within the surgical wards for emergency and elective patients and described the work as in its early stages. We were therefore unable to assess the impact this made.

Access and flow

- All senior clinical staff and managers we spoke with told us that patient flow was consistently problematic across all three units: partly due to the capacity in the critical care units and partly due to lack of capacity in other ward areas throughout the hospital.

- The risk of not being able to step patients down from HDU in a timely fashion had been identified on the risk register but was not resolved in a timely manner.
- Data from the Intensive Care National Audit and Research Centre (ICNARC) showed that problems with patient flow caused delayed discharges, and discharges made out-of-hours (between 10pm and 7am) at times that were not the most appropriate for patients. Results in SHDU were worse than national performance but similar to comparable units.
- In the last three years between 60% and, recently, 80% of all discharges were delayed by more than four hours from the patient being ready to leave ICU. That was above (worse than) the national average of around 60%. Four hours is the indicator used for comparison with other units and set by ICNARC. It has been used to demonstrate the ability, or otherwise, to move patients out of critical care in a timely way.
- Although patients remained well cared for in critical care, when they were medically fit to be discharged elsewhere, the unit was not the best place for them. It also potentially delays patients who need to be admitted.
- We were told of plans to establish a hospital discharge team to resolve the delayed discharges and that site meetings were held three times a day to monitor and manage bed flow.
- Unplanned re-admissions within 48 hours were low, and similar to comparable units.
- Data was collected in the trust on the amount of elective surgery cancelled. We saw no evidence that a lack of available critical care beds had led to any cancelled surgery.
- During our visit to ICU we saw three patients out of eight whose discharge was delayed due to a lack of available beds on the ward. The patients did not express any concerns about the delay.
- Managers told us that on occasions patients who required critical care services were nursed in the post-operative recovery area due to a lack of bed capacity in HDU and ICU. Data made available to us indicated that no improvements had been made to this situation since at least July 2013.

Meeting people's individual needs

- There were no apparent barriers to admission. Staff were able to describe the strands of equality and diversity and how reasonable adjustments would be made to ensure positive outcomes for patients.
- Due to a current vacancy there was no permanent learning disability liaison nurse employed by the trust. However, staff were able to consult other nurses with a learning disability qualification for support, and described the interim arrangements as working well.
- We saw a patient in MHDU with learning disabilities had appropriate care and care plans in place, including a hospital passport designed to give hospital staff information about their likes, dislikes and interests. Staff we spoke with told us this helped them ensure personalised care. The patient appeared calm and reassured by staff.
- Patients who lived with dementia had a separate care plan and delirium screening.
- There were translation services available, if an interpreter was needed.

Learning from complaints and concerns

- Written information about the complaints and concerns procedure was displayed in all three units we visited. The trust informed us that a total of 484 – 628 complaints per year had been recorded over the past four years. Information about how many of those complaints related to the critical care services and how they had been responded to was not made available to us.
- Staff and managers we spoke with told us they received very few complaints or concerns about the critical care services, and could not recall any recent or unresolved complaints.
- The preferred approach was for staff, on duty, to speak with people at the time the complaints or concerns were raised. The Matron would then be informed and would advise staff on how to proceed with any further response. Formal complaints were redirected to the trust Patient Advice and Liaison Services (PALS). Information about raising concerns and complaints, and the role of PALS was clearly displayed for patients and visitors.

Critical care

- Staff received feedback individually and through staff team meetings. One example was given about the need for improved communication with relatives.

Are critical care services well-led?

Requires improvement

We found that some progress had been made to implement a recovery (improvement) plan in response to our previous inspection report. Staff told us they had noticed improvements and felt that recent changes to the organisation and management structure were beneficial. However, this remained work in progress and was described to us as aspirational. Although there was a trust vision, this was not underpinned by detailed realistic objectives and plans for the staff within the services. Understanding of the trust's vision was variable amongst staff. There is a limited approach to obtaining the views of people who use the service and other stakeholders.

Performance data was collected to enable current and future performance management. Risks, issues and poor performance were not always responded to in a timely way. There was limited review of some risks, and it was not always clear what specific actions were in place to mitigate risks. As an example, delays admitting people from recovery and delayed admission to MHDU, both identified as risks prior to our April 2014 inspection, were not shown to have improved since at least July 2013. There was no record on the critical care risk register of the risks related to the non-adherence to Health Building Note 4-02 of MHDU.

Staff were generally positive about improvements to the culture and leadership within the trust and at departmental level, following recent management changes. Staff reported that leaders were supportive and supported innovation. We saw evidence of a range of innovative practice, detailed below.

Vision and strategy for this service

- The trust's vision had been reviewed at regular intervals, and a recovery (improvement) plan was in place in response to the findings of our previous inspection. This was communicated to staff through quality reports and forums.
- As part of the trust's recovery plan the action plan in the critical care services Quality Report 2014 stated the intention to review the medical oversight of MHDU. However, there was no evidence that this was completed or resolved at the time of our visit.
- Managers told us a draft business strategy was recently sent to staff; this was not available at the time of our visit and was not understood by staff we spoke with. We saw no evidence of a local critical care strategy or that one had been requested by the trust board.
- Monthly staff meetings were held and were well attended. However we looked at records of the meetings which showed discussion focussed on operational rather than strategic matters and there was no specific discussion about the vision and strategy.
- The critical care services were recruiting a critical care advanced practitioner to provide additional support to nursing and medical teams working within critical care.

Governance, risk management and quality measurement

- There was an electronic critical care risk register in addition to the trust risk register, to reflect the risks and lines of responsibility. Some staff had difficulty accessing this and were reliant on paper copies. This meant there may be different versions being referred to that were not always kept up to date or that timely action was not taken. Evidence of annual reviews that had occurred were in place, however there was little documentary evidence of more regular reviews.
- Staff were generally aware of the items on the risk register, particularly around medical staffing of MHDU, and delayed discharges. However, the critical care risk register did not present a complete reflection of the extent and seriousness of key risks: in particular the MHDU environment.
- Six risks had been on the risk register for a significant period of time including delayed discharge since 2011. There was limited evidence of regular review. Action plans were not always adequately completed or monitored effectively. Only one out of six identified risks had been resolved since our previous inspection, where an audit nurse on MHDU had been appointed.

- The unresolved risks included: medical staffing, delayed discharges, staffing reviews not validated, mixed sex breach outliers and the lack of daily attendance from a microbiologist at multidisciplinary ward rounds.

Leadership of service

- The services in ICU and SHDU were led by a consultant clinical director and a band 8 matron. There was also a Head of Nursing for the critical care service. The band 8 matron was leaving the trust in September 2015. It was unclear to us what succession planning was in place.
- Generally nursing, medical and allied health professional staff spoke positively about the leadership across the services.
- Staff we spoke with felt well supported by their line managers and felt confident in the arrangements for raising and resolving any concerns.
- The trust have highlighted leadership training, in particularly clinical leadership as a trustwide training need and currently have started a clinical leadership programme supported by another hospital trust.

Culture within the service

- Staff spoke positively about the culture within the critical care services and described communication as good. There were regular team meetings and sisters' meetings which staff were encouraged to attend and participate in. Records confirmed attendance at meetings was good.
- Managers described staff as displaying a 'can do' attitude and committed to making improvements.
- Staff felt supported in their learning and development.
- Staff described the culture as: hard working, motivated, knowledgeable, and one of learning.
- There was obvious mutual respect amongst colleagues. We observed good multidisciplinary communication and team working.
- Managers told us that the staff sickness rate for the trust and critical care services was generally lower than the England average. They also told us that there were a number of nursing staff who had returned to work in the trust from other organisations, and saw this as a positive outcome.

Public and staff engagement

- Due to the nature of critical care there was no general public involvement with how the service ran.
- A volunteer was due to start working in the ICU in September 2015 to assist with public engagement.
- Staff told us there had been improvements in consulting with them about the future of the services and facilities.
- Staff were encouraged to complete the NHS Staff survey. The trust reported that 29% of NHS Staff Survey results in the trust were 'worse than expected'. We do not have any further information about this at this time.

Innovation, improvement and sustainability

- There were approved research programmes which were promoted and documented.
- A communication rehabilitation software tool (app) had been developed by an intensive care consultant and was evaluated positively as part of a research project.
- There was a consultant nurse who led a research team within the service.
- A practice development nurse supported staff to complete induction programmes when new to the unit, and helped staff to achieve and maintain the necessary skills, knowledge and competencies required for their role in the critical care environment.
- There was active participation by medical and nursing staff with the South East Coast Critical Care network (SECCN) through attendance at meetings and virtual correspondence. This local network included NHS and independent providers of critical care services. Members of the network shared learning, experiences and innovation for the benefit of patients and staff. Managers described the impact of the network as in the early stages of development.
- Staff told us they were supported by the trust to attend local, regional and national meetings designed to share good practice.
- Nursing staff were members of the British Association Critical Care Nurses and had presented conference papers about bereavement services.
- There was a recently established critical care gym.

Critical care

- A pro-active approach to organ donation was in evidence. Staff had been rewarded for good practice through the trust's 'WOW' award scheme.

Maternity and gynaecology

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

Information about the service

At Medway Maritime Hospital (MMH), maternity and gynaecology services were managed by the women and children's division. Between April 2014 to March 2015 there were 4840 births with 4931 babies born.

The antenatal department had a multidisciplinary team approach to the provision of maternity care. As part of the department's routine clinical service, women's first visits were between 11-13 weeks and included an early ultrasound examination of the fetus as part of the antenatal screening programme to assess the risk for Down's syndrome and other chromosomal defects. A further appointment was made for 22-23 weeks for a full anomaly scan to examine the growth of the baby and determine the position and health of the placenta. The department provided a maternity care unit which allowed women from 18 weeks gestation onwards to attend for a variety of reasons be it routine testing for diabetes in pregnancy, to monitoring of the fetal heart if concerns arose. Obstetric consultant-run antenatal clinics took place in this department. These clinics were for pregnancies that were identified as high risk from the outset, or for review and management when a pregnancy was seen to be deviating from the expected course. Many specialist midwives were based in the department. Specialties ranged from fetal medicine; safeguarding; screening; diabetes and obesity and mental health. A specialist consultant in foetal medicine was also based within the department.

The delivery suite consisted of 10 delivery rooms, with four beds allocated for women requiring an induction of labour. The delivery suite also provided two obstetric theatres.

The Birth Place was the trust's midwifery-led unit. It offered more choice for women about where they give birth. In the unit there were: five birthing rooms, four postnatal beds, two birthing pools, a low risk triage (assessment) and an education room to help prepare women and their partners for life as parents. The Birth Place could care for ten women at any one time.

Kent Ward was a 24 bed postnatal ward. The ward provided care for women who had uncomplicated deliveries, either vaginally or by elective or emergency caesarean section. Women were cared for by staff ranging from midwives, nurses and maternity care workers.

Pearl ward was a 23 bed ward that provided care for women who required antenatal, postnatal, and transitional care. The ward provided care for women who were considered at risk following birth and were expected to stay for over 24 hours. Pearl ward also provided a six-bed transitional care unit for babies who required close observation but not intensive medical input.

Ocelot Ward: Ocelot Ward was a dedicated women's health ward. The ward catered for both gynaecology and general women's health.

To help us understand and judge the quality of care in maternity and gynaecology services at MMH we used a variety of methods to gather evidence. We spoke with 12 doctors including four consultants, over 30 midwives and nurses including ward managers and supervising midwives, as well as six maternity and health care assistants. We spoke with four allied health professionals. We interviewed the divisional management team. We also spoke with over

Maternity and gynaecology

20 women and four visiting relatives. We observed care and looked at women's care records. We also looked at a wide range of documents, including audit results, action plans, policies, governance reports and meeting minutes.

Summary of findings

There was a process in place to report serious incidents. Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they were fully supported when they did so. Monitoring and review activities enabled staff to understand risks and gave a clear and accurate picture of safety.

Maternity and gynaecology safety performance showed a good track record and steady improvements. When something went wrong, there was an appropriate thorough review or investigation that involved all relevant staff and women who used services. There were clearly defined and embedded systems, processes and standard operating procedures to keep women safe and safeguarded from abuse.

Staffing levels and skill mix were planned, implemented and reviewed to keep women and babies' safe at all times. Any staff shortages were responded to quickly and adequately.

Risks to women were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies. Staff recognised and responded appropriately to changes in risks to women and babies. The environment on the maternity care unit (MCU) was restrictive for staff due to its size. Staff told us the suitability of the MCU environment was under review.

We reviewed maternity and gynaecology medicines and medicines procedures. We found that Ocelot ward did not have a pharmacist who completed regular checks on medicine supplies.

Women's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. Women's needs assessments included consideration of their clinical needs, mental health, physical health and wellbeing. The expected outcomes were identified and care and treatment was regularly reviewed and was routinely collected and monitored. This information was used to improve care. Women and babies experienced

consistently positive outcomes that generally met their expectations. However, the number of caesarean sections performed by the service was slightly higher than the national average.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services.

Women and babies were cared for by a multidisciplinary team. Staff felt supported and had access to training. Consultant support and presence was provided over seven days.

Women were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from women who used the service and those close to them were positive about staff's kindness and compassion. Women's relationships with staff were positive. Women told us they felt supported and staff were caring. Staff communicated with and received information in a way women could understand. Women understood their care and treatment. Women's privacy and confidentiality was respected.

Women's needs were met through the way services were organised and delivered**.** The maternity service delivery plan was targeted at the specific needs of mothers, partners and babies known to be at risk of less positive outcomes.

The maternity unit was closed on four occasions between December 2013 and May 2015. However, two of these were due to construction work on the neonatal unit and twice due to a lack of available beds.

The needs of women were taken into account when planning and delivering services. A Picker institute patient survey 2013 found that the trust performed slightly better than the national average for staff responding to patients who rang the call button.

The vision, values and strategy of the maternity and gynaecology service was driven by quality and safety. The service's strategy had well-defined objectives that were based on an action plan following a joint strategic needs assessment (JSNA) and the previous CQC inspection. Strategic objectives were supported by measurable outcomes, which were cascaded throughout the maternity and gynaecology service and the trust's board. Staff morale was good and staff were optimistic about the direction of maternity and gynaecology services. The governance systems within maternity and gynaecology services functioned effectively and interacted with other services and directorates appropriately.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

There was a process in place to report serious incidents. Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they were fully supported when they did so. Monitoring and review activities enabled staff to understand risks and gave a clear and accurate picture of safety.

Maternity and gynaecology safety performance showed a good track record and steady improvements. When something went wrong, there was an appropriate thorough review or investigation that involved all relevant staff and women who used services. Lessons from incidents were learned and communicated widely to support improvement across the maternity and gynaecology service. However, staff could choose not to receive feedback from incidents. Improvements to safety following investigations of incidents were made and the resulting changes were monitored. There were clearly defined and embedded systems, processes and standard operating procedures to keep women safe and safeguarded from abuse.

Safeguarding women and babies was given appropriate priority. Staff took steps to prevent abuse from happening and responded appropriately to any signs or allegations of abuse. Staff engaged appropriately in local safeguarding procedures. All staff received safeguarding training at a level appropriate to their role. However, some staff had not updated their safeguarding training in accordance with national guidance.

Staffing levels and skill mix were planned, implemented and reviewed to keep women and babies' safe at all times. Any staff shortages were responded to quickly and adequately.

Risks to women were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies. Women were involved in managing risks; and risk assessments were reviewed regularly. Staff recognised and responded appropriately to changes in risks to women and babies. The environment on the maternity care unit (MCU) was restrictive for staff due to its size. Staff told us the suitability of the MCU environment was under review.

Ocelot ward did not have a pharmacist and so completed regular checks on supplies were not routinely undertaken by a qualified pharmacist.

The service had a business continuity plan in place to manage risks from anticipated changes in demand and disruption to services effectively. Plans were also in place to respond to emergencies and major situations.

Incidents

- The maternity and gynaecology service used an incident reporting system widely used in the NHS. We found incidents were consistently reported across teams; and staff used the reporting system appropriately. There was a comprehensive process of review and monitoring of incidents.
- We viewed the incidents reported on the trust's electronic incident reporting system. There were a total of 2015. Incidents had a trigger list. All incidents were posted by email and text to the director of operations, head of children and young people's services and midwifery and the trust's risk lead. Incidents were reviewed at weekly incident reporting meetings.
- The trust had reported nine incidents on the NHS strategic executive information system (StEIS), in the past 12 months. StEIS is the national framework for monitoring serious incidents in the NHS.
- Staff told us they understood their responsibilities to report incidents using the trust's electronic reporting system, and knew how to raise concerns. Staff spoke positively about learning from incidents and confirmed they received feedback on incidents that took place in other areas of the service as well as their own. However, some staff told us they could "opt out" of receiving feedback from incidents. Staff and managers told us they were satisfied there was a culture of reporting incidents promptly within maternity and gynaecology services.
- All serious incidents were action planned and monitored. Serious incidents were reviewed at monthly governance meetings and presented to the next of kin at a closure panel in person. We reviewed a sample of

investigation reports submitted by the service. Root cause analysis (RCA) was completed as part of the investigation of incidents. RCA's identified learning from incidents. Lessons learned from incidents were shared across teams. An action plan was developed as a result of RCA's. Serious incidents had action plans/next steps that were monitored until closure by the director of operations, head of children and young people's services and midwifery, and the risk lead.

- The trust had an adverse incident policy in place. This provided guidance for staff on reporting, investigating, learning lessons, implementing and sustaining change as a result of investigation findings and analysis of incidents. Staff also had access to the South of England NHS 'trigger list' this provided a prompt for staff on what constituted a serious incident and what should be reported.
- We saw the women's speciality quarterly incident report from May 2015. This reviewed the progress of all open incident reports and provided updates on incidents that had been reviewed and closed. For example, the report included a review of the closure of the neonatal unit and the impact this had on the maternity unit. The neonatal unit closures during the period were due to a lack of cots, exacerbated by planned work to the neonatal gantry requiring the temporary closure of some cots during April. Managers told us the maternity escalation to closure policy was being reviewed to include neonatal activity and capacity issues.
- The trust's adverse incident policy carried guidance and templates for staff on incident reports, recording and reporting; as well as patient safety case reviews (PSCR), these were reviews of incidents where patient safety may have been compromised. PSCR's were led by governance leads and reported at monthly governance meetings. PSCR's were action plan driven.
- The trust informed us that the service was meeting the requirements of the Royal College of Obstetricians and Gynaecologists (RCOG) 'Improving Patient Safety' document via the gynaecology and labour ward governance meetings. Every PSCR and serious incident for moderate/severe harm, or lower levels of harm if there were concerns about care or service delivery, was discussed within the multidisciplinary team at the governance meetings and an action plan was generated if required. We saw that all maternal mortalities were investigated as serious incidents; the findings were discussed at governance meetings and were shared with staff at departmental audit meetings.
- There is a contractual Duty of Candour imposed on all NHS and non-NHS providers of services to NHS patients in the UK to "provide to the service user and any other relevant person all necessary support and all relevant information" in the event that a 'reportable patient safety incident' occurs. The trust had a duty of candour form in place. This provided staff with guidance on the actions that should be taken, in regards to the duty of candour, in the event of harm or a near miss involving a patient. We viewed a letter the trust had written, under its duty of candour obligations, to a woman who had used the maternity and gynaecology service. The trust had given the woman an apology and information on an incident that occurred during a surgical procedure. This meant women could be sure that the trust's actions were open and transparent.

Safety thermometer

- The NHS Safety Thermometer provides a 'temperature check' on local and system progress in providing a care environment free of harm for patients. All maternity and gynaecology wards participated in submitting information to the patient NHS Safety Thermometer. We saw that Safety Thermometer monthly results were prominently displayed on all wards.
- The maternity and gynaecology service had a dashboard to monitor harm free care.

Safeguarding

- We were unable to speak with the lead midwife for safeguarding as they were on annual leave at the time of our inspection. Staff we spoke with demonstrated a good understanding of the types of abuse people may experience. This included an understanding of women who may have been at risk of domestic violence and also those who had disclosed a history of substance (drug and/or alcohol) misuse.
- The trust's safeguarding children's policy was compliant with the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines 3.8 the abuse of

vulnerable children. We also viewed the trust's child abduction policy. This provided clear guidance for staff to protect babies from being abducted from the hospital's wards.

- Staff were able to describe the antenatal and postnatal mental health referral process, which was consistent with the trust's perinatal mental health guidelines.
- The maternity service had a safeguarding lead midwife. Staff on the delivery suite told us that where there were safeguarding concerns about a birth they would liaise closely with local authority social workers. Staff said safeguarding care management plans would be in place where safeguarding concerns were identified. Staff were able to show us the contact details for the local authority safeguarding team.
- We saw that information on how to report safeguarding concerns and concerns about domestic abuse was available on all women's wards. For example, the delivery suite had a patient information board that contained a poster 'adult abuse' this contained the contact details for reporting safeguarding concerns to the local authority safeguarding team. Ocelot ward had discreet credit card sized information cards women or visitors could take.
- Midwives and nurses we spoke with were aware of the trust's safeguarding guidance and multi-agency procedures. Staff told us this was readily accessible on the intranet. Staff were able to demonstrate how they could access safeguarding information on the intranet.
- We viewed the maternity services staff training spreadsheet for level 3 safeguarding training. We saw that most staff had received level 3 safeguarding training. Most staff had updated their training in 2014. Some staff had updated their safeguarding training in 2013; and two members of staff had not updated their safeguarding training since 2012. It is a requirement of the intercollegiated document, 'Safeguarding Children and Young People, Roles and Competencies for Health Care Staff', March 2014, that over a three-year period, professionals should receive refresher training equivalent to a minimum of six hours; for those at level 3 this equates to a minimum of 2 hours per annum.
- We noted that a number of staff on the level 3 safeguarding training spreadsheet had no record on the spreadsheet. The trust informed us that these staff had completed level 2 safeguarding training in 2013, and the safeguarding lead and head of midwifery had agreed that these members of staff would complete level 3 safeguarding when their training was next due to be updated. The trust's policy was to update safeguarding training every three years. This meant that over 40 staff were waiting to receive safeguarding training that was in accordance with national guidance.
- Entrances to all the ward areas we visited were secure with entry via key fob for staff or by an intercom to the ward reception for visitors. The ward entrances were also signposted to remind people not to allow entry to anyone they didn't know when they were entering the wards.
- The trust told us that female genital mutilation (FGM) was relatively uncommon in the Medway population. They added that they used the RCOG approved guidance on FGM where necessary. Work was in progress on drafting an FGM policy, and was scheduled for discussion and ratification at the September 2015 labour ward forum and governance meeting.

Mandatory training

- Mandatory training included: information governance, health and safety, manual handling; health and safety; equality and diversity; consent, amongst others. We viewed information the trust had provided on mandatory training from the women's health directorate dated August 2015. This indicated that across maternity and gynaecology services most medical, midwifery, and nursing staff had completed the required mandatory training updates. For example, consultants across the service had between 91% and 100% of consultant staff having completed or updated mandatory training. There were similar figures for maternity, where out of 237 staff listed on the training record, between 86% and 99% of staff were up to date with mandatory training.
- Training was red, amber, green (RAG) rated by the trust. We noted that the training record for gynaecology, August 2015, had a red RAG rating for infection prevention and control training, with 80% of gynaecology staff having up to date training.
- Staff were provided with employee pocket books. These contained a section for staff to record the training they had attended, and to record dates when they were due

to update their mandatory training. Staff were responsible for managing their own training record. Staff training was monitored by the senior management team to ensure staff updated their training as required.

Cleanliness, infection control and hygiene

- We saw housekeeping staff cleaning on the wards and in the departments throughout our visit.
- We noted that medical equipment such as treatment trolleys had been de-contaminated, and these were marked with a sticker indicating the date they had been cleaned.
- Monthly infection control audits were undertaken. We viewed the 'saving lives' monthly infection control outcomes for women's speciality services. This was based on the DoH 'Code of Practice for Prevention and Control of Healthcare Associated Infections', (Health Act 2006). We found all the maternity and gynaecology wards monthly infection prevention and control audits regularly scored 100%. Staff told us where services did not achieve 100% compliance, the source was addressed immediately. We saw evidence from the audit spreadsheet that where wards had not achieved 100% compliance in a month, they had achieved 100% compliance the following month.
- We saw staff regularly washing their hands between treating women. Hand washing facilities and hand sanitising gels were readily available. At the time of our inspection, maternity services were regularly achieving 100% trust compliance standards for hand hygiene. We saw that gloves, aprons, and other personal protective equipment (PPE) were readily available to staff.
- 'Bare below the elbow' policies were adhered to. Staff told us they actively challenged anyone who did not follow this policy in clinical areas.
- The importance of all visitors cleaning their hands was publicised and we observed visitors using hand gels and washing their hands. The trust's infection prevention and control department's patient information leaflet 'hand washing' was available across the maternity and gynaecology wards and explained good hand washing technique as well as when patients should clean their hands.
- Inpatients on Ocelot ward were screened weekly for MRSA carriage. Maternity patients were screened if they were 'high risk' or booked for an elective caesarean section. There were no reported cases of methicillin-resistant staphylococcus aureus (MRSA) or Clostridium difficile (C. Diff) for maternity and gynaecology services in the previous 12 months.

Environment and equipment

- All equipment including resuscitation equipment was checked on a daily basis and a report was given to senior staff by 9am.
- Staff reported that there had been improvements in accessing equipment, including satisfactory amounts of equipment being available, including fetal blood analysers and fetal heart rate monitors. Laboratory facilities were available for blood and blood products. A cardiotocograph (CTG) monitor was available in all delivery suites and additional monitors were available on the ward. Satisfactory numbers of neonatal resuscitaires were available; these had been checked on a daily basis to ensure they were functioning correctly and were fully equipped.
- We saw that ward environments had been audited in June 2015 in accordance with Safer Childbirth recommendations. Where deficiencies in the environment had been identified by the audits, action plans were in place to address these.
- The neonatal unit was on the same floor as the delivery suite, this meant babies with complex needs could be transferred quickly.
- The maternity care unit (MCU) was adjacent to the antenatal clinic. The MCU was a combination of a triage service, a day assessment unit and a maternity assessment unit. The MCU offered care and treatment to both women with appointments and women whose visits were unplanned. During our inspection we found conditions on the unit were cramped. The staff station was on the unit. Staff on the MCU told us there was a risk that telephone conversations could be overheard by women attending the MCU and didn't guarantee confidentiality for people telephoning the service.
- Staff told us the screening midwife shared the office on the MCU, as the screening midwife had been required to vacate their office due to two research midwives being allocated the space.

- The MCU had an examination room and a phlebotomy/ blood pressure room. The antenatal clinic did not have a sluice. Maternity care assistants tested the urine of women attending the antenatal clinic in the MCU. Staff told us this further increased the 'traffic' in the MCU.
- We discussed the MCU environment with the maternity services management team. They told us the MCU clinical area was in the process of being reviewed. Staff we spoke with on the MCU also confirmed that a review of the MCU environment was in progress.

Medicines

- We inspected the adult resuscitation trolleys on Ocelot and Pearl wards and found these were checked regularly by staff. We viewed records medicines were being stored at the required temperatures. All the drug store cupboards were locked and controlled medicines were stored in separate locked cupboards. Where medicines required refrigeration, fridge temperatures were checked daily. There was segregated storage of drugs for epidurals.
- We found Midazolam stored in a cupboard on Ocelot ward. This should be restricted in accordance with the policy and should not have been held on Ocelot ward. The Midazolam did not have a patient's name on the box and hadn't been dispensed for individual use. Medicines were restocked through a 'top up' system, ensuring a continued supply. The pharmacy technician had not removed the Midazolam to ensure compliance with the trust's policy.
- Eclampsia kits were available to staff this meant that if a woman suffered convulsions staff could provide care and treatment in a timely way.
- Pain relief such as Entonox was routinely available on the delivery suite and in the Birth Place.
- 'To take out' (TTO) packs were available to women to facilitate a timely discharge.
- The maternity and gynaecology services had secure medicine waste management systems in place.
- Any allergies were recorded on women's treatment charts. Risk assessments for Venous Thromboembolism (VTE) were completed in accordance with NICE recommendations on VTE risk assessments, 2010.
- The maternity and gynaecology service did not have a critical medicines list, therefore were not complying with national patient safety agency recommendations (NPSA, 2010), 'Reducing harm from omitted and delayed medicines in hospital', this states trust's should "identify a list of critical medicines where timeliness of administration is crucial."
- Nursing staff training in medicines administration was up to date. Nursing staff were aware of policies on the administration of controlled drugs and the Nursing and Midwifery Council (NMC) 'Standards for Medicine Management'.
- All medication errors were reported as incidents, recorded on the electronic system, investigated and reviewed at monthly women's speciality governance meeting.
- Ocelot ward did not have a pharmacist that checked treatment charts and did routine supplies. We noted three missed doses on Ocelot ward. These were: A patient who had three missed doses of dexamethasone 6mg od on 25 August 2015, 26 August 2015 and 27 August 2015: three missed doses of pantoprazole on 24 August 2015, 25 August 2015, and 26 August 2015: and a second patient had two missed doses of Pentasa 500mg four times a day. The missed doses were at bedtime on 26 August and the morning dose on 27 August 2015.
- The pharmacist was providing a top-up service for stocks on Pearl and Kent wards.
- Women were not offered the opportunity to self-administer their medicines.
- The trust informed us that Entonox pain relief was available in every delivery suite room. If a woman's pain exceeded this they would be offered paracetamol, then Pethidine. If their pain was not controlled then women may be offered an epidural. The service had an anaesthetic registrar who covered the labour ward daily and provided an epidural service. Epidurals would be provided within 30 minutes of a patient request. If a woman has a contraindication to an epidural they would be offered remifentanil PCA, when the woman would be cared for by a midwife who would not leave the room.

- All women receiving an epidural received an epidural leaflet before they had an epidural. Epidural analgesia was delivered via PCEA.
- Women also had access to a birth pool for pain relief. Women in established labour received one to one care.

Records

- Women were given a set of 'hand held' notes. These were transferred with the women across the service. The information contained on the 'hand held' notes were also recorded on the trust's electronic records system.
- We reviewed the services electronic incident forms dating from 1 February 2015 to 30th May 2015. There were three incidents associated with incorrect data entry out of 477 entries on the system in this period. There were no common themes to the data incidents.
- The trust provided us with information that 90% of staff maternity staff and 82% of gynaecology staff had completed training in information governance. The trust had a red, amber, green (RAG) rating for mandatory training. We noted that information governance training figures for gynaecology had an amber rating.
- Newborn babies were issued with personal child health records, known as 'red books'. Women we spoke with on the postnatal ward confirmed they had received a red book and had received advice from staff on their use.
- We observed maternity staff completing and updating records across the service. We viewed five women's paper based records on the delivery suite. The 'hand held' notes contained information for women on the purpose and use of the notes. They also informed them that other records were kept electronically on the trust's system. We found in the five paper based notes we viewed that women's postnatal VTE assessments had been completed and were up to date, risks had been identified, and birth summaries were complete.
- Leaflets explaining patients' rights to access their medical records were available on the wards we visited. For example, we saw copies of the trust's leaflet 'Protecting Personal Information, a Guide for Patients' were readily available. The trust's website carried information on people's rights under the Freedom of Information Act 2000.

Assessing and responding to patient risk

- Women were risk assessed at every antenatal appointment and a plan of care was documented in their hand held records.
- The trust had a comprehensive maternity risk strategy in place. This included: risk identification; evaluation; control of risk; review and monitoring of risks/incidents at a local level; communication and sharing of successes, failures and lessons learnt.
- The service had a monthly clinic risk newsletter 'lessons learned' which was disseminated to all staff. The newsletter included a trigger list for staff that acted as a prompt for staff in recording incidents by identifying what should be recorded on the trust's electronic incident reporting system. The newsletter also gave feedback on PSCR's; incident investigations; and staffing risks.
- The services modes of delivery very similar to national average. The maternity service worked closely with the trust's: special care baby unit (SCBU, which had 16 level one cots); local neonatal unit (LNU), which had four level two cots; and neonatal intensive care unit (NICU), which had eight level three cots. Babies transferred to NICU within the network were: (a) below 27+0 weeks; (b) below 800 grammes; (c) below 28+0 week gestation twins; (d) neonates over 27 weeks who received or were likely to require ventilation for more than 48 hours and/or whose condition was deteriorating; (e) neonates who required cooling; (f) neonates requiring specialist care, for example nitric oxide; (g) complex intensive care including neonates with symptoms of additional organ failure. Both units were part of the Thames Valley and Wessex Neonatal Network and were designated LNU. The NICU was located in close proximity to the delivery suite and Birth Place, this enabled babies to be transferred quickly.
- The service used a maternity early warning tool, the modified maternity early warning system (MMEOWS) to enable staff in recognising acute illness or whether a patient was deteriorating. The MMEOWS policy was up to date. We looked at five MMEOWS charts and found that they had been completed in accordance with the trust's policy.

Midwifery staffing

- Women we spoke with told us there were enough staff to meet their needs. We saw that staffing establishment

and acuity figures were displayed on all the wards we visited. The service used the Birthrate Plus e-rostering tool to ensure there were sufficient staff to meet the demands of the service.

- Staff were very visible on all the wards we visited. Where there were shortfalls in staff due to sickness or annual leave, staff across the ward areas would be flexible and would cover shifts. Where this was not possible agency staff would be used. Procedures were in place to request agency staff. Staff told us that if agency staff were required they would request agency midwives or nurses who were familiar to the service. Staff told us that temporary staff must have relevant and appropriate training and experience and provide evidence of being a registered midwife or a registered nurse. The maternity and gynaecology service kept records of temporary staff inductions.
- The trust used the maternity dashboard to monitor staffing ratios. The trust had a worse, but improving, ratio of midwifery staff to births compared to the England average. The trust had a whole time equivalent (WTE) staffing ratio target of one midwife to every 29 women. Birthrate Plus recommendation in 2014 were that the trust works towards a one in 27 ratio. We viewed the maternity dashboard and saw that the trust had met its trust target of one to 29 every month for the past 12 months; but had not achieved the one to 27 ratio recommended by Birthrate Plus during the same period. The head of midwifery told us that the 1:29 ratio was safe; but that it limited flexibility to cope with peaks in activity.
- The trust informed us that a divisional objective was to agree a midwifery workforce strategy with the executive team. A workforce review was scheduled for August 2015 to ascertain the ratio in line with activity and acuity. The service was scheduled to present a paper to the trust's performance review meeting in September 2015.
- We viewed the labour ward meeting minutes for the previous six months. We saw that actual staffing numbers were regularly reviewed at the meetings where staffing issues were identified and discussed.
- The trust had 14 specialist midwives these included: practice development midwife; two clinical skills facilitators; diabetes midwife; mental health midwife; infant feeding co-ordinator; bereavement midwife; infant screening midwife; two fetal medicine midwives; and a safeguarding midwife.
- We viewed the Birthrate Plus summary report from July 2014. This stated that the establishment staffing figures for maternity was 127 WTE. The Trust informed us that following the Birthrate plus analysis in July 2014 a maternity workforce paper was presented to the executive team to support increased establishment for maternity leave and long term sickness. The executive team agreed a maternity establishment staff increase of 12.6 WTE. The Trust informed us that recruitment was in place to fill these roles.
- The trust used bank or agency staff to cover vacancies, short-term sickness, annual leave and planned training.
- The service used varying grades of staff to meet women's needs. Staff told us women received one to one care by a qualified midwife when in established labour. A midwife was also allocated to support women during elective caesarean section. There were operating lists, and elective caesarean section surgery took place three days a week. Women on the postnatal ward were supported by midwives, surgical nurses and maternity support workers.
- Ocelot ward had received a trust 'safe to care' certificate on the 19 August 2015 for having had 5 years, 8 months, and 20 days free from avoidable hospital acquired pressure ulcers.

Medical staffing

- The staffing establishment contained a similar percentage of junior doctors and smaller percentage of consultants compared to national average. The medical staffing skill mix was 27% consultants. This was below the England average of 35%; 7% middle career. This was slightly below the England average of 8%. However, this was in some way mitigated by the trust having 57% of medical staff at registrar level. This was 7% above the England average; and 10% junior doctors. This was 3% above the England average.
- We viewed the maternity dashboard. The dashboard provided a threshold for the consultant presence on the labour ward. The trust's maternity dashboard had a target of 98 hours whole time equivalent (WTE)

consultant cover between 8:30pm and 10:30pm seven days a week. We saw that the service regularly met the required WTE hours for consultant cover. There was additional on-call consultant rota that provided cover out of hours.

- Since the beginning of April 2015 the trust provided 98hrs of dedicated obstetrician presence on the labour ward Monday to Friday, 8:30am to 6:30pm; and Monday to Thursday nights 8:30pm to 8:30pm. There was separate consultant cover for gynaecology during these times.
- The remainder of the week there was a combined consultant cover for both obstetrics and gynaecology Monday to Friday, 6:30pm to 8:30pm; Friday night, 8:30pm to 8:30pm; Saturday and Sunday there was consultant cover for 24hrs. However, the consultant was only present in the hospital between 8:30am and 6:30pm. There was locum cover out of hours. Managers told us the locum's the service used were experienced and known to the service.
- There was middle grade cover at the hospital for obstetrics and gynaecology on Friday night and Saturday and Sunday, one of the doctors had associate specialist status.

Major incident awareness and training

- The women's quarterly electronic incident report March 2015 to May 2015 reported three unit closures. The maternity unit closed twice due to a lack of beds. Each closure was investigated as a serious incident. The trust considered the actions taken by staff to be consistent with the trust policy entitled 'Trust escalation of emergency closure of the maternity unit'.
- The trust had a 'maternity and gynaecology patient management business continuity plan'. Senior midwifery staff and senior Ocelot ward staff were aware of the plan and were able to signpost us to the document.

Are maternity and gynaecology services effective?

Good

Women and babies had good outcomes because they receive effective care and treatment that met their needs. Women's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.

Women's needs assessments included consideration of their clinical needs, mental health, physical health and wellbeing. The expected outcomes were identified and care and treatment was regularly reviewed and was routinely collected and monitored. This information was used to improve care. Women experienced consistently positive outcomes that generally met their expectations. However, the number of caesarean sections performed by the service was slightly higher than the national average.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff, and used to improve care and treatment and women and babies outcomes.

Women were cared for by a multidisciplinary team of motivated and skilled staff. Staff felt supported and had access to training. Consultant support and presence was provided over seven days.

Evidence-based care and treatment

- Staff could access policies on the trust's shared drive. Staff were able to demonstrate how they used the shared drive. The trust's policies routinely made reference to the source guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) and the National Institute for Health and Care Excellence (NICE). For example, we viewed the Ocelot ward procedures for 'criteria led discharge following procedures'. We saw that this clearly referenced the guidance the policy was based upon. The policy stated that any staff undertaking criteria led discharge were responsible and accountable for their own actions as set out by the national midwifery council (NMC) 'standards of conduct,

performance and ethics for nurses and midwives', (2008) document. The trust's policy on 'clinical risk assessment (antenatal)', was consistent with NICE quality standard 22 for antenatal care. This meant women who used the service could be sure that the trust was providing care in accordance with national guidelines.

- The trust had a comprehensive annual audit plan in place. The plan included both national and local audits. For example, the trust had undertaken an audit of the management of women with abnormal placentation to ensure compliance with the RCOG guidelines 27, 'placenta praevia, placenta previa accrete; and vasa previa; diagnosis and management', 2011. This meant women with abnormal placentation would receive early identification and management.
- The service had undertaken a retrospective audit looking at induction of labour patients in January 2015. The rationale for the audit was to ensure that all inductions of labour were: in line with guidance in terms of indication and gestation; to ensure compliance with the local protocol; and to identify delays within the process. We saw that an action plan had been put in place in March 2015 as a result of the audit in March. Actions included delays in transfer to the delivery suite being reported to the maternity bleep holder. The action plan was still being implemented at the time of our inspection and a date for review had been set for six months after the implementation of the action plan.
- Women were offered advice during the antenatal period, including: fetal anomaly screening; external cephalic version (ECV); and smoking cessation. Women were also offered a fetal scan at 36 weeks. The trust also had an 'obesity in pregnancy' guideline.
- The maternity dashboard indicated that the number of women who successfully opted for a vaginal birth following caesarean section (VBAC) ranged from between 55% and 83% from June 2014 to May 2015. The service had achieved their thresholds of VBAC, which was set at 75%, on five occasions in the previous 12 months.
- We saw that staff provided care that was in line with the NICE quality standard 32 for caesarean sections. However, the maternity dashboard indicated that the service had slightly exceeded their threshold for caesarean sections (planned and unplanned). The threshold was set at 23%, the trust had achieved between 23% and 27% from June 2014 to May 2015.

Nutrition and hydration

- The trust had achieved UNICEF 'Baby Friendly' accreditation in breast feeding standards.
- The maternity dashboard indicated that the maternity service was not meeting quality statement 5 of the NICE quality standard 37 for postnatal care. The standard relates to ensuring that women receive breastfeeding support through an evaluated and structured programme. The data indicated that the service was failing to ensure that at least 85% of women were supported when beginning breastfeeding. The maternity dashboard indicated that between June 2014 and May 2015 the service had consistently failed to meet the KPI of 85%. The service had red flags for initiation of breast feeding for every month in the 12 month period, with the exception of September 2014 when the trust had achieved 71%. Staff told us the infant feeding coordinator was working with Euroking manager regarding the accuracy of the initiation of breastfeeding data. The accuracy of breastfeeding data was included on the women's speciality risk register.
- The maternity service offered antenatal clinics to support women who were at risk of obesity and to support bariatric women, as well as those with gestational and chronic diabetes.
- Women we spoke with across maternity and gynaecology wards provided mixed reviews on the overall quality of food provided by the hospital.

Patient outcomes

- We viewed the most recent Picker institutes NHS survey of women's experiences of maternity services 2013 for MNFT. Respondents were asked about their experiences of: labour and birth; staff during labour and birth; and care in the hospital after the birth. The trust results were within the expected range and about the same as similar trusts in England.

Maternity and gynaecology

- The trust did not have any CQC outliers and results were in the expected range for: maternity readmissions; emergency caesarean sections; elective caesarean sections; neonatal readmissions; and puerperal sepsis and other puerperal infections.
- The maternity dashboard indicated that the service was not meeting its 13% threshold for emergency caesarean sections, The trust had re-introduced the use of STAN in 2014, this is a type of cardiotocograph (CTG) that uses computer analysis of the baby's heart rate and heart muscle function, to give obstetricians an idea of how a baby is coping with labour. This meant the service had taken action to reduce the risk of unnecessary intervention.
- We viewed the results of the 2013 national neonatal audit (NNAP). We saw that the trust was slightly below the NNAP standard for all babies having their temperature taken within the first hour after birth. The NNAP standard was 98-100%. The trust was achieving 89%. The NNAP standard was 100% of eligible babies receiving their first retinopathy of prematurity (ROP) screening within the time specified by the recommended in guidelines. The trust was achieving 99%. 91% of mother's were receiving a dose of antenatal steroids the NNAP standard was 85%.
- The maternity dashboard had a threshold of six third or fourth degree tears per month. The service had met its threshold for three months between June 2014 and May 2015. The service had breached its red flag threshold of 10 third or fourth degree tears on four occasions in the same period.
- The maternity dashboard indicated that the trust's (spontaneous) delivery threshold was 70%. The services performance over the previous 12 months was between 62 and 68%. This was statistically slightly higher when compared with normal (spontaneous) deliveries nationally.
- The national average in 2013-14 for ventouse and forceps deliveries was 9.1%. The trust was inline when compared with the 2013-14 national average and had met its threshold targets for five months between June 2014 and May 2015.
- The services bed occupancy was consistently slightly higher than England average at 60 to 71% over the previous eight quarters. The maternity unit had closed four times in an 18 month period. Two of these occasions were due to a lack of beds and the other two times were due to construction work on the NICU gantry.
- The modes of delivery were similar to the national average. For example, elective cesarean sections accounted for 10.5% of the service's deliveries compared to the national average of 10.9%; other emergency caesarean sections were 14.9% compared to 15.1%; normal deliveries accounted for 65.5% of deliveries compared to the national average of 60.1%.

Competent staff

- We saw that there was a weekly teaching rota in place for midwives and medical staff. Some of the session topics in 2015 had included: placenta paevia/accreta; ovarian cyst in postmenopausal women; and ectopic pregnancy.
- We viewed labour ward meeting minutes and saw that the meetings provided updates for staff on new policies, procedures and guidelines.
- Information the trust provided demonstrated that 92% of all maternity staff had received an annual appraisal in the previous 12 months. This figure included; 93% of senior midwifery managers and 91% of hospital midwives. However, gynaecology staff had a red RAG rating for appraisals with 75% of the 26 gynaecology staff having received an annual appraisal. 100% of consultants across the women's health speciality had received an annual appraisal, and 88% of registrars.
- Nursing staff we spoke with told us they were supported with their re-validation. This meant the service had support in place so that nurses were competent to provide safe and effective care. We viewed the service's revalidation spreadsheet and saw that a record was kept of when staff needed to update their professional registration.
- Junior doctors reported that they received good educational supervision and said that the consultant staff took an active interest in their teaching. For example, we saw there was a rota for registrars to teach and assess learners in all aspects of intrapartum electronic fetal monitoring. We also viewed the Friday

training rota this was a regular weekly session of training that was facilitated by senior medical staff. The rota included training sessions on: hypertension in pregnancy and ovarian cyst in postmenopausal women.

- The midwifery staff had access to a programme of in-house training. For example, we viewed the midwives continuous professional development (CPD) updates programme. Training included: recognising the deteriorating patient and adult resus; PGD's and medicines management; VTE assessment and anti-coagulation; screening; and perinatal mental health.
- The trust had completed the UK national screening committee (UK NSC) 'antenatal and newborn screening education audit', the service were meeting most of the requirements of the education programme with the exception of using UK NSC training resources to support training sessions. The service was using the antenatal and newborn e-learning module but the audit found that the service did not have the training time available to complete other modules.
- We viewed the Local Supervising Authority (LSA) Audit 2014. This was a self-assessment audit completed by supervisors of midwives. The audit looked at four domains: the interface of statutory supervision of midwives and clinical governance; the profile and effectiveness of statutory supervision of midwives; team working, leadership and development; supervision of midwives and interface with users. Audit outcomes were measured against the LSA criteria. The service had submitted evidence to the LSA of how they met the criteria in 2014 and this was verified by the LSA. The trust informed us that the 2015 LSA audit had been completed on 17 July 2015; the LSA 2015 report had not been received by the trust at the time of our inspection.

Multidisciplinary working

- The Birth Place and delivery suite had twice daily safety 'huddles' to promote effective communication across the service. These meetings were attended by the obstetrics consultant, midwife and nurse in charge from neonatal intensive care unit, Kent ward, Pearl ward, MCU, and the Birth Place.
- A bereavement midwife attended Band 7 midwives meetings on the delivery suite to discuss all processes regarding bereaved mothers and families.
- The Windmill Clinic was a joint midwifery and substance misuse clinic. The clinic held a weekly multidisciplinary meeting that was attended by: specialist midwives in substance misuse; drug and alcohol keyworkers; specialist midwives in substance misuse; safeguarding and mental health staff; and the liaison midwife from the transitional care unit on Pearl ward; as well as the neonatal liaison sister.
- We viewed the monthly minutes from the labour ward meeting for the past six months. We saw that the minutes were structured along the lines of the CQC key lines of enquiry (KLOE). The meetings were well attended by both midwifery and medical staff, including the consultant obstetrician and gynaecologist, theatres manager, and the anaesthetic lead for the delivery suite.
- Team Aurelia was a multidisciplinary team that worked closely with the obstetrics theatre team, obstetricians, anaesthetists and postnatal staff. The elective caesarean pathway had a list five days a week. This was supported by three dedicated part time midwives who prepared women undergoing a surgical birth, took them to theatre and looked after them in recovery.
- We spoke with anaesthetists and obstetric theatre staff. They told us there was good multidisciplinary working with maternity services staff; and the communication between maternity and surgery was good. All women who were having a caesarean section spoke with the anaesthetist pre-operatively.
- Staff we spoke with told us there was close liaison between the community midwives and the hospital service. The maternity service was an integrated service which included community midwives that were employed by the maternity service. Staff in the hospital were positive about the relationship with the community midwives and the health visiting team that was operated by Medway Community Healthcare.
- We saw an example of good innovative practice of joint work between the bereavement midwife and the mortuary manager. This was initiated when they followed one mother from loss to funeral to see the complete pathway. This led to changes in documentation to improve safety and enhance the identification process. It also ensured parents received

the full information and enabled time for them to make decisions following their loss. This work was on going and the aim was to introduce the practice to other areas of the hospital.

- We observed a multidisciplinary team (MDT) 'huddle' on the delivery suite. This was attended by the consultant obstetrician and the neonatal consultant as well as midwifery and nursing staff. Staff told us the trust had introduced the huddles in 2014 to enable MDT to learn together and adopt the best clinical standards in regards to care planning, handovers, and safe patient transfers.

Seven-day services

- The delivery suite, Birth Place, Kent ward, Pearl ward, and Ocelot ward operated a 24-hour service, seven days of the week.
- Obstetricians, paediatricians and anaesthetists were available 24 hours a day. Consultants provided cover for the maternity unit labour ward between 8:30am and 10:30pm seven days a week. There was an on-call rota for out of hours medical emergencies.
- The MCU was open 24 hours of the day, seven days of the week. The MCU was on a different level of the hospital to the delivery suite. This meant women who were assessed as in labour would need to be transferred to the delivery suite. Staff told us that a member of staff on the delivery suite carried a bleep at night to alert them of when a woman needed to be transferred from the MCU.
- OOH's imaging was available 24 hours of the day, but if any special tests were required OOH's, such as MRI or CT, the obstetrics and gynaecology consultant would contact the on call radiographer.
- The pharmacy department was open seven days a week. Pharmacy had an emergency cupboard for supplies. Staff could call the on call pharmacist for advice OOH's.
- Physiotherapy and occupational therapy had an on call service; but these services would normally only be contacted during office hours.

Access to information

- We spoke with the maternity and gynaecology management team in regards to the maternity dashboard. The management team told us the dashboard was reported to the trust's board on a monthly basis. However, we noted that the recording of the RAG rating for 'women delivered' on the dashboard could lead to confusion. For example, the dashboard recorded over 400 women delivered as green, this should have been recorded as red. The management team said they could see how the 'women delivered' row on the dashboard may lead to confusion; but added that they were reviewing the dashboard and were also considering the development of a gynaecology dashboard.
- All maternity teams had access to computers for booking of appointments. Leaflet and guidelines could be accessed on the computers and sent electronically to women. Midwives were able to access patient records electronically. All NHS protocols and guidelines, NICE guidelines, and Trust leaflets were available on the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with on Ocelot ward told us told us that the ward took a 50/50 ratio of patients with gynaecological and general health care needs. We viewed the staff training record for the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards and saw that 83% of staff on Ocelot ward had received the training. MCA and DoLS training was updated every three years.
- Most of the staff we spoke with on Ocelot ward demonstrated understanding of the principles of MCA and of their responsibilities under DoLS. Staff told us a mental capacity assessment was undertaken if a patient refused treatment, or if staff had a concern that a patient might not have capacity to consent to care or treatment. Staff told us there were no women receiving care on the ward, at the time of our inspection, who required an assessment under the MCA.
- Women we spoke with told us staff had spoken with them and explained their care and treatment in a way they could understand and had asked their permission before providing care or treatment.

Maternity and gynaecology

- We viewed information from the trust that demonstrated that 94% of maternity staff had completed training in consent; 100% of consultants had completed the training, and 85% or registrars.

Are maternity and gynaecology services caring?

Good

Women were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from women who used the service and those close to them were positive about staff's kindness and compassion. Women were treated with dignity and respect during interactions and women's relationships with staff were positive. Women told us they felt supported and staff were caring.

Women were involved and encouraged to be partners in their care and decisions about their care. Staff communicated with and received information in a way women could understand. Women understood their care and treatment.

Staff responded compassionately when women needed help and supported them to meet their basic personal needs as and when required. Staff anticipated women's and babies' needs. Women's privacy and confidentiality was respected.

Women were supported to cope emotionally with their care and treatment; their social needs were understood; they were supported to maintain and develop their relationships with those close to them, their social networks and community.

Services for women at the hospital were caring. We observed many examples of compassion and kindness shown by staff across all the ward areas and departments. Women and those close to them spoke highly of the care they received and told us they felt involved in their care.

Compassionate care

- We observed caring, compassionate care being delivered by staff across maternity and gynaecology services. Staff were seen to be very considerate and empathetic towards women, their partners and relatives and other people. Staff demonstrated a good understanding of patients' emotional wellbeing.
- Women we spoke with on Ocelot, Kent, and Pearl wards to told us they had been treated with respect and compassion by the staff and praised staff for their attitude and approach.
- Throughout our inspection we found the approach staff used was consistently appropriate, and demonstrated compassion and consideration for women and babies. Staff interacted with patients and relatives in a respectful and considerate manner.
- All the women we spoke with told us they felt involved in planning and making decisions about their care and treatment. For example, the partner of a woman who was in labour on the delivery suite told us the midwifery staff had taken time to explain their partners treatment and had asked their partner about pain relief. The partner told us the midwifery staffs' approach had alleviated their anxiety as first time parent.
- The most recent CQC survey of Women's Experiences of Birth, 2013, trust scored 'about the same' as other trusts in England on their experience of care and treatment during labour and birth and postnatally Staff received 9/10 from survey respondents, this was 'about the same' as other trusts in England.
- There were 45 reviews of maternity services on the NHS Choices website. These awarded maternity service a 3.5/5 star rating. We saw that trust staff had taken the time to address people's feedback on the website and had apologised where people had reported that the service had not met their expectations. 23/45 people who had rated the service on the website had given the service a five star rating.
- The trust informed us that women always had a named midwife who was responsible for their care. Women we spoke with confirmed they had a named midwife.

Understanding and involvement of patients and those close to them

- We spoke with eight women, partners, and relatives during our inspection. Most of them told us they were satisfied with the information and advice they had been given; leading up to and during labour; following the birth of their baby; or whilst receiving care and treatment.

- Staff demonstrated good communication skills during the examination of patients. Staff gave clear explanations and checked patients understanding.
- During our observation on Ocelot ward we saw medical staff explaining to a patient what they could expect to happen next and the possible outcomes of treatment. The staff member answered any questions the patient had.
- Women we spoke with told us nurses and midwifery staff always involved them in decision about their care and they had been involved in their care planning.
- We saw midwives taking time to clarify women's understanding of their care and treatment. A woman's relative on the delivery suite told us they were reassured by the midwives' knowledge and advice.
- Specialist midwifery staff provided an educational resource for women and their partners. For example, staff we spoke with told us they provided women and their partners with advice and support on a range of pregnancy related topics including breastfeeding, smoking cessation, and obesity.
- The most up to date maternity services and Ocelot ward 'Friends and Family Test' (FFT) results were displayed on the wards. The FFT is a survey which gives patients an opportunity to give feedback on the quality of the care they receive. This gives hospitals a better understanding of their patients' needs, enabling them to make improvements. We found that FFT results were consistently high across maternity and gynaecology services and better than England average.
- Across the maternity and gynaecology services women and their partners or friends and relatives had access to a wide variety of information leaflets.

Emotional support

- The service had a speciality bereavement midwife for women needing higher levels of emotional support after the birth of a stillborn baby. The bereavement midwife told us the service would signpost women to support services such as the local Kent Stillbirth and Neonatal Death Charity (SANDS).
- The trust had a speciality midwife for mental health. We saw there was a robust process in place for supporting women with mental health needs; referrals to antenatal clinics were facilitated by consultant obstetricians.
- Women living with mental health needs during pregnancy or after birth were referred to the specialist mental health midwife who offered women a one hour appointment to: discuss their mental health needs; advise them on the support available locally; and make referrals to specialist services if needed. There was a clear pathway to refer postnatal women to the obstetric lead and mother and infant mental health service (MIMHS).
- We saw that information was available on the MCU and antenatal ward for the pregnancy anxiety group (PRANX). This was a weekly support group the trust offered to pregnant women with anxiety disorders.
- Information was available across the maternity service on postnatal mental health. We viewed the antenatal and postnatal mental health leaflet. This gave women advice on spotting the signs of anxiety and depression. The leaflet also gave women advice on who to contact if they were experiencing symptoms and the contact details for psychotherapeutic support.

Are maternity and gynaecology services responsive?

Good

Women's needs were met through the way services were organised and delivered**.** Maternity and gynaecology services were planned and delivered in a way that met the needs of the local population. The maternity service delivery plan was targeted at the specific needs of mothers, partners and babies known to be at risk of less positive outcomes in Medway and Swale.

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services provided. The maternity unit was closed on four occasions between December 2013 and May 2015. However, two of these were due to construction work on the neonatal unit and twice due to a lack of available beds.

Maternity and gynaecology

The needs of women were taken into account when planning and delivering services. A Picker institute patient survey 2013 found that the trust performed slightly better than the national average for staff responding to patients who rang the call button.

Women's care and treatment was coordinated with other services and other providers. Reasonable adjustment were made and actions were taken to remove barriers when women found it difficult to access services.

Complaints were managed in accordance with trust policy and discussed at governance and staff meetings to enable improvements to service delivery.

Service planning and delivery to meet the needs of local people

- The number of births between April 2014 and March 2015 was 5,674 this was more than the maternity services target of 5,100.
- The service had introduced the maternity services delivery plan in December 2013 to guide the service's strategy. This plan was based upon the information identified from a review of the joint strategic needs assessment (JSNA); key performance indicators (KPI) agreed with the trust's commissioning partners; and local intelligence the trust had gathered as part of its governance arrangements, this included the services actions, learning, and improvements following complaints and incidents.
- A Birthrate Plus review in 2014 found that 58% of women who delivered within Medway and Swale were classified in the high risk category due to needing more specialist care as a result of health and social care needs. The maternity service delivery plan was targeted at the specific needs of mothers, partners and babies known to be at risk of less positive outcomes in Medway and Swale. The plan was reviewed at six monthly intervals. The next review date was set for October 2015.
- The maternity unit was closed on four occasions between December 2013 and May 2015. The reasons for this were: 20th January 2014 closed for 4 hours due to their being no available beds: 26th April 2014 closed for 12 hours due to their being no available beds; 2nd April 2015: closed for 7.5 hours due to extensive refurbishment works in the NICU. The refurbishment work took eight cots out of commission for five weeks whilst the NICU gantry was being upgraded: 16th April 2015: closed for 26 hours again due to work on the NICU gantry refurbishment. At the time of our inspection the work on the NICU gantry was completed. However, maternity staff had added the work on the NICU gantry to the trust's risk register due to the impact this had on maternity services.
- The service had conducted an audit of its compliance against NICE quality standard QS32 the quality standard for caesarean section. The trust were meeting all of the standards with the exception of giving women written information about the reason for their caesarean section and birth options for the future. The trust was reviewing the resources available to give women a detailed summary that would be transferrable to other units and could be used by the medical team at the booking assessment in any subsequent appointment. Work was in progress on meeting the standard as the service was linking this to a review of the maternity IT system.

Access and flow

- The maternity services delivery plan provided clear guidance on the pathways for mothers and babies from antenatal to postnatal care.
- Between June 2014 and August 2015, there were 923 readmissions out of 7,767 admissions to the maternity service. This equated to 11.88%.
- Women were able to self-refer to the service via: an online referral form; phone; or via their GP. All bookings were undertaken in community settings by the community midwives. Women from outside the area were booked and cared for in the hospital based antenatal clinic. Women had a choice as to where they gave birth. For example, the service had a 7% home birth rate. Women could also choose to give birth at the Birth Place or on the delivery suite. Women's choice would be influenced women's risk status, which was continually assessed and reviewed throughout pregnancy.
- The service had an antenatal access pathway with a flowchart. The development of the pathway was being evaluated by a multi-agency group from Medway NHS

Foundation Trust, Medway Commissioning Group and Medway Public Health to ensure that the needs of women had been considered and included in the pathway.

- Antenatal appointments were given to women in accordance with NICE guidelines 'antenatal care; routine care for the healthy pregnant woman', 2009. If a woman required an appointment with an obstetric consultant, they would be referred according to the specialist area that was required for example, diabetes, cardiac problems or obesity. The trust's fetal medicine service was provided by a sub-specialty trained fetal medicine consultant. The antenatal unit could provide cardiac scans, in-utero blood transfusions and offered a genetic outreach clinic.
- The antenatal pathway included pre-pregnancy awareness; pregnancy testing; and booking a first appointment with the antenatal clinic. The antenatal flowchart gave women information on where they could access services as well as information and advice.
- Women were advised to book with their community midwife between eight and ten weeks gestation, when blood samples were taken and follow-up appointments were made. Blood results were usually received and reviewed within ten days of being taken. Risk assessments were completed to ensure that each woman was placed on the appropriate antenatal pathway according to their individual needs.
- At twelve to fourteen weeks women received their first trimester scan as part of the combined screening programme. This was the first screening scan provided by the fetal medicine department. The fetal medicine consultant was available Monday – Friday. Fetal medicine midwives arranged follow up appointments as necessary to provide continuity. Routine scanning appointments were made in accordance with the trust's maternity services delivery plan.
- Intrapartum care, this is care provided during a woman's labour and delivery, was provided on a consultant led unit, the delivery suite; or a midwifery led unit, the Birth Place. The consultant led unit was primarily used for women with complications identified in their previous medical history, previous birth experiences or their current pregnancy or labour. The midwifery led unit, the Birth Place which was designed for women experiencing low risk pregnancies.
- There were three wards that provided postnatal care: The Birth Place accommodated low risk mothers following uncomplicated deliveries: Kent ward accommodated the majority of postnatal women from the Delivery Suite. Pearl ward admitted women and babies who required extra care in the postnatal period. There was a transitional care unit located on Pearl ward, staffed by the special care baby unit, so that babies who required extra treatment but didn't need intensive care could remain with their mothers. There were also two obstetric theatres available for elective and emergency lower segment cesarean section (LSCS).
- There were guidelines in place for transitional care, as well as criteria for discharging women and babies. Women and their babies were transferred into the care of the community midwives at the appropriate point in their care pathway. Guidelines for transferring women and babies to the community teams were in place. We viewed one woman's records on the labour ward and found that she was discharged within eight hours of the birth of her baby.
- Team Aurelia was staffed by a team of midwives. The team followed the elective caesarean pathway from pre-assessment to discharge home from the postnatal ward.
- Ocelot ward had clear procedures and guidelines for patients who accessed services and for their discharge. For example, we viewed the procedures for the gynaecology emergency clinic. The policy outlined the treatment pathway for stable women with early pregnancy or gynaecological problems requiring urgent assessment and treatment. This meant women were provided with a clear pathway for when using emergency gynaecology and early pregnancy services. The average time from G.P referral to treatment on Ocelot ward was 12 weeks in July 2015.

Meeting people's individual needs

- All of the maternity and gynaecology policies we viewed had equality impact assessment statements. This meant there was a process in place designed to ensure that practice did not discriminate against any disadvantaged or vulnerable people.
- The service had established a weekly clinic lead by a specialist consultant to follow up women who had experienced third or fourth degree perineal tears or any significant major perineal trauma that needed review during the post-natal period. There was a rapid access facility for women needing assessment or follow up through an urgent referral.
- The smoking status of parents was assessed at booking and updated throughout pregnancy. The effects of smoking on the fetus and new born baby were discussed with both parents. Carbon monoxide (CO) levels were assessed at booking since and smoking cessation clinics were offered to both parents in collaboration with Medway Public Health. A risk perception tool was introduced in April 2014 to assess the levels of CO in the mother's blood. Smoking cessation training was introduced into the annual midwives training programme.
- The trust had an obesity clinical midwifery specialist who ran an obesity clinic with an obstetrician. The service also offered an obesity support group with assistance from Medway Public Health. The clinical negligence scheme trust (CNST) requires the provision of support services for all women with a BMI of 30kg/m2. In response the trust held a healthy living clinic for women with a BMI of 35-44kg/m2 with no medical conditions.
- The Windmill Clinic was a joint midwifery and substance misuse. The weekly clinic was held in tandem with the obstetric consultant for substance misuse antenatal clinic. Any pregnant women with significant substance misuse issues could access care from a specialist midwife in substance misuse. The service could also put women in contact with a keyworker from 'Turning Point' or Medway Alcohol services. Staff told us women's privacy, dignity and confidentiality were maintained as consultation or discussion through the use of consulting rooms or the private room in the Maternity care unit
- The results from the Picker institute patient survey report 'Survey of women's experiences of maternity services 2013' found that the trust performed slightly better than the national average for staff responding to patients who rang the call button. The trust score was 8.1/10, the average for similar trusts was 8/10.
- The KH03 collects information quarterly from NHS organisations on bed occupancy and availability. KH03 information for the trust indicated that maternity services regularly had a higher rate of bed occupancy than the England average for the first quarter of 2015; but, the trends in bed occupancy were similar to the England average.
- Where English was not a patient's first language an interpreter could be booked in advance. Staff could also access a telephone interpreting service. The hospital switchboard maintained a list of languages that were spoken by members of staff and where to contact them. However, we noted there were no leaflets in the antenatal clinic in any other language other than English.
- Managers we spoke with told us midwives were very clear about the provision of one to one care for women in labour. We viewed the data on one to one care and saw that from June 2015, 100% of women had received one to one care for six out of the 12 months, 99% of women had received one to one care in five months, in April 2015 96% of women had received one to one care.
- There was an office attached to the MCU. This housed six members of staff. The office was shared with the trust's 'Call the Midwife' telephone service during office hours. Out of hours (OOH) telephone calls were diverted to the MCU. The office was also shared by: the screening midwife; two data input clerks; and the band 7 midwife from the MCU. The office space was cramped, and the door was open whilst the 'Call the Midwife' service was on the telephone to women who use the service. Staff and women who used services were using the corridor and this posed a risk that confidential conversations with women could be overheard.

Learning from complaints and concerns

- Complaints were managed in accordance with trust policy and lessons were learnt. Staff and managers told us that they preferred to resolve concerns locally at ward level. Staff said these were not recorded, but if they could not deal with the concern immediately women

would be directed to make a formal complaint. This was in accordance with the trust's policy on complaints. There were clear procedures and staff responsibilities for managing and responding to complaints.

- We viewed the complaints procedure and saw this included a flowchart to guide staff on the procedure to follow. Complaints would be dealt with by the divisional office. The matron and governance leads would be notified of a complaint. The matron would be given a timescale for investigating the complaint and sending a response. The governance lead would review the matron's investigation. The response would be forwarded to the divisional office who would respond to the person who had raised the complaint in writing. The governance lead would be sent any changes to practice for approval.
- All the women we asked, who used services, said that they had not raised any complaints with the service, and they found staff approachable if they wished to raise issues.
- Information regarding complaints and concerns was available on all the wards and units we visited. Leaflets detailing how to make a complaint were freely available. We only saw leaflets in English. Staff told us information in all languages could be requested from the hospitals accessible communications team. We saw that information leaflets provided the contact details of the local advocacy service and explained that people could receive support from the advocacy service in making a complaint. The leaflets also advised that support for non-English speakers and people who needed support with communication was available via the advocacy service.
- We saw that complaints and concerns were discussed at the monthly women's departmental governance meetings. The minutes of these meetings showed that complaints to the service were a standing agenda item and discussed at the meetings to ensure the quality of services improved. Learning from complaints was shared at team meetings and across services where applicable.

Are maternity and gynaecology services well-led?

Good

The leadership, governance and culture of maternity and gynaecology services promoted the delivery of high quality care across maternity and gynaecology services.

The vision, values and strategy of the service was driven by quality and safety. The strategy had well-defined objectives that were based on an action plan following a joint strategic needs assessment (JSNA) and the previous CQC inspection. The strategic objectives were regularly reviewed to ensure that they remained achievable and relevant. The services vision, values and strategy of sustainable improvement had been developed through a structured planning process with regular engagement from women who used the service, staff, commissioners and others. Strategic objectives were supported by measurable outcomes, which were cascaded throughout the maternity and gynecology service and the trust's board.

Staff in all areas knew and understood the strategic goals of maternity and gynaecology services. Staff morale was good and staff were optimistic about the direction of maternity and gynaecology services.

The governance systems within maternity and gynaecology services functioned effectively and interacted with other services and directorates appropriately.

Vision and strategy for this service

- The service had women's and children's division strategic objectives for 2015/16: these included 98 hours of obstetric consultant labour ward cover. We saw that the service was meeting this objective. A further objective was to confirm the staffing establishment for midwifery with the executive team, informed and measured by the Birthrate Plus analysis in July 2014. The design phase was scheduled for completion in August 2015 and agreement would be reached by October 2015. This meant work was in progress for the service to use a nationally recognised measure to establish the required number of midwifery staff.
- The trust had conducted a joint strategic needs assessment (JSNA) with a focus on the needs of those most vulnerable in collaboration with Medway Public Health in December 2013. As a result the trust provided

regular six monthly updates with contemporaneous data to clearly highlight the areas of greatest need. The maternity service delivery plan was produced in response to the JSNA.

- The maternity service received an inspection from the CQC in August 2013. The service produced a service delivery plan in response to the CQC report and JSNA. Senior staff told us the service's strategy was to embed service changes in accordance with the action plan the trust had submitted to the CQC, as well as embedding the service delivery plan.
- The delivery plan stated, "the overarching aim for driving forward maternity services is to continue to improve the quality of the service, concentrating on safety and achieving improved outcomes and satisfaction for all women and their babies. The plan will ensure that all services commissioned will deliver the most equitable outcomes to all women, including those with specific needs, from hard to reach groups, different ethnic backgrounds, those with a disability and those who find it hard to engage in general society. It will be responsive to and targeted at the specific needs of mothers, partners and babies known to be at risk of less positive outcomes."

Governance, risk management and quality measurement

- There was a clearly defined governance system in place. This included: a fetal, MCU, and antenatal medicine group; weekly incident reporting system group; labour ward forum; gynaecology forum. These groups fed into the women's health governance group, which was part of the divisional core team with children's services. This fed into the divisional board meetings; who fed into the board of directors' chief operating officer.
- We reviewed minutes from the women's speciality governance meetings. The meetings acted as regular review points for all: incidents; risks; complaints; SIs & PSCRs; monthly divisional governance meetings, and monthly divisional board meetings. We saw that the meetings were well attended by managers, medical and nursing staff.
- Risks to maternity and gynaecology service were recorded on the women's speciality risk register. We viewed the risk register and saw this contained 21 identified risks to service provision. We saw that risks on the risk register were reviewed and updated on a monthly basis. For example, the risk register recorded that the division was at risk of not meeting its NHS cost improvement programme (CIP) of 8% for 2015/16. The CIP is the identification of schemes to increase efficiency or reduce expenditure. The risk register recorded that the trust had introduced prudent measures to ensure tight financial control.
- The service had a systematic programme of clinical and internal audits in place. The women's health division had a quarterly women's health audit meeting. The meeting reviewed the progress and results from national and local audits the division had undertaken. For example, the trust had completed an audit of the first 10 caesarean sections for abnormal placentation undertaken in the interventional radiology suite. The results of the audit were to be published to invite comment from other centres and services offering a similar service. There was an action plan in place and a date for review of the action plan has been set for December 2015. Work was also in progress on a screening quality assurance report and action plan. We were informed by the trust that the report had been submitted in August 2015 and an action plan was in draft form. The report was due to be authorised by the division and public health meeting on 9th September 2015.
- The service held regular monthly meetings to review the incidents that had been reported on the trust's electronic incident reporting system. We viewed the past six months minutes for the meetings. We saw they were regularly attended by senior staff from all maternity and gynaecology wards as well as senior community staff. Incidents were discussed at the meetings and action plans put in place to address incidents.
- The women's health division had a women's speciality risk register in place that identified and managed risks. We saw that the risk register was regularly reviewed at the monthly labour ward meetings and the monthly women's speciality governance meetings.
- The management team told us the service had a maternity CQC external panel that did monthly spot-check visits and assessed how the service was preforming against the CQC key lines of enquiry.

Maternity and gynaecology

Leadership of service

- Oversight of the maternity service was by way of: a non-executive director at trust board level; a director of operations, the head of children, young people, and midwifery and a specialist clinical lead for women's services. The service had consultant level governance leads for specialties and sub-specialties.
- Ward managers told us that they felt well supported in their roles and understood their governance responsibilities. The director of operations told us they liaised frequently with the head of children, young people and midwifery services. The head of children, young people and midwifery services liaised regularly with the supervisors of midwives. Staff we spoke with told us the women's management team were visible and the head of children, young people, and midwifery services frequently visited the wards. Staff we spoke with said the senior management team were approachable.
- Staff told us that communication between the midwifery and medical teams was good. Maternity services had daily 'huddle' meetings. We observed a 'huddle' meeting and saw there was good communication between midwifery and medical staff in terms of the leadership of the service.
- The maternity dashboard was based on the RCOG 11 'quality indicators'. The dashboard recorded that the trust was achieving 100% for the one to 15 ratio for supervisors of midwives to midwives. However, the ratio was recorded as one to 21 in April and May 2015. There was a dashboard action plan in place and this was regularly reviewed by the senior management team.
- All midwives we asked told us they had a named supervisor of midwives with whom they had an annual review. A supervisor of midwives confirmed that all midwives had a named supervisor. The maternity dashboard recorded in April 2015 that the supervisor of midwives ratio was outside the national ratio. A footnote on the dashboard recorded that two midwives were in the process of completing the supervisors course and a further two midwives had started the course in April 2015. This would ensure statutory requirements in regards to the supervision of midwives were met.
- There was a range of evidence to demonstrate that supervisors of midwives were in frequent contact with the delivery suite in regards to operational issues or concerns that might have an impact on the quality of services women received.

Culture within the service

- Staff morale appeared to be high across the service. Most of the staff we spoke with told us they felt respected and valued. We saw multiple examples of staff working collaboratively and sharing responsibility to ensure women received good quality care.
- Staff and managers we spoke with told us there had been significant improvements in the maternity service in the past 18 months. Staff morale was high and this was attributed to the service's change initiative. Some senior staff also attributed this to the director of operations and head of children, young people and midwifery services driving the initiative forward.
- All the staff that we spoke with during the inspection were motivated to move the maternity service forward. Staff were committed to ensuring that women who used maternity and gynaecology services received high quality care. Staff we spoke with told us the culture in the service encouraged openness and honesty. Staff we spoke with were aware of the 'duty of candour' and their responsibilities in regards to this.

Public engagement

- The trust had a maternity service liaison committee (MSLC). The committee included people who used services representatives. The MSLC had quarterly meetings. The MSLC was made up of all the people involved in planning, providing and receiving maternity care, this included midwives, health visitors, GPs, expectant parents, and maternity services supporters. We viewed a selection of MSLC meeting minutes and saw that the meetings covered issues such as: a discussion on using a video conferencing system to provide access for people who could not attend meetings; the screening of a documentary at a MSLC meeting; people who use services being enabled to physically tour the labour wards rather than using a virtual tour of the wards. The MSLC had a Facebook page.

- The service offered home birth and positive birth support groups on the second Tuesday of every month. Both groups offered birth pool hire. Each group had a Facebook page that women could join. People could access information from the page, as well as contacting the group facilitators.
- We viewed the discharge policy for Ocelot ward. The policy had five key principles; one of which was patients and/or their representatives would be encouraged to engage and participate in the process of discharge as equal partners. The paramountcy of the needs, wishes and rights of the patient and/or their representative was highlighted in the discharge planning process. Staff we spoke with told us patients' were always asked about their views and involved in discharge planning.
- The FFT for maternity services in July 2015 asked how likely people who had used the service were to recommend: the antenatal service to friends and family if they needed similar care or treatment. Out of 37 people who responded to the FFT for antenatal services in July 2015, 34 said they would be "extremely likely"; whilst 3 responded that they would be "likely" to recommend the service. The percentages for the labour ward were 100%, there were 150 respondents; 96% of people responded that they would be extremely likely to recommend the postnatal wards; none of the respondents were unlikely to recommend the postnatal wards. The delivery suite had postcards and post boxes people could use to post their FFT responses.
- The trust took part in the NHS 'Wow' awards patient experience scheme. This is a national initiative to recognise and reward good service and best practice. The scheme relies on people who have used services nominating teams or individual staff members they have received care or treatment from. We saw that Ocelot ward had received the trust's team Wow award in February 2015.
- The maternity service arranged a number of fund raising activities for the service throughout the year. For example, we saw the delivery suite had organised a fun day with free entry for local people at a social club.

Staff engagement

- The trust produced a monthly 'lessons learned' maternity clinical risk newsletter and weekly 'Friday's News' newsletter staff to provide practice and organisational updates for staff. For example, we viewed the May 2015 'lessons learned' newsletter. We saw that this provided staff with guidance on: security vigilance in relation to infant abduction; recording a livebirth; feedback from recent serious incident reports; recommendations from PSCR's; review of common themes from serious incidents and PSCR's; learning from complaints; and updates to guidelines.
- Staff had access to the trust's health library and information service. The library had a stock of books and journals. Staff could request information if the item they wanted wasn't stocked by the trust and it could be sourced from other libraries. Staff also had access to evidence based advice and information from an international clinical information resource the trust was subscribed to. Staff were able to access this via the intranet.
- The service had participated in the strategic health authority's 'normalising' birth project in 2010. When the project came to an end the unit continued to develop and implement interventions to support normalising high risk birth. The aim of 'normalising' was to enable women to have choice and control in the decisions made in the provision of care in labour across four domains environment; equipment; staff education; and normalising promotors. We saw that the service was measured against the four domains and senior managers and senior staff regularly reviewed the service's performance against the domains. However, some staff we spoke with were unaware of the project, even though they were implementing actions from the project.

Innovation, improvement and sustainability

- The trust had introduced the 'Stop Oasis Morbidity Project' (STOMP). The project was introduced following the service recognising that some first time mothers were suffering more third degree perineum tears than expected. The initiative had resulted in a 50% reduction in the number of women with third and fourth degree tears from 3% to 1.5%. The project was awarded the North Kent CCG Streaming Francis award for learning and development 2015; North Kent CCG Streaming Francis overall winners award 2015; and the Medway NHS Foundation Trust QI Awards 2015. The team had also been invited to deliver a presentation on STOMP to the RCOG in London in November 2015. The STOMP

audit report which was presented at Women's Health Clinical Governance group. Included recommendations that were implemented. As a result of this the July 2015 outcomes for women with third and fourth degree tears were 1.44% compared to the national average of 5-7%,(RCOG, 2015).

- The service were looking for new ways through scientific research, to improve the care of pregnant women and unborn children. As part of this work, all women that attended for their 11 to 13 weeks scan were invited to participate in a large study on early prediction of pregnancy complications, such as pre- eclampsia and premature birth. The aim of this research was to try and identify the women who were at high risk of developing complications early in their pregnancy.
- The trust were taking part in a National Institute for Health Research (NIHR) funded trial called 'Respite' comparing the painkiller pethidine with remifentanil PCA. The trust had recruited 11 patients to take part in the trial.
- Team Aurelia was a multidisciplinary team. Women who were identified in the antenatal period as requiring an elective caesarean section would be referred to team Aurelia. Team Aurelia consisted of a team of two midwives and a maternity care assistant based on Kent ward that provided continuity of care for women undergoing elective caesarean section. The team undertook the pre-operative review prior to admission for elective caesarean section. Women were seen by an anaesthetist prior to surgery and an enhanced recovery process was followed to minimise women's hospital stays following surgery. Women we spoke with on Kent ward were very positive about their experience of care from team Aurelia, and said they appreciated being cared for by the same midwife during their stay in hospital.

Services for children and young people

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

Information about the service

The paediatric service includes diagnostic, treatment and care facilities for children and young people from birth to 16 sixteen years of age. The needs of young people aged 16 to 18 years of age are considered on an individualbasis with most being admitted to adult facilities within the hospital . Where a young person has particular needs, such as a learning disability or a life limiting condition, they may be admitted to the children's unit if more appropriate.

There are unit consists of two wards, Dolphin ward and the Penguin assessment unit. Children attend for day surgery at the Sunderland Day unit and the neonatal unit caters for the needs of preterm of sick newborn babies. In addition, specialist community support services are available on site. The children's outreach and specialist team (COAST) are a team of specialist nurses, carers and a specialist social worker who are based at Medway Maritime Hospital. It is a hospital based team providing a service to children outside of the hospital with life threatening and life limiting illnesses, aiming to keep them out of hospital as much as possible.

We spoke with ten parents, and numerous staff including

- a paediatric pharmacist
- three senior managers
- a play specialist
- the chaplain
- a consultant neonatologist
- a PALS officer
- an infection control link nurse
- one ward meals hostess
- six junior doctors
- four staff nurses from the children's wards
- three senior sisters
- one clinical nurse manager
- one agency nurse
- 2 team leaders (LD and COAST)
- two recovery nurses
- three paediatric matrons
- one paediatric physiotherapist
- one senior operating theatre sister
- one student nurse.

We met with the lead doctor for child safeguarding, the lead nurse for child safeguarding. We were made aware that there was a lead midwife for child safeguarding working on the maternity unit but we did not meet with them as part of the review of children's services.

We inspected four full sets of notes including the nursing care plans, prescription sheets and medical records. We inspected four paediatric medical guidelines, five sets of nursing guidelines and three neonatal guidelines. We attended a mortality and morbidity meeting, and attended the neonatal and paediatric handover meetings

An unannounced inspection of the children's services at Medway Maritime Hospital was carried out on 8 September, following the main announced visit. On this visit we reviewed child safeguarding arrangements, looked at the transfer of children between the emergency department and the ward and observed evening care on the ward. We spoke with nine nurses, including matrons and sisters, in the children's emergency department and on the ward. We spoke with the lead paediatrician for children's services at the hospital and a junior doctor whjo was on duty. On this

visit we reviewed twelve patient records and where we needed clarification, discussed the records with staff. We spoke with three children and their families. We also sat and observed care on the ward.

Summary of findings

Children's services at Medway hospital provide effective, caring and responsive support to premature babies, sick children and their families. However, we judged that 'Safety' required improvement.

There was no electronic flagging system in the children's ED and this posed a risk that children seen or admitted who were known to be at risk of abuse may not have been readily identified. We saw several examples where there were lapsed in recognising and managing child protection. The Trust-wide safeguarding team was not adequately resourced to meet the demands on the service.

There were good systems in place to identify a deterioration in the condition of children on the unit but we found an instance where a child suffered a perforated appendix due to delays in identifying and treating the presenting condition.

There was an open and transparent approach to reporting and learning from incidents. Infection prevention and control measures were in place to minimize risks to those who used the service. Medicines were managed safely and staff followed relevant guidance to ensure the best outcomes for children and young people.

Patient safety was assured though vigilant monitoring of any deteriorating child and in providing optimum staffing ratios, effectiveness of services were geared to reducing emergency readmission rates, caring was evident throughout the whole service where a team multidisciplinary approach to care prevailed. Responsiveness of the service was manifest through close working arrangements with community-based services, which ensured that children could expect to be cared for at home via community nursing services. The service was well led and all the staff we interviewed spoke positively about providing high quality care that was aligned to the trust-wide vision of ensuring that patients received safe, clean and personal care. Although there were some discrepancies in optimum staffing levels of doctors and nurses, arrangements were in place to minimise risk.

Services for children and young people

Are services for children and young people safe?

Requires improvement

The hospital did not have an electronic flagging system in the children's ED although there were other systems and processes for safeguarding arrangements. However, children seen or admitted who had a child protection plan in place might not be identified. This meant children presenting with an injury who were at risk of abuse might not be recognised and managed with this information in mind. There were lapses in the safeguarding arrangements that we identified on both our visits.

Whilst in general, there were good systems for identifying when a child's condition was deteriorating, we saw an example of where a child suffered a perforated appendix and was at risk of serious complications because their presenting condition had not been diagnosed or treated in a sufficiently timely manner.

Children's services at Medway had very good incident reporting systems that staff described in detail. Staff were aware of their responsibilities to report and lessons were learnt where incidents had taken place. The clinical areas were visibly clean and well maintained.

There were systems in place to ensure that patients were protected from the risk of harm associated with hospital-acquired infections. Staff undertook regular training to ensure they could recognise and respond to the needs of vulnerable patients.

Incidents

- We spoke with a range of medical, allied health professionals a play specialist and nursing staff. They were able to fully describe the incident reporting system, and were able to explain their roles and responsibilities with regards to the reporting of incidents. Furthermore, staff members were able to explain, and provided examples of how lessons learnt had been disseminated from incidents and accidents.
- The electronic reporting system was closely monitored by the matrons. The recently introduced, "Paediatric Pages", a regular emailed bulletin, was an effective way of sharing lessons learned from incidents with staff members.
- We saw that when children were operated on that the operating department staff were using a copy of the Surgical Safety Checklist recommended by the World Health Organisation (WHO) and the National Patient Safety Agency (NPSA). The Trust was using a copy of this checklist for each person to ensure that staff were consistent in the checks they performed. All checks performed were completed clearly and contained all the elements included on the WHO checklist.
- Information provided to us in advance of our inspection indicated that there had been no "never events". A never event is a 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers' (Serious Incident Framework, NHS England, March 2013).
- A total of 76 incidents were reported via the Trust's incident reporting system for the period March to May 2015. None of these incidents were classified as serious incidents. These were attributed to the children's services across the trust including the community. Twenty three of the incident reports were attributable to medication errors with one causing temporary harm requiring a minor intervention. Two were related to incorrect dosages and one showed an antibiotic administration error on the neonatal unit which required blood tests but which subsequently showed that no harm had occurred. Four incidents were attributable to laboratory investigations.
- Twenty five of the incident reports were related to the readmission of babies to the neonatal unit, primarily because of weight loss or jaundice. This was an increase of 14 from the previous quarter. This increase was explained by the introduction of NICE guidance on the assessment of babies in the community using Bilirubinometers to measure the levels of bilirubin in the babies blood.
- Seven incidents were classified as accidents and injury during this quarter. One of these was a moderate injury related to a diathermy burn which was a well-known risk

of the surgical procedure. The Trust Duty of Candour guidance was applied in this situation and the family were made fully aware of the circumstances around the incident

- During our inspection we were made aware of a child safeguarding incident which had occurred in the children's emergency department and involved Dolphin Ward. This procedural incident was subsequently recognised by the lead doctor for safeguarding who escalated the concern via the incident reporting system so that future safeguarding training could be used to minimise the risk of a reoccurrence of the incident.
- A Serious Incident (SI) is a serious incident requiring investigation. We saw information within the Trust incident reporting pack which demonstrated that where SI's occurred these were investigated and reported to the commission and other external agencies.
- We reviewed each of the incidents that had been reported and there was evidence that senior members of the team had reviewed each incident. Each incident had detailed information regarding any immediate action taken as well as any action taken as a result of any subsequent investigation.
- Information about incidents considered at the bi weekly mortality and morbidity meetings were cascaded to staff via the recently introduced "Paediatric Pages", a newsletter system via email and hard copy which gave safety information to staff across children's services.
- There had been no recorded instances of pressure ulcers, falls or catheter related urinary tract infections in children's or young people's services.
- Staff attended morbidity and mortality meetings twice a week and a monthly meeting which was held jointly with safeguarding, and where serious incidents had been escalated where indicated. The action plans were monitored at the monthly meetings
- All neonatal serious incidents were discussed at regional neonatal network meetings. We attended one such meeting where we observed high levels of discussion around individual children.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate, severe harm, or death and we observed wall mounted posters within children's services which explicitly explained the duty of candour for visitors to the clinical areas.
- The staff working throughout children's services could demonstrate that that they had a good understanding of their roles and responsibilities in relation to the duty of candour.
- We saw that nurses joined the medical handover twice daily and that this was augmented by twice daily safety huddles.

Cleanliness, infection control and hygiene

- The clinical environment of all aspects of children's services were visibly clean and the carers we spoke to told us that the areas were constantly being cleaned and that they regularly observed staff members maintaining hygiene and undertaking regular cleaning activities, and that, "Everywhere was very clean."
- We looked at the paediatric unit ward assurance inspection report dated 16 August 2015 which showed that there was good multidisciplinary working around infection prevention and control across children's services at the hospital.
- Staff, of all grades and disciplines, working within children's and young people's services had a very good understanding of their roles and responsibilities in relation to cleaning and infection control practices.
- We made observational checks of the cleanliness of the environment within the neonatal unit, on the Dolphin paediatric ward, the Penguin Assessment Unit and the Sunderland day unit and all were visibly clean and well maintained.
- We spoke with one of the regular hospital cleaners who worked on the children's wards and she explained her cleaning schedule to us. She told us that the differing coloured mop heads for each area were disposed of daily. She told us that she felt an integral part of the children's services team.
- The cleaning schedule for the Dolphin ward domestic refrigerator was incomplete and the cleaning register had only been completed on three of the days of August

2015. Clarification was sought on the refrigerator cleaning schedule from one of the supervisor members of domestic services who confirmed that it should have been undertaken on a daily basis.

- Temperature monitoring of medication refrigerators, domestic and breast milk refrigerators were fully compliant with standards. Records showed that medicine and breast milk refrigerators were cleaned daily.
- Hand hygiene audits were conducted each week. The results of these were communicated to the central Infection Control team in the Trust as part of the on-going collection of hand hygiene data. This data showed that hand hygiene compliance was regularly 100%.
- We observed staff members carrying out regular hand hygiene practices and wearing personal protective equipment such as gloves. The clinical areas all had prominent laminated hand hygiene posters evident on walls and parents told us that they had been taught hand hygiene by the nursing staff.
- We conducted Infection Prevention and Control (IPC) checklists with the IPC link nurses for each of the children's services clinical areas. We were able to confirm that there were regular IPC meetings and we inspected the minutes of these meetings via the trust intranet.
- IPC information was given to all new staff at induction and all staff received annual infection control updating via classroom instruction and augmented with clinical supervision by the IPC link nurses. The emphasis on hand hygiene was tangible throughout the whole unit with innovative hologram presentations of the lead nurse for IPC being screened at the entrance of each clinical area.
- Staff within children's services received annual updates for IPC training. We inspected the training records and these were fully compliant.
- Infection control policies were readily available via the trust intranet and infection control information was displayed prominently within each clinical area for staff and visitors. We saw that all staff adhered to bare below the elbow protocols.
- We interviewed one of the play specialist who explained to us that the toys and play areas were cleaned daily and that all toys were wipe-able. We saw that the playroom and outdoor play areas were visibly clean.
- Cleaning schedules were in place and there were clearly defined roles for cleaning and decontaminating equipment. Cleaning schedules were documented and audited for compliance on all children's areas. We inspected the cleaning schedule on Dolphin ward for example and noted that it was 100% up to date.
- During our inspection of the recovery area we observed that the area was visibly clean and we inspected the cleaning schedule and noted that adherence to the schedule was fully compliant.
- We inspected the Sharps bins in each clinical area and they met all national standards and were correctly labelled.
- We inspected the sluice areas of Dolphin Ward and the Penguin Assessment Unit which were visibly clean and tidy. We inspected the two ward commodes, which were clean and had proprietary 'I am clean' tags attached.
- We inspected the children's services linen room and it was fully stocked and correctly stored.
- Children's and young people's services reported zero cases of Clostridium difficult positives for August 2015 and zero cases of Methicillin-Susceptible Staphylococcus aureus (MSSA) Bacteraemia for March 2015. All babies admitted to the special care baby unit were screened for Methicillin Resistant Staphylococcus Aureus (MRSA).

Environment and equipment

- There was vigilant monitoring of access to all clinical areas via CCTV security cameras and we noted tailgating door protocols which were evident throughout all parts of children's services. Although, during our evening visit we were able to enter the children's ward area by following a visiting grandparent in.
- The clinical environment of children's services, including the neonatal unit, were built in the 1990's and remain contemporary. The main Dolphin inpatient ward and the adjacent assessment unit are configured as large modern bays with a range of side rooms with en suite bathrooms. The inpatient ward has direct entry to a

large outdoor play area accessed via the play room. The Sunderland day unit for children has direct access to the operating theatres and a specific child recovery suite area .The recovery suite being adjacent to the day unit facilitates easy transfer of patient's back to their bed area. The neonatal unit was noted to be modern and fully equipped.

- Clinical equipment throughout children's services was found to be in date and fully maintained. The neonatal unit and the other children's clinical areas had sufficient equipment to provide safe care to premature babies and sick children.
- We made observations of the paediatric recovery bay attached to the operating theatre and adjacent to the Sunderland day care unit. The recovery equipment including that used for resuscitation was up-to-date and fit for purpose and checked daily by the nurses who staffed recovery.
- The Electro-Biomedical Engineering Department, (EBME) was responsible for the maintenance, repair and management of medical equipment within the trust. Staff we spoke to were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention.
- We inspected all the resuscitation equipment and trolleys throughout children's services and the trolleys were clean, secure, updated and had been checked and logged on a daily basis.
- Breast feeding pumps were plentiful and breast pump hire was available for mothers.

Medicines

- Medicines and controlled drugs were secured safely and appropriately accounted for in the records we inspected. The resuscitation drugs were securely stored and checked daily.
- We inspected and checked the daily drug fridge temperature logs and found that regular checks had been undertaken and recorded to ensure that medicines were stored at the correct temperature.
- All nurses were given their own personalised signature stamp and we saw evidence of their use in three care plans, three medication charts, three nursing records and four Paediatric Early Warning System (PEWS) charts that we inspected.
- The paediatric pharmacist told us that she was the only pharmacist employed to cover children's services. She attended the paediatric wards frequently to discuss any pertinent issues with the senior medical and nursing staff but was not able to provide a daily service. The pharmacist told us that pharmacy cover for children's services was overstretched and more resource was needed to ensure an optimum service. She attended the multidisciplinary neonatal grand ward rounds weekly but did not have capacity to routinely check drug charts in all areas of children's services. Some checking of drug charts was undertaken by generic pharmacists within pharmacy to ensure prescription accuracy. Junior doctors attended paediatric prescribing training within the department on staff induction. Arrangements for out of hours or annual leave cover was unclear.
- The pharmacist told us that clinical guidelines for medication prescriptions and the paediatric version of the British National Formulary were available via the trust intranet.
- We checked medication records of four sets of patient records and found that they had all been appropriately completed with all relevant information including dosage and route of administration.

Records

- Records within children's services were maintained through paper records with separate medical allied health professional and nursing records. The neonatal records were multidisciplinary.
- We inspected four sets of patient records and we saw that the care plans were individually and holistically focused. The record inspection confirmed that risk assessments had been completed and physical and emotional needs had been documented. A paediatric physiotherapist we spoke with confirmed that there was good multidisciplinary record keeping.
- On our evening visit we looked at eight sets of patient records and saw that the trust was maintaining a comprehensive record of the plans and care for each

child on the ward. Essential information was easy to find and it was clear where there were particular considerations, such as safeguarding concerns, that staff needed to be aware of.

Safeguarding

- All staff members we spoke to across neonatal, children's and young people's services demonstrated a clear awareness of the referral process they must follow should a safeguarding concern arise. This was corroborated following discussions with the safeguarding leads.
- All staff we spoke with confirmed that safeguarding was part of the initial induction training and our discussions with a group of new intake trainee doctors who had commenced work some weeks earlier confirmed that they had been level two training at induction with level three training scheduled.
- The trust had a safeguarding strategy in place, which followed the key principles as set out in 'Working Together to Safeguard children' (2015) which states that "It is the responsibility of employers to recognise that in order for staff to fulfil their duties in relation to safeguarding and promoting the welfare of children and young people, they will have different training needs which are dependent on their degree of contact with children, young people, adults". This was confirmed by the diverse range of staff within the MDT that we interviewed during the inspection.
- Safeguarding updating was discussed at annual appraisal. All clinically qualified staff had completed level 3 safeguarding updated training and this was confirmed after inspecting the mandatory updating records.
- The safeguarding referral pathways operated within the children's emergency department were not sufficiently robust to capture all out of hours place of safety scenarios.
- We looked at child safeguarding in the children's emergency department as part of our unannounced inspection. There was no electronic flagging system available to provide a prompt to staff where a child was known to be at risk and had social services involvement. The hospital relied on parents telling the admitting nurse that they had a social worker involved in the care of the family. Staff had access to a database for Medway based children but for children and families from outside this area there was no information available. The Protection of Children in England (Laming 2009) recommends that all accident and emergency departments used a flagging system to ensure children who were identified as being at risk were identified as soon as they presented at the unit.
- Whilst in the department we saw that a toddler had presented with scalds to the upper surface of their foot. The incident had occurred two days previously. We spoke with the matron who said they would, "Normally look on the database" and record it on the rear of the chart. This had not been done. They agreed this was a potential 'at risk' child and that a call to the social services should have been made.
- A newly appointed lead safeguarding children nurse had been in post for – six weeks and had begun to review all attendances and notes to ensure child safeguarding concerns were being acted upon.
- A safeguarding concern had been observed during the main inspection visit where a child should probably have been admitted for safety reasons was sent home after a telephone conversation with a paediatrician despite ED staff feeling this was inappropriate. The children's ED matron had convened a meeting with staff from the ED and paediatric staff to draw up a new referral and admission pathway to ensure there was a clearer response should a similar situation occur in the future. We saw this new pathway was displayed in the treatment areas of the ED.
- We saw that the trust had a safeguarding webpage on its public internet which outlined the availability and purpose of child safeguarding and protection training. Safeguarding training was mandatory and was arranged through the safeguarding team. This was confirmed by all members of staff we spoke with including a play specialist who had been updated the previous month.
- The trust had a safeguarding policy, a designated consultant safeguard lead and a designated safeguarding nurse who we interviewed. Staff were fully aware of the process of engaging with the safeguarding policy and all we interviewed were able to describe the mechanisms for doing so.

- Our inspection of the safeguarding update data base showed 96% compliance for level 3 updating. Training passports had been introduced in collaboration with the safeguarding team and attendance at safeguarding updates was monitored. Any noncompliance for whatever reason was recoded and subsequent dates offered. Confirmation of attendance was monitored through the annual appraisal system. We ascertained that health care support workers including the play specialist had been updated. The medical staff we interviewed told us that safeguarding updating was part of their annual appraisal system and the doctors we interviewed all confirmed their level three safeguarding updates had been completed Trainee medical staff told us that they received safeguarding training at induction.
- We saw very good evidence of joint working with the local social services department to ensure the on-going safety of a child considered to be at risk. The family was not allowed unsupervised access but the mother wished to remain in the hospital with the child. Staff on the ward had provided one to one supervision, in discussion with the local authority. They had moved beds around to ensure mum could be close by but that the foster mother remained in the room with the child.
- We saw the medical records of another child where the response to suspected non accidental injury was slower than ideal. A baby admitted with bruising had a radiology report that showed two different aged fractures when their x-rays were reported on 2 September 2015. The notes suggested that the x-rays be sent for specialist paediatric radiology review. No safeguarding plan was created until the safeguarding advisor commented on 5 September 2015, leaving the baby and any siblings at potential risk.

Mandatory training

- All the medical trainees we spoke to told us that they participate in major incident planning and simulation exercises.
- All mandatory training was organised at the beginning of every year by the sisters of each of the children's services areas. We were able to inspect the training schedules and all staff were noted to be appropriately updated and annotated on the record. Mandatory training included for example, safeguarding, moving and handling and resuscitation which were completed every 12 months. This was corroborated by the senior sister of the unit.

Assessing and responding to patient risk

- We saw that sick children were monitored by staff for signs of deterioration through the use of a Paediatric Early Warning Score System (PEWS) and SBAR (situation, background, assessment and recommendation) to ensure their safety and well-being.
- The use of this PEWS system enabled staff to monitor a number of indicators that identified if a child's clinical condition was deteriorating and when a higher level of care was required. Staff we spoke to in children's services were aware of the appropriate action to be taken if patients scored higher than expected, and patients who required close monitoring and action were identified and cared for appropriately in all areas of children's services.
- There was a process in place for referring children who were deteriorating via the South Thames Retrieval Service (STRS), and the Children's Acute Transport Service (CATS) which specialises in the inter-hospital transfer of critically ill children in South London. Children requiring intensive care management prior to retrieval were cared for by the resuscitation team within the high dependency area of Dolphin ward. The neonatal unit at Medway is a dedicated level 3 neonatal intensive care unit and caters for all babies except those requiring very specialist services or surgery.
- The nursing staff employed within acute children's services had attended the Paediatric Immediate Life Support (PILS) course. The paediatricians have advanced paediatric life support training.
- On our unannounced visit we saw the records of a seven year old child with a perforated appendix. The surgeons had initially attempted to manage the situation conservatively with antibiotics were problems getting an MRI scan under general anaesthetic as when one was booked the anaesthetist failed to turn up. They were on the ward for some 12 days with appendicitis before the operation was performed after their appendix had perforated. There is no NICE guidance around paediatric

appendicitis but guidance and information issued by the Royal College of Surgeons suggest that a paediatric appendicitis should have been managed in a more timely manner.

Nursing staffing

- Staff we interviewed told us that they do not use formal acuity tools to balance patient dependency with staffing levels. Staffing levels were adjusted as required on a daily basis using bank nurses and when necessary agency nurses.
- The Oliver Fisher Neonatal Unit report for 2014 showed that in addition to the 23 neonatal nurses there were 3WTE vacancies on the unit and three had been filled via recruitment. There were 60 WTE nursing staff and health care assistants within the general paediatric areas with five new appointee nurses commencing in September 2015.
- Children were cared for by a contingent of fully trained and registered children's nurses in all children's areas and in the recovery area adjacent to Sunderland day unit. Non clinical support workers undertook equipment cleaning and checking following established protocols.
- Infants on the neonatal unit were cared for by registered nurses, 76% of whom who had undertaken post qualifying courses in neonatal care. We were informed that nurse staffing levels on the neonatal unit was sub optimal and did not meet the British Association of Perinatal Medicine (BAPM) staff standards. The aim of this organisation is to improve the standards of perinatal care in the British Isles. However, this was risk managed by NHS Professionals bank staff. The staff we interviewed told us that all bank nurses employed had been provide with induction training and that many were actually current or former staff working additional shifts.
- We were informed by the mangers of the children's services that 11.5 WTE nursing posts were to be made available for the staffing of the new high dependency unit.
- We inspected the nursing rosters of the general paediatric areas and the neonatal unit to assess if they met the RCN guidelines, 'Defining staffing levels for children and young people's services' (Registered nurses to sick children/Neonatal services for infants requiring intensive care). The guidelines suggest staffing ratios of 1:4 for general paediatric areas and I to 1 for neonatal intensive care. We examined the off duty rosters for the 4 week period 29-6-15 to 26-7-15 to confirm that these standards were being upheld partly through the use of 13 temporary registered nursing staff.
- Nurses we interviewed in all clinical areas were confident that there were sufficient staff at all times to provide safe care. We found from information reviewed from the rosters that senior nurses were present for each shift on the areas that made up children's services, which was meeting RCN guidelines. The risk register for June 2015 showed that three neonatal nursing posts had been filled from the six WTE vacancies.
- The numbers of staff planned and actually on duty were displayed at the ward entrance in line with guidance contained in the Department of Health Document 'Hard Truths', which states that processes should be in place so that staffing establishments are met on a shift-by-shift basis.
- Play provision for sick children was inadequate as children's services employed but two play specialists to cover all the clinical areas. This did not meet best practice which has been articulated in 'Getting the right start: National Service Framework for Children Standard for Hospital Services' (2003). It has been recommended that all children staying in hospital have daily access to a play specialist and the use of play techniques should be encouraged across the multidisciplinary team caring for children. The team should be able to offer a variety of play interventions to support the child at each stage in his or her journey through the hospital system (guidelines are available from the National Association of Hospital Play Staff Guidelines for Professional Practice 2003.
- Student nurses we spoke with from Canterbury University told us that they felt well supported by their mentors and confirmed that the NMC rule which stipulated that they must work with their mentor for 40% of the time spent on placement was fully met.
- We were told by the senior sister of theatres and the clinical recovery sister that since children's services had taken over the Sunderland day care unit there were always two trained children's nurses available for help in recovery. The paediatric recovery area had two

allocated bed spaces for children which are child friendly and are only used exclusively for children. Children were returned to the Sunderland day unit very quickly. We were informed by the theatre recovery sister that plans were going to be submitted to the board in October 2015 for a totally separate children's recovery area.

- We attended nursing handovers in the neonatal unit and the Dolphin children's ward during which each infant/child was fully discussed. The nursing handovers were not multidisciplinary and primarily concentrated on the nursing management of each child and the plan of care for that day. Other ward rounds were multidisciplinary and would for example have included allied health professionals.

Medical staffing

- The medical skill mix achieved similar percentages of consultants and junior doctors to the England average was made up of a larger percentage of registrars compared with the England average. Out of a total of 60 WTE, 29% of medical workforce were consultants, 15% middle grade and 47% at registrar level and 8% juniors.
- We examined the medical staff rosters for the period 1-7-2015 through to 31-7-2015 and there were sufficient staff on duty on each day in all areas of children's services to achieve safe care delivery. However we were told that there was a shortage of registrars with 5 in post rather than the nine scheduled. The risk register summary for June 2015 showed that children's services were short by 2.6 WTE specialist registrars and 2.6 WTE senior house officers.
- The six junior doctors we interviewed told us that there was a good team spirit within children's services and that it was well organised with good teaching opportunities.
- The consultant establishment for general paediatrics was six with six consultant neonatologists, three paediatric surgeons (two as joint appointments with Kings College London) plus visiting consultants from Great Ormond Street Hospital and the Evilina Children's Hospital.
- Parents we interviewed told us that the medical staff delivered high quality safe care with one mother telling us that breast feeding support within the neonatal unit was excellent and that she would recommend the unit to her families and friends.
- Doctors told us that medical cover was good with enough middle grades available at all times. Trainees told us that the consultants were fully involved in care delivery and would always come in for very sick babies and children.
- The RCPCH standard that at least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent) was being met within children's services at Medway and the paediatric and neonatal medical handovers we attended as part of the inspection was detailed and informative.

Major incident awareness and training

- Nurses and doctors we spoke to were highly ware of the major incident plans for the trust and the information had been communicated to staff via the intranet with frequent updates.
- Staff we spoke with were familiar with major incident plans, including fire, winter and summer preparedness.

Are services for children and young people effective?

Good

The trust utilised a range of evidence based policies and guidelines which were based on national guidance. Auditing of compliance with national guidelines took place; where there was identified poor compliance action plans were developed to address the shortfalls. There was good evidence of multi-disciplinary working. There were systems in place to ensure that the clinical, psychosocial and general health needs of children could be met; this was delivered through a comprehensive assessment process which was family centred.

The trust's Oliver Fisher Neonatal Intensive Care Unit is recognised as one of the top five neonatal units in the UK in providing high quality care by the National Neonatal Audit Programme. This programme is funded by the Department of Health through the Healthcare Quality Improvement.

Services for children and young people

Evidence-based care and treatment

- Staff we spoke with told us that evidence based practice (EBP) guidelines and protocols were available via the trust intranet and the trainee doctors we interviewed told us that the EBP and NICE protocols and guidelines were easy to access. During the inspection we checked a sample of the protocols and confirmed that they were contemporary and up to date.
- Children's services at Medway had participated in a full range of service delivery audits such as monthly infection control commode audits and infection control audits of the neonatal unit. One infection control audit from the neonatal unit and dated 11th April 2014 showed an 88% compliance rate. Additionally a full range of clinical audits were undertaken and completed in 2014/15.For example a Neonatal referral pattern audit of a sample of 225 babies showed that 43% of referrals were accepted into the unit. This figure included referrals from across the county and beyond. Where a cot is not available another place within other network hospitals would be found.
- The paediatric satisfaction audit survey for paediatric surgery conducted with 64 families showed that 95% felt that their privacy and dignity was completely respected. Many of the doctors we interviewed told us that they were involved in clinical audit and we examined a comprehensive list of audits ranging from temperature control of new-borns with hypoxic ischemic encephalopathy through to diabetic ketoacidosis management.
- Staff we spoke to confirmed that a '15 step challenge' had been undertaken. The 15 Steps Challenge is a tool to help staff, patients and others to work together to identify improvements that will enhance the patient experience and was part of The NHS Institute for Innovation and Improvement's productive ward series.

Pain relief

- Parents of children we spoke with told us that they received the appropriate level of pain relief and the nursing staff we interviewed told us that there was a good multi-disciplinary team (MDT) approach to the management of child pain. Children's services utilized a range of pain assessment scales. The parents we interviewed confirmed that staff frequently assessed their child's level of pain and offered analgesia as appropriate and checked at intervals to ascertain the effectiveness of the medication. We were told by staff that we interviewed that the processes for identifying and managing pain were fully embedded in practice and the PEWS charts had a section on assessing pain.
- Pain assessment tools, such as the FLACC and Wong's Smiley faces were evident throughout children's services and we saw these being used by the children's nurses to assess post-operative pain in children in the Sunderland day surgical unit.
- The play specialist we spoke with and other care staff had access to a full range of diversional play materials. 'Starlight distraction boxes' containing diversional toys were available throughout children's services including the assessment unit.
- Topically applied local anaesthetic was applied routinely prior to cannulation and was used in conjunction with diversional play.
- Staff we interviewed told us that they had access to the hospital pain team and other pain management strategies from the children's outreach and specialist team (COAST).

Nutrition and hydration

- The Neonatal unit was seeking full United Nations International Children's Emergency Fund, UNICEF accredited baby friendly status and had a strong commitment to breast feeding. Health care staff supported mothers to express breast milk for their babies and breast pumps were available to hire at a nominal charge. Breast feeding facilities on the neonatal unit were in place and staff members' were noted to be positive in helping and supporting breast feeding mothers.
- Breast milk storage on the neonatal unit met the Royal College of Nursing RCN Breastfeeding in children's wards and departments guidance for good practice. This entailed providing mothers who needed to express breast milk with a dedicated facility that was appropriately furnished with well-maintained and sterilised equipment for the safe expression and storage of breast milk. Fridges used to store expressed breast milk were labelled as such and posters or advice leaflets on safe storage instructions provided. Fridges where expressed breast milk was stored were appropriately

secured to prevent unwarranted access. We inspected the fridge records to ascertain that the temperatures had been checked. Throughout 2014, 78 babies being cared for on the neonatal unit benefited from pasteurised donor milk.

- The Children's ward menus were imaginatively designed, with a full choice of nourishing food and snacks being available. A range of ethnically diverse meals were accessible. We inspected the menus and spoke with the ward hostess who administered the meals to the children. When possible children would cohort for meal times to promote socialisation.
- We observed the ward nutrition hostess as they prepared the menu choices in the Dolphin ward kitchen the heating of the individual meals was undertaken with full health and safety considerations including the use of microwave food thermometers. Hot food was available at lunch times and sandwiches available in the evening. We were told that this was soon to change with hot food being made available in the evening later in 2015. We were told that children were allowed to eat in the hospital canteen with their parents should they so wish.
- Mothers we spoke to told us that the food for children was good and that they were very happy with the dedicated parent room where they could acquire drinks and snacks. Parents told us children could request food not on the daily menu. For example, one child wanted and received tuna pasta bake.
- The Dolphin ward domestic refrigerator cleaning log had not been signed for most of the month of August. This was reported to the domestic supervisor.

Patient outcomes

- Participation and performance in national audit. In addition to participating in the Neonatal National audit programme a full range of quality improvement projects had been completed including a neonatal abstinence syndrome audit.
- Paediatric asthma audits performance. The multiple admission rate for asthma within children's services was 25.5% compared to the national average of 16.9% for England.
- Paediatric diabetes audit performance. The Medway paediatric diabetes audit data for 2013/4 showed that the trust performance related to controlled diabetes was about the same as the England and Wales average.
- There were emergency no readmissions after emergency admission at Medway NHS Trust among patients in the under 1 age group between January and December. There were emergency readmissions following an elective admission in the 1-71 year old age bracket between January and December 2014 but no treatment speciality reported six or more readmissions. For non-elective admissions in the under 1 and 1 to 17 year age brackets no speciality at the trust had 6 or more admissions.
- The trust rate of multiple emergency admissions for children aged 1-17 shows a higher than average for Asthma, diabetes and Epilepsy, compared to the England average. Multiple admission rates for children and young people aged one to 17 with Asthma was 25.5% against an England average of 16.7% between February 2014 and January 2015. For patients with diabetes it was 21.7% against an England average of 14.1%. For patients with Epilepsy the multiple admission rate for individuals in age range of one year to 17 was 35.3% compared with 28% for the England average in the same period.
- The trust's Oliver Fisher Neonatal Intensive Care Unit was recognised as one of the top five neonatal units in the UK in providing high quality care by the National Neonatal Audit Programme. This programme is funded by the Department of Health through the Healthcare Quality Improvement.

Competent staff

- All staff we interviewed told us that they had timely and productive annual appraisals and personalised support for their roles. At appraisal, all mandatory training attendance among others was planned and discussed. Junior doctors we spoke with told us they were all allocated supervisors.
- Revalidation of doctors was planned at annual appraisal and the nursing team were fully aware that nurse revalidation was to commence in the Autumn of 2014.

Services for children and young people

- The parents of children we spoke with told us that clinical staff were excellent and that they were happy with care delivery to their children.
- All staff working in paediatric wards had undertaken paediatric immediate life support courses (PILS) and had been annually updated. This allowed the nurses to provide care to seriously ill children or children in cardiac arrest until the arrival of a cardiac arrest team. The high dependency unit was available until either the child s condition improved or transfer to a local paediatric intensive care unit was necessary.
- The matron we interviewed informed us that all nurses working in the paediatric wards were qualified children's nurses.
- The senior nurse of the neonatal unit informed us that, 76% of the nurses working there had undertaken a post qualifying courses in neonatal intensive care.
- Children's services are supportive of post qualifying nurse education, which was offered primarily by Canterbury Christ Church University. Nursing staff had access to a full range of modules and courses. Specifically for example nurses were sponsored to undertake study modules to acquire skills in neonatal nursing. The need for post qualifying education was identified at the annual performance reviews and prioritised according to need. Funding had been made available to support staff undertaking advanced neonatal nurse practitioner masters programmes and neonatal intensive care courses.
- All pre-registration nursing students were given 5 induction days, and staff nurses were enabled to attend mentor preparation programmes.
- Doctors and nurses were enabled to attend simulation training and a new wireless high fidelity manikin was used to teach neonatal care skills.
- Parents we spoke to told us that they had confidence in the staff caring for their children and babies.
- The doctors we interviewed told us that children's services provided good training for medical trainees.

Multidisciplinary working

- We observed good working relationships between all grades of staff and all professional disciplines working on the neonatal unit and the paediatric wards. The physiotherapist and paediatric pharmacist we interviewed told us that multi-disciplinary working was good.
- We were told by the matrons and all the nurses we interviewed that there was good MTD working on paediatric wards and the neonatal unit and that neonatal networks functioned well together with good relationships between the unit and the Kent neonatal transport service.
- We were told by doctors and nurses we interviewed that the relationship between the paediatric wards and tertiary referral centres e.g. The Evilina Unit at St Thomas's was good.
- We noted during handovers that there was a tangible level of corporate working and team spirit.
- We were told by the play specialist that MDT working across the service was good with both play specialist feeling very much part of the team.
- Nurses and the paediatric physiotherapist told us that that team working was good across children's services and that they felt supported by their colleagues in the multidisciplinary team.
- There were significant strategies in place to care for children with either learning disabilities or mental health problems. The Dolphin ward had a large teenage facility which was well equipped with adolescent recreational equipment. The matron we interviewed told us that there was good support from child and adolescent mental health services. We checked the ward for ligature points and all the curtain rails were collapsible. We interviewed the nurse manager of the community nursing team for children and young people with learning disabilities. The team which works closely with the inpatient children's unit employs both children's nurses and learning disability nurses who visit the unit each day to support families whose children have a learning disability. The nursing team employ a rage of communication strategies including Maketon a language programme using signs and symbols to help this group of children to communicate. We were told by nurses we interviewed on Dolphin ward that there was good links with the learning disability team.

Services for children and young people

- Although transition from paediatrics to adult services was generally good, for young people with learning disabilities it was less good. To help, all such children were issued with red cards. Children who were red card holders could be fast tracked for admission to Dolphin ward.

Seven-day services

- Children's services including the neonatal unit operated across the week, with day care medical procedures and surgery coordinated Monday through to Friday with differing specialities on differing days. We inspected the off duty rotas for doctors and nurses which showed 7 day working, Consultant cover was always available.
- Children requiring intensive care management and ventilation were stabilized within the Dolphin high dependency unit before being transferred to the anaesthetic department of the operating theatres prior to retrieval by the CATS team.
- Pharmacy to children's services cover was provided by a single paediatric pharmacist who told us that she was not able to offer a full service across the working week.
- We interviewed the paediatric physiotherapist who told us that she was not able to offer a full 24/7 service. She had received a Trust WOW award for her contribution to care.

Access to information

- Parents we spoke with told us that the doctors and nurses kept them well informed with information about their babies and sick children. The parents of children with long term conditions felt that there was good engagement and access to leaflets within the clinical areas. Many leaflets were available on line from the World Wide Web via a range of charities etc. Staff were always willing to print off information leaflets for parents.
- We examined a wide range of information for families in Dolphin ward including posters entitled "going to hospital" and "safer sleep for babies."

Consent

- Staff told us how consent was obtained from parents and where appropriate from the child or young person concerned across children's services in the trust. The trust had robust polices pertaining to consent and we found that consent was obtained in line with trust policy and the principles of Gillick competency assessment. 'Gillick Competence' refers to any child who is under the age of 16 who can consent, if he or she has reached a sufficient understanding and intelligence to be capable of making up their own mind on the matter requiring a decision. Student nurses we spoke with understood the difference between consent and assent in younger age children and the play specialist helped explain to children using hospital play equipment and in language they could understand what was going to happen to them during procedure. The learning disability team were always available to help with assent in children with learning disabilities. Play specialist also played a major part in explaining procedures to younger children using play materials. We were told that all nurses receive mental capacity act training during induction.
- The WHO safety checks prior to surgery included checking that consent had been obtained.

Are services for children and young people caring?

Good

Care was observed and said by parents to be delivered with kindness and compassion. Children were fully involved in their care and independence was encouraged. Parental involvement of care was encouraged and children's services had a family centred care philosophy which extended across each area. Strategies were used by staff to ensure that children and young people had age and appropriate support during the delivery of their treatment and care. This was especially true of children with learning disabilities.

Parents and children were involved in planning their care and information was shared with them so they could be fully informed on what would happen to them. There was access to specialist expertise to support the delivery of children and young people's care needs.

Compassionate care

- We observed infants, children and families being looked after in a caring and compassionate manner. Mothers with infants on the neonatal unit told us that communication between them and care staff was

excellent. All staff we spoke with including the junior doctors and nurses told us that there was significant emphasis on the six Cs which underpinned their practice. The Chief Nursing Officers' campaign to encourage compassionate care in English hospitals is based no's '6 Cs' which are Care, Compassion, Competence, Communication, Courage and Commitment. We observed that doctors and nurses maintained high levels of privacy and dignity using the ward bay curtains Mothers who were breast feeding had access to private rooms to express their milk and resident parents had access to bedside put you up beds. We saw that staff adhered to the principles of individualised care. Parents had access to a special parent's room where they could get refreshments.

- The play room of Dolphin ward was spacious and well equipped with age appropriate toys for children with a large outdoor play area accessed directly from the playroom.
- Parents we interviewed told us that the nurses were friendly, polite, courteous and explained everything they did.

Understanding and involvement of patients and those close to them

- Feedback from families was valued and positive patient stories featured prominently in the Oliver Fisher Neonatal Unit Annual Report for 2014.
- Breast feeding facilities on the neonatal unit and the support given by staff was exceptional.
- The results from friends and families test was prominently displayed within children's services and many, thank you cards were displayed. Dashboard information on a variety of topics including hygiene was prominently displayed for parents. The Sister of Dolphin ward showed us the data from the previous months FFT which demonstrated that 100% of parents would recommend the ward. Similarly the data from the Children's Survey showed scores of over 8 relating to caring.
- Throughout children's services CCTV was used to ensure people were safe there were clear and unambiguous protocols in place to address tailgating. These were prominently at the entrance to each clinical area displayed Saville procedures were also in place.
- Parents and children told us that nurses and doctors and other care staff kept them informed of their child's progress through the admission. We observed staff talking with parents and children, explaining their treatment and giving information about their child's progress.

Emotional support

- We observed all staff members interacting with children and their parents in a polite and friendly manner and children's services had access to two specialist nursing teams for help and assistance in providing additional emotional support to families. The community nursing team for children and young people with learning disabilities are based on site and can provide support especially in managing behaviours associated with learning disability. We interviewed the nurse manager of this service who told us that her team had contact with children's services on a daily basis. Additional support for inpatient children with life threatening and life limiting illnesses was provided by the children's outreach and specialist team (COAST) who area team made up of specialist nurses, carers and a specialist social worker who are based at the trust. We interviewed the nurse manager of this service who told us that her team provide support to children in hospital and subsequently in the home environment.
- Children with mental health problems were supported by the child and adolescent mental health services (CAMHS) which was provided by Kent and Medway NHS and Social Care Partnership Trust (Tier 3) and South London and Maudsley NHS Foundation Trust (Tier 4).
- We spoke to a range of parents in the neonatal unit, and the units which made up children's services including the assessment unit. Parents told us that the doctors and nurses explained everything to them in language they could understand and that they were very caring at all times.
- The hospital chaplain we spoke to told us that there was a dedicated trust chaplaincy service available to support families in need.
- Parents were offered facilities to stay with their children in hospital, were made welcome and could remain at all times to provide emotional support for children.

Services for children and young people

- Staff we spoke with including doctors told us that the Language Line and access to interpreters was always available to children and their families.
- The play facilities provision including the adolescent room were good.

Are services for children and young people responsive?

Good

The care ambiance across children's services was found to be spacious, clean and bright with good recreational facilities for children and their carers.

The children's services within the trust met the needs of young patients (0-16years) and their parents and carers. There was ready access to children's services via the children's accident and emergency unit or via a GP referral service offered there.

Close working arrangements with community based services some of which were based within the curtilage of the trust ensured that children could expect to be cared for at home via community nursing services. There were formal arrangements in place for children to be transferred to tertiary hospitals with large children's units if more complex in-patient care was required.

The coast and learning disabilities teams based within the trust worked seamlessly with the acute services team. Whilst the trust website provided access to the 'children first for health' website which was an award winning health and hospital information website for teenagers, children and parents the link did not function. This service was utilized by many smaller children's units around the UK is now part of Great Ormond Street Hospital.

Children scheduled for day case interventions on the Sunderland day unit were invited to attend pre-assessment clinic to help them and their families meet with the nursing team, and opportunities were provided for children and their parents/carers to ask any questions.

Service planning and delivery to meet the needs of local people

- Services for children in the trust had been developed to work in conjunction with adjacent larger local children's units which offered specialist services for children. Children's services had short waiting list times. The consultant of the week was readily available to discuss referrals for outpatient or inpatient care with local primary care physicians.

Access and flow

- Information provided to us in advance of our inspection indicated that the median length of stay for children at Medway was in line with the England average for both elective and non-elective admissions where children were under one year of age, and for elective admissions for those aged one to 17.
- There were arrangements in place for the transfer of critically ill children to specialist centres in London via the CATS retrieval service. We were told by doctors and nurses that these arrangements worked well and policies for the transfer of patients could be accessed electronically.
- Parents were encouraged to remain with their children whenever possible and were offered accommodation via put you up beds within the ward bays. Parents of children attending for day care accompanied their child to the anaesthetic room for surgery.

Meeting people's individual needs

- Parents we spoke with acknowledged that translation services were available to them. The doctors and nurses we interviewed were fully aware of how to organise translation services for families.
- The Kent Child and Adolescent Mental Health Service (CAMHS) liaised with Dolphin Ward to ascertain if there were any children with mental health issues. Child and Adolescent Mental Health Service could be accessed 24 hours a day. The learning disability team were available to support families with inpatient children with learning disabilities and the Coast Team with patients with complex illnesses.
- As part of the chief executives 'WOW' awards a number of staff working with children's services including a physiotherapist we interviewed had been conferred with awards.
- We found that parents were enabled to stay with their child whilst in hospital. Mothers we spoke with were very happy with these arrangements.

- Play specialist support was insufficient for the number of children requiring support. This restricted the scope of work the play specialists could undertake and limited their involvement in areas such as distraction during painful or frightening procedures.
- Mothers we spoke to told us that the food for children was good and that they were very happy with the parent sitting room where they could access refreshments.

Learning from complaints and concerns

- Learning from complaints was shared via team meetings with staff receiving feedback form the Patient Advocacy and liaison service (PALS). The PALS service was located in a very austere environment with no natural light and accessed only via an external telephone.
- We were told by the PALS team that there are low levels of complaints and when we inspected the data base of PALS incidents for the June 2014 through to June 2015 there were only eight paediatric contacts with the service compared to 1,387 for surgery and anaesthetics for the same period. The majority of complaints were minor in nature ranging from scheduled outpatient appointments, late blood results and missed immunisations.

Are services for children and young people well-led?

Good

There were systems in place to ensure good governance and monitoring of standards for children and infants who required acute medical care and surgical intervention and investigations.

It was apparent that staff were proud to work for the trust and they believed that they had addressed all the key issues raised following the previous CQC inspection. It was clear from speaking to parents that the they felt confidence in the services being provided especially those within the neonatal unit staff were aligned to, and supported the trusts wide vision of providing safe, clean and personal care. Leadership of individual aspects of children's services was good with staff speaking positively about their immediate team leaders. The aspirations of the new chief executive and her management team were fully supported by the staff.

Vision and strategy for this service

- Staff spoke positively about providing high quality care that was aligned to the trust-wide vision of ensuring that patients received safe, clean and personal care.
- Staff members were aligned to the trust wide quality improvement strategy and were able to describe the shared vision for the trust of the chief executive and the management team.
- We identified that there was an all-encompassing vision and strategy which was attributed to the overall provision of children's services at the trust, which encapsulated neonatal intensive care provision, acute care provision, day care, outpatients and community paediatric services.
- The senior nurses we spoke to told us that the new Chief Executive had developed an effective communication strategy.

Governance, risk management and quality measurement

- An analysis of the children's risk register summary for June 2015 showed that action plans and controls had been put in place to reduce risks.
- We were told that there were arrangements in place for governance, risk management and quality measurement associated with the care of children and infants across the trust. We found that the arrangements enabled them to measure the quality of the services they provided, as well as having appropriate governance systems in place.
- Doctors and other health care professionals we spoke with told us that the serious incident meetings across children's services were an effective strategy to escalate risks where required. These meetings and the associated quality board meetings facilitated monitoring of action plans and to consider and reflect on situations when the delivery of care had not gone according to plan. These meetings allowed staff to learn from incidents and to consider and implement any actions that may have needed to be taken. Additionally

these meetings considered reviews of policies, medical pathways, reviews of existing and new risks, safeguarding concerns and financial and human resource performance.

Leadership of service

- Staff working with children and infants on a daily basis told us that that day-to-day clinical leadership was very good and that they received timely and appropriate support from their immediate line managers.
- We observed ward mangers communicating with their nursing staff in a positive way and the nurses we spoke with believed that there was an excellent team spirit in place.
- The staff nurses we spoke to on told us that the matrons had an open policy regarding whistle blowing and that they had good leadership qualities.
- The middle grade and junior doctors we spoke with told us that they felt very well supported by the cadre of consultants.
- The neonatal unit were participating in the National Neonatal Audit Programme which has been implemented to assess whether babies admitted to neonatal units in England receive consistent care in relation to key criteria such as the proportion of babies receiving breast milk at discharge.

Culture within the service

- Most staff that we spoke with told us the trust was a good place to work with many of them having worked there for many years.
- Staff and parents we spoke with told us that children's services within the trust were good.

Public and staff engagement

- The team within children's services had undertaken the productive ward 15 step challenge to allow them greater insight into the family journey. The 15 Steps Challenge is a tool to help staff, patients and others to work together to identify improvements that will enhance the patient experience and was part of The NHS Institute for Innovation and Improvement's Productive Ward Series.

End of life care

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

Information about the service

An End of Life Care (EOLC) Clinical Nurse Specialist (CNS), worked four days a week and was employed by Medway Foundation NHS Trust (MFT). They worked in an integrated manner with the Hospital Palliative Care Team (HPCT) provided by Medway Community Healthcare. The HPCT and CNS delivered palliative services to all clinical areas across the hospital. The HPCT consisted of access to a palliative care consultant, four part time palliative care CNS's and a secretary/multidisciplinary team co-ordinator.

The palliative care team were available Monday to Friday 9am to 5pm. Out of hours the Wisdom Hospice provided advice and support regarding palliative care. The palliative care consultant was a locum and on site three times a week. Outside these sessions EOLC was provided by clinical staff within the hospital.

We visited a variety of wards across the hospital including Gundolph, Keates, Milton, Arethusa, Bronte, Byron, Harvey, Lawrence, McCulloch, Phoenix, Sapphire, Tennyson, Will Adams and Wakely wards. We also visited the patient affairs office, PALS, mortuary and hospital chapel. We reviewed the medical records of seven patients at the end of life, seven drug charts and 11 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records. We observed care provided by medical and nursing staff on the wards. We spoke with two patients receiving EOLC and six of their relatives. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results provided for patient survey and other performance information held about the trust.

For the purposes of the inspection, only services provided by Medway Hospital NHS Foundation Trust were reported and rated.

End of life care

Summary of findings

We found that at a local level the EOLC CNS and HPCT worked hard collectively to provide good end of life care. Their aim was to provide and maintain end of life educational sessions across the hospital and to introduce the EOLC competency framework.

We found that staff at ward level provided patient centred care and wanted to deliver good care through training and support but they were unclear about their roles in delivering EOLC. There was no training for EOLC and the Chief Nurse confirmed that the EOLC education budget was not used. The hospital staff provided sensitive, caring and individualised personal care to patients who were at the end of life. Patients and their relatives told us that staff were caring and compassionate and treated patients with dignity and respect. On the wards we visited we observed staff that were doing their best to provide caring and dignified EOLC. This was due to previous knowledge obtained and pride in their work rather than due to specific training from the trust.

The EOLC CNS demonstrated a high level of evidence based specialist knowledge and worked effectively in conjunction with the HPCT. We observed that they both supported and provided advice to other staff and they were highly regarded across the trust.

There was evidence that systems were in place for the referral of patients for assessment and review to ensure patients received appropriate care and support. We saw evidence that urgent referrals were seen on the same day. In the period November 2014 to April 2015 there was a total of 618 referrals (approximately 1,200 per annum) made to the hospital palliative team. Between April 2014 and March 2015 there were 1,906 deaths at the hospital.

The National Care of the Dying Audit 2014 made organisational and clinical recommendations to ensure that dying people and their families got the care and support they needed and deserved. Results of the audit showed that Medway Maritime Hospital achieved two out of seven for organisational indicators and seven out of 10 of clinical indicators compared to the England average.

The End of Life Care Strategy, published by the Department of Health in 2008, set out the key stages and the National Institute of Health and Care Excellence's (NICE) End of Life Care Quality Standard for Adults (QS13) set out precisely what EOLC should look like. These were both for adults diagnosed with a life limiting condition in all care settings. EOLC is defined as a patient with less than 12 months to live no matter the diagnosis. The End of Life Care Policy (2014) provided by the trust was not robust as it was aimed at care of the dying patient only and there were no prerequisites for advance care planning.

The hospital did not have an EOLC strategy in place. The EOLC action plan was not fit for purpose and did not link to the EOLC steering group agenda. Without service improvements the EOLC provided by the hospital was unsustainable. This was due to the reduced specialist palliative resources, lack of EOLC education and leadership. Additionally, the absence of a robust policy and strategy did not provide a suitable framework and guidelines for staff to adhere to.

The EOLC service provided by the hospital had significant governance issues. There was no governance framework to support delivery of good quality care. There was no comprehensive assurance system or service performance measures in place.

There was no overall leadership of the EOLC service in the hospital. There was little evidence of divisional or consistent board input. The National Care of the Dying Audit 2014 recommends that the trust had a named board member with responsibility for care of the dying. The Chief Nurse confirmed there was an absence of a non-executive lead.

The hospital were unable to make a clear distinction who the hospital medical lead for EOLC was. Additionally, it was unclear what the Chief Nurse was responsible for regarding EOLC. Further questioning of the Chief Nurse regarding EOLC at the hospital resulted in their admission that the service was not adequate. They were unable to provide any evidence of plans for the future or those said to be in progress or underway.

End of life care

Are end of life care services safe?

Requires improvement

The trust had an electronic incident reporting system to aid the reporting of incidents. Permanent nursing staff, porters and mortuary staff were able to give us examples of how to report incidents. However, we were informed that they did not receive feedback.

There was no recognised coding system to identify incidents related to EOLC. We were not provided with evidence of learning from incidents and changes in practice as a result during the inspection. A true picture of EOLC incidents across the trust was not available and learnings from these incidents did not inform improvements to the quality of care delivered to EOLC patients.

The mortuary area was clean and staff in all departments we visited were able to demonstrate appropriate hand hygiene and complied with the trusts policies and guidance on the use of personal protective equipment.

Medicines were prescribed and given appropriately although there were discrepancies in the algorithm for symptom management for patients in EOLC. The hospital had guidance in place around the completion of the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms. However, our findings showed that DNACPR forms were not consistently meeting with this guidance.

The mortuary staff, porters, PALS and Patient Affairs Officers evidenced that they were up to date with their mandatory training.

Incidents

- The trust had an electronic incident reporting system to aid the reporting of incidents. Permanent nursing staff, porters and mortuary staff were able to give us examples of how they reported incidents. A member of staff on Tennyson ward told us they were able to report an incident where a patient was aggressive to them. Staff on McCulloch ward told us that they reported incidents regarding shortages of staff. Both of these staff members told us that they had not received feedback.
- Mortuary and portering staff informed us that there had been no incidents reported regarding the transportation of the deceased. However, the electronic recording tool's data submitted from the trust informed us that there had been two incidents reported in May 2015 when the deceased had entered the mortuary without a wristband attached.
- The PALS officers logged all their activities on the electronic incident reporting system. These included complaints, assistance requests and suggestions for improvement. These were relayed into monthly reports which were distributed to each division to implement change in service provided.
- Mortuary staff told us that their refrigerators were more than 20 years old. We were informed this was on the trusts risk register and preventative maintenance was being performed. Service records were observed.
- There were no 'Never Events' relating to EOLC services. 'Never Events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- Staff told us that monthly morbidity and mortality meetings were in place. These were attended by medical and nursing staff and other members of the HPCT. Action points were recorded at the end of each meeting and learning points discussed.
- There was no recognised coding system to identify incidents related to EOLC so identification of these incidents within the data submitted by the trust was made by highlighting words such as: palliative, end of life, dying, terminal, Liverpool Care Pathway, and syringe driver as key elements within the text. Data from April 2014 – July 2015 (sourced September 2015) showed 35 incidents.
- Analysis of the data showed a reduced standard of care for EOLC patients. This related to poor discharge planning where patients were not referred to the community nursing and palliative care teams, to ensure streamline care between care providers. Inadequate or no care packages in place following discharge to the patients preferred place of care resulting in poor care and distressed relatives. No copies of DNACPR orders following patients on discharge. Poor medicine management processes including missing medication on discharge, no information given to families re-administration and delays in accessing urgent

medication on the wards and prescribing errors. We were not provided with evidence of learning from incidents and changes in practice as a result during the inspection.

- We found no evidence of systems in place to discuss and review end of life incidents at the 'End of Life Steering Group' where actions and learnings could be disseminated across the trust. Nor were incidents reviewed by the Lead EOLC specialist nurse. A true picture of EOLC incidents across the Trust was not available and learnings from these incidents did not inform improvements to the quality of care delivered to EOLC patients.

Cleanliness, infection control and hygiene

- We observed that the mortuary, including viewing area, was clean. This was confirmed by observation and viewing the cleaning rotas.
- We saw ward and departmental staff caring for patients on the EOLC pathway complying with the trusts policies and guidance on the use of personal protective equipment (PPE). We observed staff were bare below the elbow, sanitised their hands between patient contacts and wore aprons and gloves when they delivered personal care to patients.
- We saw on all wards visited that there was hand gel available at entrances and notices reminding staff and visitors to use them.

Medicines

- The trust's End of Life Care Policy (2014) contained an algorithm for symptom management for patients in EOLC. The guidelines were comprehensively set out and presented in an easy to follow manner. We spoke with medical and nursing staff who were able to show us the guidance.
- However, we observed that the guidance was not robust in its directives. The algorithm contained an inappropriate dosage for opiates. Additionally the maximum dosage in 24 hours was not specified for specific medication (for example cyclizine).
- Moreover the levomepromazine dose prescribed was difficult to calculate from the ampoule strength listed. Also the dose for nausea was lower than that for agitation and this was not made clear in the prescribing. This prescribing could be open to error from inexperienced staff and given the trusts lack of EOLC training this was an issue.
- We looked at drug charts for seven patients who were EOLC and patients had been prescribed anticipatory medication. However, we saw that two patients had not had the appropriate medication prescribed despite their potential of having fits, and four of the records did not state a maximum dose during a 24 hour period.
- On Byron ward we observed that there were omissions for anticipatory medication on patient records. One record showed that the wrong medication had been prescribed for pain and there were wide variations of doses prescribed. This was a risk for junior staff.
- On Bronte ward we observed nursing staff dispense the prescribed medication for the syringe driver along with the appropriate checks for an EOLC patient on the ward.
- All patients on an EOLC pathway were discharged from hospital with a 'crisis medication pack' and advice sheet. This ensured that patients on EOLC had all their medication prescribed and available to them on their discharge from hospital which ensured streamlined care was maintained.
- We reviewed the MAR (Medication Administration Record) chart of a patient who was receiving end of life care (EOLC). The chart had IV (intravenous) morphine prescribed which was administered to the patient. However, we noted the trust policy for anticipatory medicine does not advocate the use of IV morphine; it suggested the use of Morphine subcutaneously (delivered under the skin). We asked the agency staff nurse if this was normal procedure to give IV to EOLC patients in ward areas and we were told that it was. This meant that hospital policy was not being followed and IV morphine was being administered in an inappropriate clinical area where staff may not have been competent in dealing with the side effects associated with intravenous morphine.

Records

- In the mortuary we observed a good standard of record keeping and all registers were seen.

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- On visiting the Patient Affairs Office we saw that systems were in place to process death, burial and cremation certificates. We were talked through the process by the officer who showed us what the role involved.
- Holistic assessment of patients were completed and reviewed by ward staff. We saw evidence in the notes that patients were recognised as requiring to be turned at appropriate times and this was recorded as being undertaken by nursing staff. Additionally it was documented that regular mouth care was given and the necessary hydration maintained.
- Patients receiving care from the palliative team had their documentation updated when reviewed. This gave information around changes in patient care needs and medicines management. Frontline staff on the wards would implement the changes as required such as applying a syringe driver or changing medication. We observed that the palliative team provided hand written updates in the patients' medical notes and also updated the palliative team computer system.
- We saw on Bronte ward that patient records were written by nurses and doctors in a combined format with nurses writing in the progress notes identified as 'nurse'. We were told that agency staff were also trained in this format. Nurses and support workers completed the bed side notes.
- Across the wards visited we reviewed seven medical records that contained an individualised end of life care plan and this was kept in the patients red folder. However, notes were inconsistent with completion of patients name and NHS number on each page.
- The hospital had guidance in place regarding the completion of the 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms. The guidance was well set out and gave good direction around what information is necessary in each part of the form to be compliant. In May 2015 the hospital audited the completion of DNACPR forms which highlighted risk and was re-audited in August 2015. The trust acknowledge there has been some improvement in DNACPR completion and also recognise that there is a clear need for staff education.
- While visiting ward areas we checked medical records and we viewed 11 DNACPR forms. We saw that all decisions were recorded on a standard form at the front of the notes.
- There were variations in the completion of the forms across the hospital. Eight of the forms showed that a discussion had taken place. All but one of the forms seen were countersigned by a senior healthcare professional.
- However, on Byron ward we saw that that one set of patient's notes did not record meaningful conversation regarding DNACPR or capacity assessment results.

Safeguarding

- Staff demonstrated a good knowledge and understanding of safeguarding vulnerable adults.
- Safeguarding e-learning was part of mandatory training and this was monitored by ward managers.
- The relevant local authority and social services numbers were available for staff.

Mandatory training

- We were shown the mandatory training that the porters received which was stored electronically on a central file. The porters and managers we spoke with told us that their mandatory training was up to date and included adult and child safeguarding, fire, infection control, manual handling and mortuary training.
- The porters told us that they had received training to support the movement of patients to the mortuary after they had died. The training included the use of the mortuary out of hours to ensure that mortuary procedures in and out of hours were adhered to. The porters we spoke with were able to describe the process in a knowledgeable manner and were able to demonstrate that all patients were treated with dignity and respect.
- The porter manager informed us that they were in the last stages of co-ordinating a course with Mid Kent College to enable porters to obtain a professional qualification that included dementia and moving and handling training. The porters we spoke to said they were positive about this opportunity.

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- The PALS and Patient Affairs Officers also evidenced that they were up to date with their mandatory training.
- Staff on orthopaedics and elderly care wards told us that they received mandatory training for dementia and they told us that this included some aspects of EOLC.
- On Bronte and Tennyson ward we saw evidence that staff received syringe driver training from train the trainer and they were all up to date. However, staff on Lawrence ward were unable to provide evidence that they had received training for the use of syringe driver pumps as staff kept this information themselves and there was no central ward based copy. When patients were discharged home the pump was changed for a Mckinley syringe driver. They informed us that a CNS in equipment services would provide on the spot training for this particular syringe driver if required.
- The trust used syringe drivers which were not portable and were a safety hazard for those patients who were still mobile. Patients who were discharged from hospital still requiring the use of a syringe driver were disconnected from the ward pump and had a different pump attached in the community. Ward staff did not receive training in this pump.

Nursing staffing

- Medway Maritime Hospital employed a Clinical Nurse Specialist (CNS) who worked full time over four days a week. We were told by the CNS that they were originally employed to advocate the EOLC strategy and not hold a specific caseload. However, due to an increasing workload their responsibility had changed and they were required to work with the HPCT to provide palliative care across the hospital.
- The EOLC CNS worked collaboratively with the HPCT which was provided by Medway Community Healthcare, a separate provider. The HPCT employed four part time staff that equalled three whole time equivalent (WTE) CNS. they also employed one part time secretary/ multidisciplinary co-ordinator.
- During our inspection we asked ward managers about their staffing levels and whether they felt adequate staff were on the wards when caring for patients on an EOLC pathway. On McCulloch we looked at the off duty rota that demonstrated the staff shortages experienced on this ward. On the day of inspection the ward had a senior staff nurse, newly qualified nurse and two support workers for 24 patients. We were told that patient care was not compromised but staff did not have their allocated breaks and patients did not receive medication in a timely manner. Additionally, this meant that there was a risk that care could be compromised for EOLC patients who required four hourly observations.

Medical staffing

- The hospital did not provide continuity with EOLC consultant support and advice as the Palliative Care Consultant, employed by the Wisdom Hospice, had retired. Their replacement had been appointed but was not yet in post. A locum consultant, when available, visited the hospital three times a week and could be contacted at the hospice at other times.

Other staffing

- The mortuary had three WTE staff and one part time assistant. The mortuary informed us that coping with the pressures of winter had been "horrific" the previous winter. However, plans had been implemented for this year. Extra space had been planned for and a 1 x WTE locum mortuary assistant had already been booked.

Are end of life care services effective?

Requires improvement

The hospital had implemented some standards as set by The National End of Life Care Strategy (2008) published by the Department of Health and the National Institute of Health and Care Excellence's (NICE) End of Life Care Quality Standard for Adults (QS13).

The hospital told us that they do not record data that determines the percentage of cancer and non cancer diagnosis referrals. The palliative care team receive approximately 1,200 referrals per annum. In 2014, the hospital experienced a total of 1,373 deaths. For the period November 2014 to April 2015 there was a total of 618 referrals to the palliative care team. During this period 272 deaths were patients under their care during this period.

We saw evidence that across the wards and departments we visited the HPCT supported and provided

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evidence-based advice to other health and social care professionals. Alternative EOLC guidance had been developed in response to the national withdrawal of the Liverpool Care Pathway.

We were concerned that we found no organised advance care planning as required by 'Once Chance to get it Right' 2014 by the National leadership Alliance for the Care of the Dying Person. Additionally there was no evidence of EOLC training and there were inappropriate referrals to the palliative care team.

Evidence-based care and treatment

- The National End of Life Care Strategy (2008) published by the Department of Health, set out the key stages for end of life care, applicable to adults diagnosed with a life limiting condition. The National Institute of Health and Care Excellence's (NICE) End of Life Care Quality Standard for Adults (QS13) sets out what EOLC should look like for adults diagnosed with life limiting conditions.
- 'Once Chance to get it Right' 2014 by the National leadership Alliance for the Care of the Dying Person sets out five priorities of care in the last few days and hours of life. This document determines the duties and responsibilities of health and care staff to ensure the priorities are achieved. the priorities are actions taken in accordance with the patients needs an wishes, sensitive communication, involving patients and their relatives in decisions, needs of relatives actively explored and respected and provision of an individualised care plan.
- The hospital had provided a palliative care team to implement part of the Nice Quality Standards for Improving Supportive and Palliative Care for adults. We saw evidence across the wards we visited that the palliative team supported and provided evidence based advice when caring for patients reaching the end of life. Guidance and instruction was given regarding complex symptom control and individualised care of the patient.
- The palliative team supplied the wards with an EOLC pack which was known as the 'purple folder'. We saw that it contained information leaflets for relatives with contact numbers and chaplaincy support; algorithm for symptom management in EOLC; Comfort Plan for the Dying Patient; family communication sheet; prevention and management of pressure ulcers for patients approaching EOLC and special concessionary parking permit for relatives. We observed the folder present on wards and staff on Arethusa ward told us that this information was easily accessible.
- Data received prior to inspection informed us that the trust was listing, on the summary hospital level mortality indicator (SHMI), that they had more deaths associated with palliative care when compared to the national average. However, the trust informed us that the data submitted included activity for Medway Community Healthcare which meant that the number of finished provider spells and observed deaths was overstated. At the time of writing this report no further data was available to confirm this.

Pain relief

- Pain levels were routinely collected together with vital signs and pain was promptly treated. We saw these recorded in the patient records we looked at.
- One example we observed while on Wakely ward. A newly diagnosed palliative patient reported that on admission had uncontrollable pain. This was controlled with oral analgesic and the patient reported they could now "get on with their life."
- We reviewed patients' medical records and saw that patients had regular assessments for pain and appropriate medication given frequently and as required.

Nutrition and hydration

- On Will Adams ward we observed a patient record that contained specific instructions regarding an individualised care plan for fluid and nutrition for a patient who was at risk of aspiration. The dietician had assessed the patient and identified and documented that the patient required pureed food and thickened fluids only. The food chart in the patient notes revealed that staff had given the patient solid food. This was observed by the dietician who documented the omission and that they had seen inappropriate food and drink left by the patient's bed. The dietician spoke to staff to emphasise the individualised care plan. We were not shown the report of this incident.
- Relatives on Byron ward informed us that they had concerns that the patients on the ward were not

receiving the appropriate nutrition and fluid. Relatives had been feeding their family member but had seen other patients' uneaten food being removed and no assistance given.

Patient outcomes

- Results of the National Care of the Dying Audit 2014 showed the hospital achieved two out of seven organisational key performance indicators (KPIs). The hospital achieved below the England average for access to information relating to death, access to specialist support for care in the last hours/ days of life, trust board representation, clinical provision/ protocols regarding after death care and formal feedback processes for the bereaved.
- The hospital scored above the England average for EOLC education and training and prescribing medications for the five key symptoms for EOLC. However during our inspection we observed that there was not an EOLC education programme and the guidelines for the prescribing of medications was not robust.
- The results of the audit showed the hospital achieved seven out of 10 for clinical KPIs. The hospital scored below the England average for reviewing patients nutritional and hydration requirements and reviewing care after death.
- The hospital told us that they do not record data that determines the percentage of cancer and non cancer diagnosis referrals. Additionally they do not record data regarding the numbers of patients who died within 30 days after referral to the palliative care team.
- The palliative care team receive approximately 1200 referrals per annum. In 2014, the hospital experienced a total of 1373 deaths.For the period November 2014 to April 2015 there was a total of 618 referrals to the palliative care team. The palliative care team report 272 deaths were patients under their care during this period.
- The End of Life Care Strategy (DOH 2008) and NICE EOLC Quality Standard for Adults (QS13) both define EOLC as a patient with less than 12 months to live. The policy provided by the trust was aimed at a patient in the last days of life and there was not a strategy in place to accommodate the full remit of EOLC.
- The End of Life Care Policy 2014 provided by the trust asserts that "people dying in our care receive the best possible end of life care in accordance with their expressed wishes and preferences." Furthermore, "ensure that care of the dying person is informed and supported by an individual EOLC plan, encompassing the physical, psychological, spiritual and social aspects of EOLC, uniquely expressed by each person."
- We observed and were told by staff that there was not an established advance care plan (ACP) document in use in the hospital. The EOLC CNS informed us that they had participated in the design of the ACP document used by the community teams which can be accessed by the ambulance service. We were told that doctors wrote in patients' medical records any discussions with patients and relatives regarding ACP.
- This was confirmed by a consultant who told us that not all consultants and GP's were engaged in ACP. Since 2007 the local community hospitals have been under the care of GP's where previously they had consultant support from Medway Hospital, which enabled ACP to be completed. A consultant specialising in geriatrics told us that they are behind in ACP but work closely with the palliative team.
- Although we had been told that patients had the option to be registered on the 'My Wishes' register (Adastra), we found no evidence of this being in use on the wards we visited. 'My Wishes' sets out the wishes and preferences of the patient. The register could be accessed by GP's, A&E and out of hours service and ensured that the wishes of the patient were adhered to and that no treatments were delivered against the patient's wishes. Moreover, the Chief Nurse when questioned told us that the trust did not access this often and could not confirm how patients who present at A&E could be identified as EOLC.
- In response to the withdrawal of the Liverpool Care Pathway in 2014 the hospital had developed a 'Comfort Plan for the Dying Patient'. The plan follows some of the '5 priorities of care' defined by the Leadership Alliance Care of Dying People 2014. It encompassed the documentation of an initial discussion with patient/ family but did not contain reference to on going regular discussions and/or updates.
- Furthermore, the care plan stated that patients commenced on the plan were to be referred to the HPCT and this was listed as a role and responsibility of

staff in the trust policy (5.17). We looked at a set of EOLC patient notes on Tennyson ward who did not have complex needs but was referred to HPCT as per protocol. This was an inappropriate referral and use of HPCT time and expertise. A possible explanation for this was as staff told us on Bronte and Lawrence wards they had not received any training in the use of the care plan

- 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 appropriately completed.

Competent staff

- We saw evidence that mortuary staff, porters, PALS officers and the patient affairs officers had appraisals performed annually with Personal Development Plans.
- The HPCT operational policy 2015-2016 stated that the role of the EOLC CNS was "to provide education in EOLC for all staff at MFT." Additionally the National Care of the Dying Audit 2014 recommends that staff receive mandatory training in the care of the dying.
- We found no evidence across the wards we visited that staff received training in EOLC. This included communication, bereavement, spiritual issues of patients and culturally specific issues around death.
- Information provided by the trust informed us of the courses provided by the trust. The 2015 Nurse Education Handbook did not contain any courses relevant to EOLC. The four day induction programme lists EOLC as a topic that may be included but was subject to change.
- The induction pack for agency staff, temporary trained practitioners and junior doctors did not contain any reference to EOLC or palliative care training.
- The chaplaincy service was assisted by 30 volunteers of which two were ordained. Their induction involved a six week course which included spiritual care and ethics and practice of when visiting a ward. The chaplain also told us that they talked to nursing staff regarding spiritual care at their induction.
- The chaplain acknowledged that there was a lack of EOLC training at the hospital. We were told that there had been EOLC study days previously which chaplaincy partook but these were stopped by the trust as they did not consider this training to be mandatory.
- Staff on McCulloch ward told us that although there was no specific training in EOLC, nurses can receive one to one training from the EOLC CNS. Doctors on the ward told us that they learned on the job and from their seniors.
- We were told of an incident on McCulloch ward where a member of staff had identified an incorrect prescription of an anticipatory drug and informed the doctor. They told us that this was known from previous hospice experience not through training by the trust.
- Lawrence ward had a link nurse for EOLC. Wakely ward told us that they two members of staff who have requested to be EOLC link nurses but this had not been pursued by the hospital.
- We spoke to staff on the Endoscopy ward who said that bereavement training would be appropriate for their role. A member of staff on an elderly ward explained that they had attended a bereavement course in the past but this was self-funded as the trust did not offer such courses.

Multidisciplinary working

- We observed the palliative care team were involved in a multidisciplinary team (MDT) meeting every Wednesday morning and this was attended by a Hospice Consultant, EOLC CNS and HPCT CNS. The MDT coordinator arranged the meeting to ensure that all patients under the care of the palliative team were discussed. This ensured that a MDT approach to care was received by all patients.
- The HPCT had daily meetings in the morning to discuss all patients on the current caseload and any new referrals.
- We were told that all patient information was stored on a computer system and an easy to read 'live board' in the office. This showed the active caseload and which CNS was assigned to each patient. The board also showed who required telephone advice and who was waiting for a hospice bed.

End of life care

- The mortuary manager and chaplain were both involved in meetings for the EOLC steering group. The chaplain told us, as an advocate for EOLC care they had been involved in the development of the 'Comfort Plan for the Dying Patient'. The chaplain was a facilitator for 'Schwartz Rounds' within the hospital. This is a support group for clinical staff and we were informed that it was well attended.
- The Patient Advice and Liaison Service (PALS) was operated by two full time staff and the office was open Monday to Friday 9am to 4pm. They assisted, advised and signposted patients and relatives. They told us they helped to reduce the number of formal complaints the hospital received. All their activities were logged on the electronic incident reporting system. The officers demonstrated very good knowledge of their roles and their competency. The PALS officers told us they received limited correspondence from the public regarding EOLC.
- We observed evidence that there was good MDT working between mortuary, porters, pathology, funeral companies, maternity and coroners. The mortuary manager met with service leads and told us that the mortuary felt very much part of the trust.
- The mortuary works to the Human Tissue Authority (HTA) regulations, standards and guidance. We observed examples that good, regular local audits were performed.
- We saw an example of good documentation by the dietician on Bronte ward. They had received a referral which was triggered by the MUST tool and appropriate action was taken.
- Staff on Lawrence ward told us that they used a modified early warning score (MEWS) to identify a deteriorating patient and nurses will prompt doctors if patients are approaching EOLC. McCulloch ward told us that all patients started on the EOLC care plan are referred to HPCT. Staff on Arethusa ward told us that they involve the palliative team early when EOLC patient identified. Additionally, staff on Phoenix ward told us that the HPCT were good at responding to queries.

Seven-day services

- The National Care of the Dying Audit 2014 recommends that patients have access to face to face palliative care services seven days a week.
- The HPCT provided a service Monday to Friday 9am to 5pm. We were told that they tried to ensure that three CNS were on duty during these times but this depended on annual leave and sickness. Outside these hours frontline nursing and medical staff could contact the Wisdom Hospice for support and advice.
- We were informed that during January and March 2015 the HPCT piloted a study to provide a six day service, including Saturdays. However, due to staffing issues they were unable to continue.

Access to information

- Records for patients identified as end of life contained care plans, anticipatory medications and evidence of multidisciplinary input into care and treatment.
- The EOLC resource folder, the 'purple folder' contained current information and trust documentation collaborated by the EOLC CNS. However, on wards we visited the folder was not in a prominent position.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Medical staff we spoke with understood the DNACPR decision making process and described decisions with patients and families. They tried to provide clear explanations to ensure that the decision making was understood.
- Medical staff understood the Mental Capacity Act and we were shown examples of mental capacity assessments on the clerking documentation and also on Bronte, Tennyson, Sapphire, Byron and Harvey wards.
- Staff on Will Adams ward explained to us the process of completion of Deprivation of Liberty Safeguards (DOLS) for patients who were discharged using the fast track system as they had been assessed as lacking capacity to give consent.

End of life care

Are end of life care services caring?

Good

The hospital staff provided sensitive, caring and individualised personal care to patients who were at the end of life. We spoke to patients and relatives who were complimentary about the care they had received.

On the wards we visited we observed compassionate and caring staff that were doing their best to provide caring and dignified EOLC. This was due to previous knowledge obtained and pride in their work rather than due to specific training from the trust.

We observed data provided regarding the local bereavement survey which was analysed by the EOLC CNS and sent to the specific ward areas for action.

No bereavement support was offered to families after the death of their adult relative within the hospital.

Compassionate care

- During our inspection we observed EOLC that was sensitive and caring by all staff. We saw the individualised patient centred care and advice given to a newly diagnosed palliative patient who had been referred to HPCT that morning. Within two hours the CNS had responded, assessed and reassured the patient. They gave advice on the discharge process, medication and signs and symptoms to expect.
- The PALS officers told us that patients and relatives spoke very highly of the EOLC CNS. In turn we observed kind and clear responses from the PALS officers towards patients, relatives and ward staff.
- Staff we spoke with on all wards we visited said EOLC was a vital part of their role and they enjoyed the relationships they formed with patients and their relatives. Staff on Tennyson and Bronte wards showed that they gave compassionate care to the dying patient and facilitated the family to help with care if they wished to including personal hygiene, mouth care, feeding and fluids. Staff on Gundolph, Keates and Milton wards ensured EOLC patients were placed in a side room, if available, to maintain privacy, and they supported the relatives.
- During the inspection a relative of an EOLC patient on Bronte ward, who lived some distance from the hospital, spoke to the inspection team and told us that their relative was treated with dignity and respect. Staff sought consent prior to treatment and provided explanations. However, when their relative was on Will Adams ward staff were unable to give such good care as they were short of staff but trying to do their best. The relative praised a specific doctor on Will Adams ward who was "wonderful" contacting them with updates.
- We observed that staff were very knowledgeable about individual patients on Harvey ward. They knew details of individualised language and behaviours that were needed in order to provide the best care for their patients. We saw evidence that consideration was given to the best interests of a patient but also working with the relatives. A relative of an EOLC patient on Tennyson ward gave positive comments regarding the care their relative received. They told us that staff were caring, gentle, welcoming and accommodating to individual needs.
- We spoke with relatives of a patient on Milton ward who was in the dying phase. They told us that staff of all grades were “brilliant” and facilitated their presence with their relative 24 hours a day. They told us that their relative was in the safe hands of the ward staff.
- We observed that mortuary staff and porters demonstrated care of the deceased and protecting their dignity. We spoke with six staff on three different wards who all demonstrated their knowledge of care for the deceased patient and followed guidelines. All care was delivered in a dignified and respectful manner.
- Staff on Wakely ward were proud to show us an article that was printed in the local newspaper recently about the ward. A family was praising the “excellent” care their dying relative received.

Understanding and involvement of patients and those close to them

- The hospitals EOLC survey was implemented in March 2013 which correlated with the recommendations of the National Care of the Dying Audit 2014. It was based on the National Bereavement Survey and had been

through the appropriate governance processes. It provided feedback from the families and friends of those who were cared for at the hospital during the last hours and days of their lives.

- The survey was distributed by the Patient Affairs office along with the medical certificate of death and applied to all adult in hospital deaths. The EOLC CNS analysed the results which were sent to the specific ward areas to action. We were not provided with any evidence of any action taken.
- The completed survey for the period April and June 2015 asking how their loved one was cared for in the last days of their life showed that 66% reported excellent, 22% good, 9% fair and 3% a poor service. This showed some improvement to the same question for the period January to March 2015 which was 50% excellent, 37% good, 9% fair and 4% poor.
- Staff on Tennyson ward told us they received feedback from the 'Friends and Family Test' and EOLC survey. They keep comments in the 'better together' folder on the ward. This folder was seen and showed that out of 23 responses 9 were extremely likely and 13 were likely to recommend Tennyson ward to friends and family.

Emotional support

- The chaplain told us that when a patient was discharged and they required further spiritual input the chaplaincy team were able to assist if it was part of a religious issue. However, they were unable to provide counselling or bereavement support for a discharged patient.
- No support was offered to families after the death of their adult relative within the hospital. This service would be beneficial to relatives as confirmed with data received from the EOLC survey for the period April to June 2015. 3% stated that they had accessed a bereavement service and 23% would access support if provided by the hospital.

Are end of life care services responsive?

Requires improvement

The hospital palliative care team provided face to face care for patients at the end of their life and were supported by the local hospice. Out of hours the hospice could be contacted by frontline staff for telephone advice and support.

All wards had side rooms where they could accommodate the dying patient. This depended on whether it was appropriate and whether the room was available. We observed across the wards we visited that staff supported relatives to stay with their EOLC patients.

The hospital had a relative's room, viewing area of the mortuary and a chapel that accommodated all faiths as well as no faith. The chaplaincy service was available five days a week. An on call service was provided for out of hours.

Staff in the PALS office worked to address issues and concerns promptly. The EOLC bereavement survey was fed back to specific ward areas to action. We were not provided with any evidence of any action taken.

Service planning and delivery to meet the needs of local people

- The EOLC CNS and HPCT were described by all staff we spoke with as professional, responsive and supportive with specialised advice and knowledge. Where a patient was referred to the team they were prompt in responding, assessing the patient and planning care and other required referrals to, for example, therapists.
- The palliative care team and nursing staff acknowledged that they did not have sufficient staff to support all EOLC patients and prioritised those with the most complex care needs.
- All wards had side rooms where they could accommodate the dying patient. This depended on whether it was appropriate and whether the room was available. Staff told us that they kept patients on the main ward if they had no relatives or if the patient requested to remain on the ward.

End of life care

- Where the preferred place of death was known staff endeavoured to facilitate this. However, rapid discharge for patients who wished to die at home was sometimes delayed and therefore did not always happen. We were told that this was sometimes due to hospital processes and sometimes to external delays with funding and care packages for complex needs. We were not provided with any evidence to support this.
- The mortuary informed us that plans had been implemented to cope with the pressures of winter for this year. Extra space had been planned for and a 1 x WTE locum mortuary assistant had already been booked for the period.
- We observed across the wards we visited that staff supported relatives to stay with their EOLC patients.
- We visited the Cedar Room, a room specifically for EOLC relatives which was opened in 2012 and funded by the league of friends. The EOLC CNS was very proud of the room and took personal pride in ensuring that the room was kept clean and well stocked. The room had a visitor's book where families had made comments which included "Grateful and appreciative of cedar room and it has been a blessing to stay here."
- Additionally relatives of a patient on Milton ward told us that the Cedar room was "brilliant" and the use of the special concessionary parking permit was "brilliant and beneficial."
- The mortuary had a viewing suite where families could visit their relatives. They were escorted by a patient affairs officer who would stay with the relatives in the waiting area during the viewing.

Meeting people's individual needs

- During our unannounced inspection we noted a patient who was considered as needing EoLC (End of Life Care) transferred to McCullough ward. This patient passed away ten minutes after they arrived on the ward. We asked the staff on this ward why the patient had been moved when they were so clearly at the end of their life. Staff told us that they accepted the admission from the HDU (High Dependency Unit) because there was a pressure on beds. We went to HDU to ask how the decision to move this patient was made. Staff told us that they were being "pressured" to do the transfer because a level two patient in recovery needed to be admitted. We asked the staff if they felt that transferring a patient so clearly at the end of their life was the best option. We also asked if staff had taken into account this patient's privacy and dignity, care continuity and the emotional care needs of both the patient and their loved ones. Staff agreed that this was not the best of choices given the circumstances and understood the unpleasant implications and unnecessary upset for this patient and their family.
- We also visited the recovery (also a level two care area) to help understand how the decision to carry out that particular transfer was made. Records we viewed demonstrated good staffing levels in recovery on the evening on 8 September 2015 (six nurses on duty between the hours of 7pm - 8pm). In that time frame, the recovery area had a total of six patients which was a nurse patient ratio of 1:1. The patient log showed us that the patient who required level two care in HDU was admitted to recovery at 6:10pm, the ward was called to indicate they were ready for discharge at 7:20pm and the patient was actually discharged at 7:40pm. That meant the patient had a total stay of one hour and thirty minutes which was not an excessive length of time considering the time needed for recovery, and other patients length of stay in the recovery area that evening. Staff in all areas told us that the decision to move the EoLC patient was taken by the bed management/bed bureau team. Concerns were raised during both inspections that staff responsible for bed management and patient flow do not have clinical backgrounds. Therefore there may be a lack of insight necessary when making these decisions, which in this case, had a negative impact on the patient and their loved ones. We were disappointed that the nurses involved in the transfer did not feel confident on this occasion to advocate in the best interest of this patient.
- Many staff raised concerns about the lack of a bereavement service within the hospital. An information booklet was given signposting families to support organisations outside the hospital and what to do next. We asked a manager of the patient service centre about bereavement services offered and they replied that they "presumed this was covered by the palliative care team."
- The mortuary had a viewing suite, which was divided into a waiting and viewing room. The suite was clean and provided facilities for relatives such as comfortable

seating, tissues, and information booklets about bereavement. The suite was neutral with no religious symbols which allowed the suite to accommodate all religions.

- The chaplaincy service was available five days a week, including weekends, 9am to 5pm as well as providing an on call service for out of hours to patients, relatives and staff. Information regarding the chaplaincy services which included counselling, ward visits and performing funerals was given to relatives as part of the EOLC package devised by the HPCT.
- The chaplaincy service was notified directly from the bed bureaux when a patient had been recognised as EOLC and they were able to introduce themselves to patients and families. The Chaplaincy and Spiritual Care Annual report (2014/2015) informed us that there had been a 12% increase in visits to patients classified as being EOLC since the previous report.
- The chapel accommodated all faiths as well as no faith. The hospital had a separate prayer room for Muslims and the chaplain told us that the majority of Muslims preferred to use the chapel. Prayer mats were available but no washing facilities.
- Staff on Bronte ward told us that normally there were strict visiting times but there were open visiting times for patients who were EOLC.
- We observed a patient on Milton ward who was admitted with a rare deteriorating disease and was in the last days of life. The doctor on the ward obtained the necessary specific information regarding the disease to ensure that patient, family, staff, mortuary, coroner and pathology were up to date with the condition and specific process following death.

Access and flow

- All patients within the hospital requiring palliative care had access to the HPCT Monday to Friday 9am to 5pm. Outside these hours frontline clinical staff could contact the Wisdom Hospice for advice and support.
- During our inspection we were informed that the Wisdom Hospice had closed their inpatient bed unit, which held 15 beds, for refurbishment in July 2015. The hospital had access to four beds at St Bartholomew's Hospital for use until the in bed unit opened again. The hospice advice line was still active and accessible for staff and patients.
- We were told by staff on the wards that we visited that they knew how to access the HPCT if required and would actively involve them in EOLC patients.
- The HPCT aimed to assess new referrals within 48 hours. This was confirmed when we observed the EOLC CNS assess a new referral on Wakely ward. The CNS responded to the referral within a two hour window.
- The Patient Affairs Office was under the domain of the Patient Service Centre. The office was operated by three full time staff and was open Monday to Friday 9am to 5pm. The officers issued death, burial and cremation certificates and escorted relatives to the viewing area of the mortuary.
- All trained porters had access to the mortuary and out of hours they contacted the site manager.
- Staff on Sapphire ward told us they experienced difficulties discharging patients as there was a lack of nursing homes in the area appropriate for patients with dementia and long term conditions.

Learning from complaints and concerns

- Should a query or concern be raised the person would be directed to the PALS office who would liaise with the ward, nursing staff or consultant as appropriate. All efforts were made to resolve issues as quickly as possible for patients and their relatives.
- All contacts were logged on an electronic system including queries and advice, concerns and formal complaints.
- Data was not provided by the trust that gave a true picture of EOLC complaints.
- The EOLC survey provided feedback from families and friends of those who were cared for at the hospital during the last hours and days of their lives. The EOLC CNS analysed the results which were sent to the specific ward areas to action. We were not provided with any evidence of any action taken.

Are end of life care services well-led?

End of life care

Inadequate

The hospital had no overall leadership of the EOLC service. There was little evidence of divisional or consistent board input. The National Care of the Dying Audit 2014 recommends that the trust has a named board member with responsibility for care of the dying. The Chief Nurse confirmed there was an absence of a non-executive lead. The hospital were unable to make a clear distinction who the hospital medical lead for EOLC was. Additionally, it was unclear what the Chief Nurse was responsible for regarding EOLC. Further questioning of the Chief Nurse regarding EOLC at the hospital resulted in their admission that the service was not adequate. They were unable to provide any evidence of plans for the future or those said to be in progress or underway.

We found that at a local level the EOLC CNS and HPCT worked hard collectively to provide good end of life care. Their aim was to provide and maintain end of life educational sessions across the hospital and to introduce the EOLC competency framework.

We found that staff at ward level were very patient centred and wanted to deliver good care through training and support but they were unclear about their roles in delivering EOLC. There was no training delivered for EOLC and the Chief Nurse confirmed that the EOLC education budget was not used.

The EOLC service provided by the hospital had significant governance issues. There was no governance framework to support delivery of good quality care. The hospital could not provide data on the diagnoses of patients referred to the palliative care team. Therefore, there was no comprehensive assurance system or service performance measures in place.

The End of Life Care Strategy (DOH 2008) and NICE EOLC Quality Standard for Adults (QS13) both define EOLC as a patient with less than 12 months to live. The policy provided by the trust was aimed at a patient in the last days of life and there was not a strategy in place to accommodate the full remit of EOLC. The EOLC action plan was accepted by the Chief Nurse that it was "not fit for purpose" and did not link to the EOLC steering group agenda.

Without service improvements the EOLC provided by the hospital was unsustainable. This was due to the reduced specialist palliative resources, lack of EOLC education and leadership. Additionally, the absence of a robust policy and strategy did not provide a suitable framework and guidelines for staff to adhere to.

Vision and strategy for this service

- The EOLC CNC and HPCT had a clear vision to provide a strengthened service and enhance the overall support provided at ward level. Their aim was to provide and maintain end of life educational sessions across the hospital and to introduce the EOLC competency framework. Additionally to maintain collaborative partnerships with services in the community to ensure timely and streamlined care.
- We observed that the mortuary manager had a positive vision for the future. We were told that they had developed a business plan for a new mortuary and for replacing the present refrigerators.

Governance, risk management and quality measurement

- We found that the EOLC service provided by the hospital had significant governance issues. There was no governance framework to support delivery of good quality care. It was unclear what the Chief Nurse was responsible for regarding EOLC.
- HPCT does not produce an annual report. Moreover, a risk register was not supplied for EOLC. There was no risk register supplied for EOLC. The risks associated with the lack of clarity regarding EOLC strategy was raised at the clinical support services performance review meeting on 22nd July 2015 and added to the August 2015 corporate risk register.
- There was no comprehensive assurance system or service performance measures in place. Additionally staff on the wards were unclear about their roles in delivering EOLC.
- The hospital did not have an EOLC strategy in place. The EOLC action plan was accepted by the Chief Nurse that it was "not fit for purpose" and did not link to the EOLC steering group agenda.

End of life care

- We were told by the EOLC team that they could not access their risk register and were not involved in business planning.

Leadership of service

- We found good leadership of the palliative care team. This was evident speaking with the team who were all professional, focused and worked together for the good of the patients in their care.
- The National Care of the Dying Audit 2014 recommends that the trust has a named board member with responsibility for care of the dying. The Chief Nurse confirmed that they were the executive lead for EOLC and confirmed there was an absence of a non-executive lead.
- The hospital were unable to make a clear distinction who the hospital medical lead for EOLC was. In an interview with the Chief Nurse and their deputy they thought it was a consultant anaesthetist but during our visit we located the medical lead within the directorate of medicine.
- Further questioning of the Chief Nurse regarding EOLC at the hospital resulted in their admission that the service was not adequate. They were unable to provide any evidence of plans for the future or those said to be in progress or underway.

Culture within the service

- All the staff we spoke with spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility. It was very evident that the EOLC CNS and HPCT had a patient centred approach to care.
- We found that the staff were very patient centred and wanted to deliver good care through training and support. At present no training was being delivered and staff's skills were not being developed. The Chief Nurse confirmed that the EOLC education budget was not used.
- Across the wards we visited we saw that the EOLC CNS and HPCT worked well together with nursing and medical staff and there was obvious respect between not only the specialities but across disciplines.

Public engagement

- The EOLC survey was distributed by the Patient Affairs office along with the medical certificate of death and applied to all adult in hospital deaths.

Innovation, improvement and sustainability

- Without service improvements the EOLC provided by the hospital was unsustainable. This was due to the reduced specialist palliative resources, lack of EOLC education and leadership. Additionally, the absence of a robust policy and strategy did not provide a suitable framework and guidelines for staff to adhere to.

Outpatients and diagnostic imaging

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

Information about the service

Medway Maritime Hospital offered outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up were required. The hospital offered 36 different speciality clinics including medical and surgical specialities, women's health, pain management, orthodontics and allergy.

The diagnostic and imaging department carried out routine x-rays as well as more complex tests such as Magnetic-Resonance Imaging (MRI) and Computerised Tomography (CT) scans.

In the last calendar year the trust offered 350,608 outpatient appointments. Of these appointments 23% were first appointments, 45% were follow up appointments, 14% were cancelled by the hospital,13% were appointments cancelled by the patient , 5% were patients that did not attend their appointment (DNA). In the three month period prior to the inspection, on average, 9% of patients did not attend their appointments, this is greater than the national average. Seven out of the 36 specialities had a lower than national average DNA rate. The greatest average DNA rate was in the paediatric diabetes clinic at 19.5%.

In the same time period the diagnostic imaging department had 241,402 patients attend appointments.

During our inspection we visited outpatient areas one to seven, the neurosciences unit, the Macmillan cancer care unit, phlebotomy, pathology, orthotics and diagnostic imaging departments. We spoke with 157 members of staff, including managers, consultants, nursing staff, administrative staff and allied health professionals. We spoke with 13 patients and their relatives.

Outpatients and diagnostic imaging

Summary of findings

Overall we found outpatient and diagnostic services at Medway Maritime Hospital to be inadequate.

We were concerned how the trust managed and responded to incidents. Some staff reported incidents but not all staff had access to the system for reporting incidents. There was no evidence to suggest that lessons had been learned following a never event.

The trust was consistently not meeting their two week targets for patients suspected with cancer and in addition to this there was an inequality in waiting times between patient groups. There were delays in patients getting scans and the results of these scans. This impacted on them getting treatment in a timely manner. The latest referral to treatment times data revealed that the Trust was below the NHS England target. The patient service centre was not always able to give patients appointments within the target times set by NHS England and the clinical commissioning groups.

The Computerised Tomography (CT) scanner had been identified as a risk with potential for mis-diagnosis and the quality of the outsourced radiology reporting could not be assured. The radiology department were sending increasing numbers of scans to be reported by external companies.

The diagnostic imaging services had inconsistent data for waiting and reporting times. This made it difficult for the trust to plan services for the future and there was no future planning in place. Some data indicated patients were waiting up to 84 days before a diagnosis was made. This meant they did not start treatment within the 31 or 62 day timescale. Increasing numbers of investigations were being sent to external agencies for reporting, but the trust had no robust assurances of its own that the quality of reporting.

There was no plan in place for developing future services in radiology. Staff acknowledged that the trust was making changes and that the senior management team were more visible. However, many staff told us that there was a barrier between senior management and a divide between their teams and the management team. Some staff reported a bullying culture. At the time of our inspection we were unable to see any clear strategies to develop robust systems and processes to be able to monitor and maintain these targets.

Infection control audits were consistently below the trust target in many areas of outpatients and diagnostic services and there were no action plans to address these shortfalls.

We found there were good systems for the storage of medicines and the management of confidential records.

The outpatients nursing team worked to maintain a good patient experience within their department and patients we spoke with told us they were treated with dignity and respect. Staff training records were up to date.

The orthotics department was providing an effective and efficient service to patients. We found that treatment generally followed current guidance.

We found that there were arrangements to ensure that staff were competent to look after patients.

Patients generally had access to clinics out of normal working hours and were cared for by a multidisciplinary team working in a co-ordinated way.

Staff had received appropriate training in their obligations under the Mental Capacity Act.

Staff acknowledged that the trust was making changes and that the senior management team were more visible. However many staff told us that there was a barrier between senior management and a divide between their teams and the management team.

Patients and their relatives were positive about their experience of care. Patients were treated with privacy and dignity and were given the right amount of information to support their decision making and patients could get the emotional support they needed.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Inadequate

We rated safety in outpatient and diagnostic imaging services as inadequate because;

The two week wait pathway targets were not being met by outpatients or radiology and key posts in cancer services were vacant. Referral to treatment times were below the England standard which meant patients were not receiving treatment at the right time.

Delays in receiving diagnostic tests and their results meant 31 and 62 day targets for cancer treatment could not be met. The Computerised Tomography (CT) scanner had been identified as a potential for mis-diagnosis and managers had no certainty about the quality of the outsourced radiology reporting.

A never event investigation had identified deficiencies in the completion of the World Health Organisation (WHO) pre-operative checklist. This had been assessed by the patient safety group at the trust and found to still be lacking in the interventional radiology department. This meant that assurances could not be given that lessons had been learned from this incident.

Incidents

- Staff in the outpatient and diagnostic imaging departments used an electronic commercial software system (DATIX) that enabled incident reports to be submitted. Training in the use of this system was not mandatory across the trust. We found that 74% of the nursing staff had received training for using this system. Staff told us that agency staff were unable to access this system. There was no clear process about how agency staff reported incidents. Which meant that the trust could not be assured that all incidents in the department were being reported.
- We saw staff were reporting a variety of incidents using the system and that a monthly report was produced summarising these incidents. In addition to this staff told us they had feedback from about incidents at staff meetings. We saw this demonstrated when we reviewed minutes of nursing and radiology meetings.
- During the last year one never event and two serious incidents were reported across OPD and Radiology. These incidents had been investigated and root cause analysis undertaken.
- The never event investigation identified that the surgical checklist had not been completed prior to an interventional radiology procedure. We requested copies of World Health Organisation (WHO) checklist audits in interventional radiology prior to inspection and received one report carried out by the patient safety group which indicated that there were no audits of the WHO checklist in interventional radiology. 100% compliance was required to assure patient safety. From this study, interventional radiology, where the never event occurred, scored 93%. The report concluded that assurances were not received that interventional radiology would continue to be compliant in completion of the checklist and patient safety could not be assured. An action plan following the never event identified that the WHO checklist should be audited regularly. The department were unable to provide audits from interventional radiology which meant that assurance was not given that WHO checklists were being used correctly and routinely in the department.
- Incidents reported in radiology were discussed in the imaging and nuclear medicine governance group, we saw minutes of the meetings. In addition to this senior staff told us that incident trends and investigations were discussed in patient safety meetings.
- Staff told us that the radiation protection advisor was easily contactable should advice be required for reportable incidents required under The Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 2000. Some IR(ME)R incidents required notification to the Care Quality Commission (CQC) under regulation 4 (5). However, we noted that one reportable incident occurred two months before a notification to CQC was made. On this occasion the incident was not reported to CQC in a timely way.

Cleanliness, infection control and hygiene

- Overall we found that the Department of Health's 'Code of Practice on the prevention and control of infections and related guidance' was complied with in outpatient and diagnostic imaging services. There were systems in place to reduce the risk and spread of infection. A virtual

nurse greeted people entering the hospital at the main entrance, informing them of the importance of good hand hygiene. Hand sanitizer gel dispensers were available.

- We found that the environment was clean, hygienic and well maintained. Patients that we spoke with told us they felt safe with those treating them and the departments they visited were clean. This was supported by a survey conducted in March 2015 that showed 100% of 825 patients surveyed found the waiting area clean and tidy in the imaging department's waiting area. During our visit we saw evidence of regular cleaning checks being undertaken of the clinical equipment and areas that were the responsibility of nursing staff to clean. There was documentation indicating that cleaning checks had been completed in clinic rooms that we visited.
- When we checked clean and dirty utility rooms, we found them to be cleaned to a good standard, with cleaning records that evidenced regular cleaning had been undertaken.
- Infection and prevention control training formed part of the trust mandatory training programme that was updated yearly. Mandatory training records held in the department showed that 95% of nursing staff had attended infection control training.
- Hand hygiene audits for outpatients and diagnostic imaging consistently reported 100% compliance over a 12 month period, but on eight occasions a result of no return was recorded when a department failed to get their result in on time. Clinical support services reported 100% compliance for 11 months of a 12 month period and in May 2015, reported only 83% compliance in the audit.
- Staff were bare below the elbows and staff were observed washing their hands in line with the World Health Organisations guidance 'Five moments of Hand Hygiene' before and after interacting with patients. Hand gel was available in all areas that we visited.
- Sharps audits were part of the infection control audit completed annually. The last audit, in September 2014 reported 100% compliance with sharps management in imaging, ultrasound and MRI units. It reported over 97% compliance in nuclear medicine, osteoporosis department, interventional radiology, CT and outpatient area seven. 90% compliance was reported in outpatient areas one to four and five, with 91% compliance in the breast unit.
- An infection control audit was completed annually in all outpatient and diagnostic imaging areas. The audit included environment, linen management, sharps and waste management, care of equipment, hand hygiene, personal protective equipment (PPE) and documentation. The last audit was in November 2014 and only three of the eight imaging modalities achieved the trust target of 95%. Outpatient areas one to four, five and seven did not achieve the trust target. We did not see any action plans to address these shortfalls.

Environment and equipment

- We saw that service records for equipment in diagnostic imaging were in date and complete. One of the CT scanners had been on the risk register since January 2010. This was due to its poor image quality which could have resulted in misdiagnosis. We were unable to find any incidents directly related to this problem at the time of inspection. The Royal College of Radiologists states that all CT scanners greater than seven years of age should appear on the departments risk register and staff told us that the second CT scanner was eight years old and would be entered onto the risk register. The management team told us that they were waiting on the estates department to make alterations in order for a new scanner to be installed which they hoped to be in March 2016.
- Resuscitation equipment was available and easily accessible. We saw that regular checking of resuscitation trolleys was taking place, with supporting documentation to confirm that daily checks were being undertaken and recorded. However, in area five a resuscitation trolley was stored within a patient treatment area. This meant that if a patient was having a procedure it could have prevent staff gaining quick access to the trolley. We asked to see a copy of the last annual resuscitation trolley check audit. We were provided with one audit dated August 2013 but saw that it was only applicable to one trolley. This meant that only one trolley out of five had been audited in a two year period. This did not provide assurance all trolleys were being audited annually.

Outpatients and diagnostic imaging

- Waiting areas were spacious and in good decorative order. Bariatric chairs were available and had been specifically made of the same materials as all other waiting area chairs maintaining patient dignity as they did not stand out as being different.
- There was no carpeting in the outpatient treatment areas that we visited in compliance with HBN 00-093.82 which states carpets should not be used as this area has a high probability of body fluid contamination.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Lead aprons were available to protect staff operatives and we saw from records that these were checked regularly by the radiation protection supervisor. Lead doors were in place, but on the risk register, as they were supported on wooden door frames, which was resulting in cracking of the door frame. The risk register stated that the cracking around the frames also caused concern as eventually this would breach radiation protection regulations. At the time of our inspection we found that the replacement of these doorframes was not included on the estates programme of works.
- Disability access audits had been completed for all outpatient and diagnostic imaging areas with no issues identified. However, in phlebotomy issues had been identified with the external door which was opened manually, and opened outwards onto a downward slope. This made it potentially dangerous for unaccompanied wheelchair users. We saw that there was a plan in place to replace the existing door with an electronically operated sliding one.
- We saw examples of recent workspace inspection audits and environmental audits conducted by the senior nursing team. This included actions arising and used the 15 steps challenge to assess the outpatient areas.
- Prior to our inspection we requested patient led assessments of the care environment (PLACE) audits for outpatients and diagnostic imaging departments. Despite being advised that we would receive them during inspection we have not received them.

Medicines

- We saw that medicines were stored safely and securely in locked cupboards in all the outpatients and diagnostic areas we visited. Prescription pad checks were in place and being recorded. We requested prescription pad audits and received a copy of a daily checklist for prescription pads in areas one to four only. This contained no information to enable identification of the serial numbers of the prescription sheet used, the patient prescribed to or the Doctor prescribing. Therefore the department did not have systems in place to ensure the safe use of prescription pads.
- We saw that when applicable medicines in outpatient departments were stored in dedicated medicines refrigerators. The temperature of these refrigerators were checked and recorded daily to ensure that the temperature remained within range. This meant that there was assurance that medicines had been stored consistently at the correct temperature.
- The Medicines Health and Regulatory Agency (MHRA) monitored medicines within the nuclear medicine department and we saw copies of the most recent inspection in August 2013. Inspections are required every two years. This provided independent assurance of systems and processes for the storage and management of these medicines.
- Pharmacy monitored the outpatient prescription turnaround time on a monthly basis. The key performance indicator was to turnaround 70% of prescriptions within 30 minutes in line with the national patient safety agency (NPSA) targets. In a 12 month period this target was achieved twice. Daily monitoring of the turnaround times in Pharmacy was implemented and improvement demonstrated as the turnaround time increased to 80%.

Records

- Records were stored in a secure area, that could only be accessed by authorised staff.
- In the last calendar year on average 29,480 medical records were obtained each month for outpatients. Data was not available for a five month period during that time. We saw that for seven of those twelve months, 11 patients were not seen due to notes being unavailable.
- In the last 12 months 67 incidents were related to medical records. The most frequent incident was of the wrong patient's records being found in another patient's notes. The patient service manager told us that when investigating these incidents, it was not always possible

to trace back to where the error had occurred. A campaign had recently been launched involving posters and screen savers to alert staff to increase the awareness of misfiling documents in notes. Continued monitoring of incidents relating to medical records would identify how successful this campaign had been.

- In the outpatients department the matron told us that they had a porter dedicated to bringing notes to and from the department, ensuring that all records are taken back at the end of the working day. The records were then stored in the patient service centre prior to be returned to an offsite storage site.
- A patient archiving computer system (PACS) was used for the storage of diagnostic imaging tests. However, staff told us that they experienced issues relating to the compatibility of that system with the radiology reporting system. This often resulted in the final report of an examination not being available on PACS. We saw that an incident had been raised as a result of this on one occasion in four months.
- As a result of increased capacity issues, diagnostic tests were consistently being outsourced to external companies. In the last four months, 2,165 reports had been completed by external companies. The PACS system was not accessible to these companies, so there was potential for issues to arise as the external reporter could not see a patient's previous scans. This could lead to a delay in diagnosis or misdiagnosis if a previous examination could not be compared to. In addition to this, staff told us that if an external report had an abnormal finding an email was then sent to radiologists located in the diagnostic imaging department at Medway Maritime Hospital. Staff told us that a radiographer then had to look through these reports on a daily basis to get the results and pull out the newly diagnosed cancers. Staff told us this procedure was taking six hours a day and there was a potential for cancers to be missed.
- Other records we requested such as equipment checks and safety information that were relevant to the running of the service could mostly be produced without delay either in paper or electronic formats.

Safeguarding

- We saw records to confirm that 100% of nursing staff had received vulnerable adult safeguarding training. In addition to this 100% of nursing staff had participated in training for safeguarding children, Level two and nine nursing staff had achieved safeguarding children level three training.
- When we spoke to staff they were able to explain what steps they would take if they identified a safeguarding concern. However, no vulnerable adult or safeguarding children referrals had been made by outpatients in the last 12 months, which could suggest no one knew how to raise one.
- We saw the trust had a current whistleblowing policy which included recommendations that came from an investigation as a result of whistleblowing concerns. This indicated that staff felt able to raise concerns and recommendations were made as a result of those concerns. However some staff told us they felt unable to speak up and stated "if you talk, you walk."

Mandatory training

- Staff were aware of the mandatory training they were required to undertake and the outpatient nursing team kept their own records for mandatory training .We saw copies of training records that indicated the majority of the nursing team were up to date with mandatory training.
- We saw records that showed 93% of nursing staff had received fire safety training, 90% had undertaken health and safety training, 100% equality and diversity and 94% infection control.
- 92% of nursing staff had current basic life support (BLS) training, in addition 90% of nursing staff had paediatric basic life support training. However, some staff told us that their BLS training did not include training in the use of an automatic electronic defibrillator.
- 100% of nursing staff had received moving and handling training.

Assessing and responding to patient risk

- A patient with suspected cancer requires an appointment within two weeks of the date of the referral. During our inspection we looked at the procedure for managing patients on the two week wait for suspected cancers. The standard operating procedure stated that, "Where there is insufficient capacity to book patients emails to be sent to Service

Managers, but should there still not be any available capacity after 48 hours, an escalation email to be sent to the Service Manager PSC, and Team Leader." During the two days of our inspection, we saw 19 patients breach the two week wait in lower gastrointestinal pathway and another 17 in the same pathway who could not be offered an appointment within the two week timescale. Daily escalation emails had not been responded to by the service manager during those two days. In addition to this, other referrals received on the two week pathway during those two days were able to be put in clinics available within a two week period, which indicated that there was an inequality between patients depending on which specialty pathway they were on. As patients were being booked in the first instance on the 14th day, there was no flexibility in the system if a clinic cancellation occurred. This had happened the preceding week and patients were still waiting re-appointment.

- These referrals were received into the patients service centre via a dedicated fax machine. Staff told us that some patients received an appointment within two weeks, but others did not. This was dependent on which speciality they were under. During the two days there was no clinical oversight of these patients. We also noted that two patients in the breast speciality breached and there was no clinical oversight of them undertaken during those two days.
- As there was no clinical oversight of patients referred via the two week pathway there was no ability to ensure that the general principles for booking was in accordance with the trust's Access Policy (6.7.1). This stated "All patients must be seen in order of clinical priority and length of wait". In addition to this, patients on the two week wait pathways were waiting varying amounts of time dependent on the specialty they were assigned to and not using a fair and equitable process. In quarter one, only 28% of patients with lower gastrointestinal symptoms referred on the 2 week pathway had their first appointment in two weeks as compared to haematology and testicular specialties who achieved 100%.
- At the time of inspection a patient's referral would remain in the patient service centre until they had been appointed. This meant patients were not appearing on a tracking system until they had their first appointment, which made it difficult to track them and escalate longer waiting times. It also impacted on data quality. The resulting impact on the care of these patients and their future treatment options was beyond the scope of this inspection, but regard was given to it by the inspection team.
- In the radiology department at the time of inspection a patient could expect to on average four weeks for a urgent CT scan and five weeks for an urgent MRI scan. Some patients waited just over eight weeks for an urgent CT scan. In addition to this at the time of inspection on average urgent diagnostic tests took four weeks to be reported on. This meant in some cases urgent patients waited 12 weeks (84 days) before a diagnosis was made. This meant they would not be receiving treatment within 31 or 62 days in line with national standards.
- In diagnostic imaging, the imaging manager told us it could take up to three weeks for a referral to be vetted before the patient could be offered an appointment. This caused further delay in gaining access to any diagnostic tests.
- The leadership team told us that the quality of reporting scans by external agencies was not checked by the trust. The Trust were reliant on external sources to oversee the quality of reporting and therefore, didn't have any robust assurance measures of their own in place. In addition to this, third party reporters did not have access to patients' previous scans to view, so were unable to make comparisons. This meant that there was a potential risk to the patient of non-escalation of findings.
- The trust suspended referral to treatment time (RTT) reporting in December 2014, because of concerns with the quality of data being recorded at that time. It was restarted in June 2015 after the data quality issues had been resolved. The incomplete RTT standard is that at the end of each month 92% of all patients waiting to start treatment should have been waiting for less than 18 weeks.
- The trust failed to meet the incomplete standard in June 2015, with 77.2% of patients waiting within 18 weeks.

The standard was not met by any of the 14 specialties at the trust. For comparison, 93.2% of NHS England patients were waiting within 18 weeks. NHS England overall achieved the standard.

- The total number of patients waiting for treatment (i.e. admitted and non-admitted) was greatest for dermatology, with 6,556 patients waiting at the end of June 2015.
- Within nuclear medicine we saw that patient identification checks were occurring. A patient satisfaction survey completed in May 2015 recorded that 99% of patients reported that they had their identification checked at reception and 98.8% were checked prior to the examination.
- Phlebotomists used personal data assistants (PDA's) on the wards which gave assurance that the right patient was being treated.

Medical staffing

- Medical cover for clinics was arranged within the divisions. Doctors that we spoke with felt that there was good team working within their clinics.
- Low radiologist staffing levels was on the imaging and nuclear medicine risk register as it impacted on patients flow, cancer wait targets and patient outcomes.

Radiology staffing

- On average over the last three months CT and osteoporosis departments were fully staffed. Ultrasound and interventional radiology departments were less than one staff member short per day on average. However, in the general imaging and the breast clinic, on average they were three members of staff short every day. This could have had a significant impact on two week care pathways.

Nurse staffing

- The outpatients department was staffed by a matron, two Band seven senior sisters, six Band six clinical sisters. These staff supported Band five, three and two nurses.
- Matron informed us that the Band six nurses had areas of special interest and would regularly cover certain clinics. The Band five, three and two nurses had generic competencies which enabled flexibility in covering clinics as required.
- At the time of our inspection there was one Band six vacancy and three band five vacancies.

Major incident awareness and training

- The trust had a major incident plan and business continuity policy and we saw a copy of this that identified the role of the outpatient department with a supporting action card.
- In the event of a major incident the role of outpatient area five was to provide support to relatives/friends of major incident victims and the victims themselves as required on discharge from the emergency department.
- Staff we spoke to were aware of their role in the event of a major incident. They told us the lead nurse during an incident would refer to an action card for instruction as to their role in a major incident.

Are outpatient and diagnostic imaging services effective?

In radiology there was evidence of regular auditing occurring as a requirement for participation in the imaging services accreditation scheme. However, there was evidence that NICE guideline NG12 was not being adhered to with regards to the two week cancer pathway. We saw good multidisciplinary team working in one stop clinics and clinics were open over the evening and weekends.

Evidence-based care and treatment

- Diagnostic imaging services participated in the Imaging Services Accreditation Scheme (ISAS). ISAS is a patient-focused assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. A requirement of the programme was to audit services regularly. We saw that a variety of audits were on-going in the imaging departments which could evidence that best practice was being achieved.

Outpatients and diagnostic imaging

- We saw a copy of the last Medicine and Healthcare products Regulatory Agency (MHRA) inspection report of the nuclear medicine department, which stated that operations were compliant with the principles and guidelines of good manufacturing practices as laid down in Directive 2001/83/EC. This gave independent assurance that quality was being maintained in this area. In addition, blood bank operations were compliant with the Blood Safety and Quality Regulations 2005/50.
- In microbiology, biochemistry, haematology and blood transfusion departments we saw that clinical pathology accreditation (CPA) was maintained. This provided independent assurance that accredited services were meeting standards.
- In outpatients, NICE guidelines NG12, 'Suspected cancer, recognition and referral', were not being met in some specialities with regards to the two week wait.

Competent staff

- The matron told us that Nursing and Midwifery Council (NMC) registration was automatically checked for nursing staff via the e-rostering system.
- Cannulation competency records for Radiology staff were seen and in date.
- There was a system of annual appraisal in operation and data confirmed that 100% of nursing staff were up to date with their appraisal.

Multidisciplinary working

- There were breast, urology and vascular one stop clinics held at the hospital. These clinics involved medical, nursing and radiology staff working together.
- We saw that a gastroenterology clinic was held the day after the multidisciplinary team meeting, making the most effective use of information shared at the meeting.
- Several staff in outpatients and radiology departments told us they felt there was good team working within their departments.

Seven-day services

- Outpatient departments were open from 8:30am to 5pm two days a week. Clinics operated from 8:30am to 8:30pm three days a week and on a Saturday morning from 9am to1pm. In the past calendar year, outpatients ran 654 evening clinics and 197 clinics at the weekends. This meant that that patients were able to access clinics outside of normal working hours.
- The general x-ray department was open 24 hours a day, seven days a week. A walk in service was offered to GP patients from 8:30pm to 5pm.

Access to information

- In the transfusion department an electronic blood ordering system (EBOS) had been developed as part of the trust's 'Listening into Action' scheme. The EBOS had reduced errors in ordering and improved communication between clinicians and laboratory on the progress of each request. Currently the system was only in use for clinical haematology but the trust was looking to roll the system out trustwide, which would improve compliance with the new international organisation for standardisation (ISO) standards for laboratories.
- The trust used an electronic system to track patients. Staff told us that the systems were not user friendly and there had been delays to putting some patients on to the system.
- An electronic system was used for patient appointment bookings and staff told us that there was no automatic alert to indicate the length of a patient's wait time for treatment. Staff told us that they entered this information manually, which was time consuming.
- Radiology reporting was being outsourced to external companies. These companies did not have access to the PACS system at Medway hospital and were therefore unable to refer to a patient's previous scans.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 100% of outpatient nursing staff had received training on the Mental Capacity Act 2005.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services caring?

Good

We spoke with 13 patients during our inspection. They told us staff treated them with dignity, care and respect at all times.

We saw staff interacting with patients in caring and respectful manner. We witnessed staff informing patients of any clinic delays and giving the reasons for those delays.

Compassionate care

- In Medway the 'Friends and Family Test' results for April, May and June 2015 (Q1) showed that on average 86% would recommend outpatients versus 6% that would not. The national average for April, May and June 2015 was that 92% of patients would recommend outpatients versus 3% who would not recommend it. In addition to this the nursing team collated local friends and family data and in July 2015 a survey of 394 patients resulted in 94% recommending outpatients compared to 2% that would not recommend outpatients.
- Patients and their relatives that we spoke to told us that they had been treated with dignity, respect and care.
- There was an outpatient reception desk in the main entrance hall to the hospital, where there was a queuing system. The queue was a short distance from the reception desk, which protected patient confidentiality by preventing other patients from overhearing those that were booking in. In addition to this, there was a concierge who assisted patients where possible and spoke with patients if the queue for the reception desk appeared to be growing in length.
- The outpatient nursing team told us how they regularly responded to feedback given by patients. An example of this was how they had introduced baskets of toys for the children of waiting patients, following feedback received from patients. They also offered a colouring competition with prizes given, which was held regularly. In addition to this they had arranged for volunteers to take a tea and coffee trolley to waiting patients in all outpatient areas. The volunteers told us that they wanted to give something back to the departments that had looked after them so well. Voluntary donations for the refreshments were used to fund other projects in the outpatient department to improve the patient experience.
- We saw staff in outpatients and diagnostic imaging interacting with patients in a caring and respectful manner. We witnessed staff informing patients of any clinic delays and giving the reasons for those delays.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they had received enough information prior to their appointment and that the team treating them had given a good explanation of the investigations they were going to have and why.
- We saw there were a variety of health-education literature and leaflets produced by national bodies. Some of this information was general in nature whilst some was specific to common ailments. This literature was available in all waiting areas of the outpatients departments.

Emotional support

- Within the outpatient areas one to four, there was a 'quiet room' that staff, patients and their relatives could access if bad news had been broken. In the breast clinic there was a carer support group available to those that required it.

Are outpatient and diagnostic imaging services responsive?

Inadequate

The trust was significantly below the NHS England standard for referral to treatment times (RTT) for all specialities. There were breaches of the two week wait pathway for patients with suspected cancer.

On the whole, the outpatients and diagnostic imaging service lacked the ability to respond to the demands on their service. There was a considerable amount of fire fighting.

Outpatients and diagnostic imaging

Some areas of outpatients were able to offer an extremely responsive and flexible service to patients. In particular, the haematuria clinic, patients with testicular cancer and the orthotics department all saw and treated their patients in a timely manner.

Service planning and delivery to meet the needs of local people

- Once a week the outpatient management team met to discuss capacity issues and data was provided up to four weeks ahead on the clinic rooms which would be available.
- Evening and weekend clinics gave more options to patients to attend appointments at more convenient times. In addition to this the walk in service for general x-ray enabled patients to attend at a time more suitable for them.
- A text reminder service had been introduced and managers told us that since its introduction there had been a reduction in patients that did not attend (DNA's). In the three months prior to inspection the DNA rate was 9% across all specialties, which is greater than the DNA rate in NHS England. 23 out of 36 specialities had a DNA rate greater than NHS England average. The largest DNA rate was in paediatric diabetic medicine at 19.5%.
- We saw that in rheumatology there was a review list of more than 1600 cases which had not been reviewed by a clinician. Staff told us that they were not sure if within those cases, there were new patients awaiting appointment, patients awaiting a follow up appointment or discharge.
- There was no protocol or policy for turnaround time for clinic letters to GPs and no auditing for the time it took for these letters to be sent. This indicated that there was no overview or monitoring of this. We saw that clinic letters took up to and over one month in some specialities, causing a delay in the on-going care of patients. Staff told us they felt that the delay in getting letters out was the result of the review of administrative staff and the withdrawal of administrative support.

Access and flow

- Patients with haematuria had access to a one stop clinic and could be seen within two weeks. There was no waiting time for patients with suspected testicular cancer.
- Routine outpatients' first appointments could be accessed in two ways. The 'Choose and Book' system which enabled a patient referred by their GP to book an appointment themselves with a choice of place, date and time electronically. A direct referral to a service was registered by the patient service centre and taken the same day to the speciality or division for clinical coding. The referral was then returned to the patient service centre where an appointment was offered to the patient. There was inequality in the way these referrals were being processed, one system taking longer than the other.
- In the three months prior to our inspection over 17,400 patient appointments were cancelled by the hospital. In this period 381 different specialty clinics were cancelled with less than six months notice. The most common reason for cancellation of a clinic with less than six weeks notice was staff annual leave. This was contrary to the procedure for cancellation of clinics which states that at least six weeks notice should be given for cancellation of clinics.
- In the orthotics department, 90% of patients were seen on the same day or next day. At the time of our inspection the longest wait for an appointment was 10 working days.
- A reporting radiographer provided 'hot reporting' for the A & E department, which gave the referrer an immediate result of the investigation and led to a patient receiving an appropriate treatment in a timely manner.
- The average clinic over-run time for the three months prior to our inspection was one hour and the most common reason for this was complex patients.
- We saw that in a 12 month period, the total number of calls received from the call centre increased from 12,706 to 16,626. In addition to this the percentage of abandoned calls increased form 24% to 49%. No explanation was given for this.
- In 2014/15 27% of all PALS enquiries were about outpatients. 317 of those 559 queries made were in relation to patients trying to make an appointment or an appointment not being made. This indicated that patients were having difficulty accessing appointments, but no explanation was given as to the reason for this.

Outpatients and diagnostic imaging

- In the radiology department at the time of inspection a patient could expect to on average four weeks for an urgent CT scan and five weeks for an urgent MRI scan. Some patients waited just over eight weeks for an urgent CT scan.
- Prior to inspection we requested the average reporting times per diagnostic test for radiology. We received two sets of data. One indicated that patients on the two week pathway and urgent patients waiting for a diagnostic test had a two week wait for CT and MRI. Routine patients waited four weeks. The second set of data was titled average wait yet indicated the maximum wait for a report, which was four weeks for the two week pathway and urgent patients in CT and MRI. On inspection the imaging manager showed us a spread sheet of data where the longest wait for a report for a urgent CT scan was eight weeks and MRI wait was six weeks. Patients on the two week pathway waited four weeks for a scan to be reported on. The imaging manager told us there was no clinical oversight of the reporting waiting list. The inconsistent data, indicated that the imaging management team did not know what the exact length of wait time for each diagnostic test was.
- The data indicated in some cases urgent patients waited 12 weeks (84 days) before a diagnosis was made. This meant 31 and 62 day targets could not be met.
- In addition to this the imaging manager told us that prior to a patient having a diagnostic test, the referral went through a review process. At the time of inspection, the time it took to review MRI referrals was one week. CT took three weeks to review and ultrasound referrals took up to four weeks to review. It was not clear if this was included in or in addition to the waiting times reported.

Meeting people's individual needs

- A member of the outpatient nursing team had developed a pictorial system for identifying patients with a learning disability (smiley face) or patients living with dementia (butterfly) to the clinician in clinic. This was indicated by placing a discreet sticker on the patients' notes. These patients were 'fast tracked' to prevent a long wait. In addition to this, a resource box was available with information to assist the clinician, patient and their carer further.
- The matron told us the outpatient nursing team clinically prepared notes 48 hours before patient appointments. This enabled the nurse in clinic to identify which patients needed an examination on arrival, so they were fully prepared prior to their clinic appointment.
- We saw nursing staff give a snack box to a patient who arrived on transport and was due to have a long wait for clinic.
- There was a water fountain in phlebotomy for patients to access while they were waiting. A café was situated near the main outpatient reception for patients to access refreshments. In addition to this we saw a volunteer visiting outpatient areas with a tea and coffee trolley for waiting patients.
- We saw a sign language information poster in the outpatients department and staff told us they were able to access interpreters if required, via a central booking system.
- In all outpatient areas, there were signs informing patients of waiting times and at the time of inspection, we were told this was going to include the reason for delays in the near future. We saw nursing staff informing patients regularly of length of delays and the reason why.
- Nursing staff provided children that attended the outpatients department either as a patient or with a relative with colouring books and toys. In addition to this they held a colouring competition regularly.
- The minutes from the most recent patient experience group indicated that 64.5% of patients were seen within 15 minutes. The trust target was that 80% would be seen within this period, but there was no strategy for how tot achieve this. This meant that the trust were not meeting their target on patient waiting times.

Learning from complaints and concerns

- Between April 2014 and May 2015, 27.5% of all enquiries PALS dealt with were in relation to outpatients.
- In phlebotomy, they identified that there was a period of poor sampling in A & E, this led them to provide teaching to those that required it. Staff told us providing teaching reduced the occurrence of this.

Outpatients and diagnostic imaging

- Outpatient nursing staff were using a 'Friends and Family Test' to measure patient experience. This was fed back at every patient experience group meeting. In addition to this a PALS report was also discussed. We saw copies of the minutes of these meetings.
- Complaints were discussed at nursing and pathology, staff meetings and we saw minutes of these meetings.
- In outpatient waiting areas, information leaflets about how to make a complaint were available.

Are outpatient and diagnostic imaging services well-led?

Inadequate

Patients were not receiving appointments in accordance with the two week wait and the trust were significantly below the national standard for referral to treatment times. At the time of our inspection we could not see robust systems in place to monitor this or to deal with breaches as they arose.

In addition to this, diagnostic imaging services could not provide clear data on waiting times and had no clear strategy to deal with the increasing requests for diagnostics tests and reports.

There was inconsistency in cultures within outpatients and imaging departments. Some staff told us they felt engaged with their teams, whilst others told us "if you talk, you walk."

Vision and strategy for this service

- Some staff were aware of the 18 month improvement plan, but many others told us that there had been such a constant amount of change that there was no stability within the trust. Several staff told us that they met improvement plans with scepticism.
- Several staff told us they felt there was more stability in the organisation since the appointment of the new chief executive and that they were visible. They told us about drop in sessions where they had a chance to meet and talk to the new chief executive.
- The trust had a vision of 'Better Care Together'. The outpatient nursing team showed us a folder which demonstrated how they were contributing toward this vision, which was accessible by all staff members. Information about this vision was available to staff via the trust intranet. Several staff told us how they contributed to 'Better Care Together'.

Governance, risk management and quality measurement

- At the time of inspection there was no clear strategy on the future planning for the radiology services. Diagnostic tests were being sent to an external company for reporting, but this only occurred when a backlog had developed. Projected numbers were not being looked at to prevent the backlog from occurring. This indicated that the service was reactive rather than being a proactive service.
- There were no assurances around the quality of reporting radiological investigations from external companies. The management team told us that another company was dealing with it. This showed that the monitoring of that contract was not robust and that management had stepped back from their responsibility for the oversight of this service.
- There was inconsistent management of the two week pathways between specialities which led to some patients waiting longer than others. There was no clinical oversight of referrals received or the booking process. This gave no assurances that risk to these patients was being mitigated.
- We saw minutes of nuclear medicine and imaging meetings where the risk register and other risks were discussed and given a rating of red amber or green. In one example, where imaging services external accreditation scheme assessors had raised concerns that health and safety issues did not appear to be discussed or lessons learned. This statement changed the rating of health and safety from amber to green and did not appear to be a reflection of what was being identified by the external assessors. This indicated that risks to the organisation were not being managed effectively.

Leadership of service

- The standard operating procedure for the two week cancer patients was reliant on the administrative staff of the patient services centre staff escalating breaches to the service manager. There was no standardisation of

the management of these patients after their referral had arrived in the patient service and the leadership on the management of these pathways was inconsistent. There was no clinical oversight of these patients throughout the appointing process. Key posts in cancer services were vacant and staff told us they felt unsupported by the service manager.

- Staff told us they felt the new Chief Executive would provide stability and was visible in and around the hospital. In addition to this the pathology department felt that the trust had supported them through a period of instability when the department merger with another trust had been proposed and then rejected.
- Some staff in outpatients told us they felt there was a barrier between themselves senior management, but were able to discuss issues with their local managers. Several staff in radiology reported that there was a divide between their teams and the management team.

Culture within the service

- Many staff in outpatients and diagnostic imaging departments told us they were proud of working for the trust and of the work they undertook. They told us there was good team working within their individual teams.
- Some staff in radiology told us they were aware of bullying and harassment that had taken place within their department. They told us there was an attitude of "you talk, you walk."

Public engagement

- The outpatients department ran a 'Patient Experience Group' every month. During these meetings, staff and patient representatives discussed comments cards, 'Friends and Family Tests' and PALS reports. This enabled them to discuss service improvements that could improve the patient's experience. We saw the copies of the minutes for the last three meetings. A breastfeeding cubicle and chair were put in one of the outpatient waiting areas as a result of these meetings.
- Within the outpatients departments, volunteers took a tea trolley to the waiting areas to offer tea and coffee waiting patients. Some of the volunteers told they had been patients themselves and wanted to give something back to the department.

Staff engagement

- Staff in the diagnostic imaging department told us they felt unsupported in their roles and that staff retention was poor. In addition to this, they felt the manager was inaccessible and failed to respond to emails. We saw evidence of this being identified in a report relating to an investigation into whistleblowing concerns that had been carried out by the trust.
- Although several staff told us they were proud to work for the trust, they did not feel involved in decision making processes, especially with regards to change. Staff told us they felt change was imposed upon them regularly without prior consultation. Several staff told us they felt overworked and undervalued.

Innovation, improvement and sustainability

- The patient service centre was not always able to give patients appointments within the target times set by NHS England and the clinical commissioning groups. At the time of our inspection we were unable to see any clear strategies to develop robust systems and processes to be able to monitor and maintain these targets.
- Within the diagnostic imaging department there was an increasing reliance on outsourcing radiology reporting in order to maintain reporting times. There were no assurances of the quality of reporting by the trust. We were unable to see any strategy or future plan to deal with the increasing numbers of referrals and reports.
- In the transfusion department an electronic blood ordering system which had been developed as part of the trust's 'Listening into Action' scheme. The system had reduced errors in ordering and improved communication between clinicians and laboratory on the progress of each request. Currently the system was only in use for clinical haematology but the trust was hoping to roll the system out trust wide, which would potentially improve compliance with the new ISO standards for laboratories and have an impact on patient safety.

Outstanding practice and areas for improvement

Outstanding practice

The orthotics department demonstrated a patient centred approach. They had been identified by NHS England as a service to benchmark against, because of the waiting times (90% of all patients seen the same day or next day), low cost per patient and clinical evaluation of each product they used.

The maternity team had Team Aurelia, a multidisciplinary team that provided support for women identified in the antenatal period as requiring an elective caesarean section. The team undertook the pre-operative review prior to admission for elective caesarean section. Women were seen by an anaesthetist prior to surgery and an enhanced recovery process was followed to minimise women's hospital stays following surgery.

The hospital play areas for children were very well equipped with a commendable outdoor play area that was well used.

The neonatal unit is seeking UNICEF accredited baby friendly status where breast feeding is actively encouraged and mothers are given every opportunity to breast feed their babies.

The outpatient nursing team demonstrated good clinical leadership, competent staff, forward thinking and planning with regards to capacity issues. They regularly assessed their environment, sought feedback from and worked with patients regularly to improve the patient experience.

Areas for improvement

Action the hospital MUST take to improve

Take immediate action to improve patient flow. This must be achieved without impacting other services provided within the departments and have a risk balanced approach so not to impede on other services delivered.

Review the environment within the emergency department (ED) to meet patient demand effectively.

Take actions to ensure patients are discharged from the critical care unit within four hours of the decision to discharge to improve the access and flow of patients within the critical care services.

Ensure that staffing levels within adult ED meet patient demand.

Ensure that all patient records in ED are accurate to ensure a full chronology of their care has been recorded.

Ensure there is an effective clinical audit plan in place.

Ensure that major incidents arrangements are suitable to ensure patients, staff and the public are adequately protected and that patients were cared for appropriately in the event that a major incident occurred.

Urgently review the two week cancer pathways for each speciality and ensure that there is clinical oversight of those patients waiting in order to mitigate the risks to those patients.

Provide clinical oversight of patients waiting on incomplete pathways to ensure they are seen on a basis of clinical need in accordance with the trust Access Policy.

Review and provide assurance that processes that are in place to ensure that World Health Organisation (WHO) checklists are completed prior to an interventional radiology procedures.

Ensure Trust wide incident reporting processes and investigations are robust, action plans are acted on and systems are in place to ensure that lessons are learned.

Have robust procedures in place to give assurance of the quality of radiology reporting done by external companies.

Address the risks associated with reducing exposure to radiation in the diagnostic imaging departments. This specifically relates to the wooden door frames supporting

Outstanding practice and areas for improvement

the protective lead doors that are cracking under the weight. Although entered on the risk register there were no plans in place to address this potential breach radiation protection regulations.

Ensure that the medical staffing levels in MHDU meet the requirements of the intensive care core standards.

Ensure that MHDU complies with the Department of Health best practice guidance: Health Building Note HBN-04.01.and intensive care core standards.

Ensure that governance and risk management systems reflect current risks and the services improve responsiveness to actions required within the risk register.

Ensure clinical areas are maintained in a clean and hygienic state, and that the monitoring of cleaning standards falls in line with national guidance.

Store confidential patient records securely.

Improve the completion of mandatory training rates.

Ensure there are adequate numbers of nurses on duty at all times to meet its own needs assessment and national guidance.

Review mortality and morbidly in those specialities where outcomes are below national averages to determine if there are any contributing practice considerations to address.

Ensure that all staff understand their responsibilities under the Deprivation of Liberties Safeguards (DoLS) and discharge these in line with legal requirements.

Improve the quality of discharge plans to decrease the number of delayed transfer of care.

Improve the timeliness of responses when managing to formal complaints.

Ensure that governance meetings, including mortality meetings are held as scheduled.

Improve the quality and availability of performance and safety information to all departmental managers and the divisional management team.

Ensure patients undergoing cardiac procedures where they required sedation are treated by appropriately competent staff at all times as outlined in national guidance to minimise the risk to patients.

Ensure clinical oversight of activity provided and ensure appropriate audit trails and quality measurement tools are in place.

Review its current handover practice. This should include a focus on the structure, quality, and format of the actual handovers. It should also review the process to ensure that patients dignity, privacy and Confidentiality is not compromised.

Review the capacity of the safeguarding team and ensure more effective communication and working collaboration from the safeguarding team.

Ensure that local policy and protocol around EOLC are reviewed to ensure they are consistent with national and best practice guidance.

Ensure robust leadership at board and non-executive level to provide an EOLC service as per national guidelines.

Take action to ensure that EOLC patients are not moved in their final hours.

A review of the competency levels of staff responsible for making these decisions should be undertaken and relevant training provided when deficiencies are noted.

A review of the out of hours discharges and frequent bed moves may be useful to identify trends and themes.

Improve the governance, risk and quality management processes in the surgical department.

Review the quality of the senior leadership to ensure efficient, supportive and quality leadership.

Review its current strategy to improve engagement, moral, recruitment and retention. It must also ensure that it reviews the bullying reported to ensure staff welfare.

Approved temperature monitoring devices in ICU and HDUs should be used to demonstrate compliance with recommended temperature ranges and to ensure the quality and integrity of medicinal products is not compromised during storage.

Ensure theatre lists are staffed by appropriately competent staff at all times as outlined in national guidance to minimise the risk to patients.

Outstanding practice and areas for improvement

Store medicines according to the manufacturer's instructions. Ensure that inappropriate medicines are not stored in ward areas. Ensure it complies with FP10 tracking as dictated by national guidance.

Ensure that IV morphine is not being administered in inappropriate opiate clinical areas by staff that may not be competent to deal with the side effects.

Produce a critical medicines list to comply with NPSA/2010/RRR009. Improve mandatory training compliance rates.

Ensure fridges and Medication storage temperatures are recorded in line with national guidance and best practice.

Ensure staff follow trust policy for the administration of anticipatory medication for EoLC patients.

Medicines in adult ED must always be stored in accordance with trust policy.

Manage allegations of bullying and whistleblowing, and performance management in line with agreed policies. The trust must also ensure it is meeting its duty of care toward staff who are under the care of Occupational Health.

Action the hospital SHOULD take to improve

Provide a stable and focussed leadership in divisional teams.

Ensure all staff understand the organisations strategic recovery plan and their personal role and responsibilities in delivering the plan.

Engage patients in the planning, design, delivery and monitoring of services.

The trust statement of vision and values should be translated into a credible strategy with well-defined objectives that are understood and acted upon by staff working in critical care services.

Provide mandatory EOLC training for all staff.

The trust should review clinical pathways to ensure they are consistently followed. Review the results of the annual infection control audit undertaken in all outpatient and diagnostic imaging areas and produce action plans to monitor the improvements required.

Introduce a policy and protocol to ensure that clinic letters to GPs are dispatched in a timely manner with audits to maintain assurance.

Difficult airway management equipment on SHDU should be checked using a checklist, and a record kept of those checks, to ensure it is readily accessible and fit for purpose.

Take necessary action to ensure the Joint Advisory Group on GI Endoscopy (JAG) accreditation can be maintained.

Share performance data from the national safety thermometer with wards and departments to enable them to track trends in improvement or identify emerging concerns.

Ensure all storage areas are fit for purpose and that items are store appropriately. Consider how the fabric of clinical areas is maintained. Ensure records of 'intentional rounding' are consistently completed.

Benchmark its acute medical unit performance against the standards set by the Society of Acute Medicine.

Ensure that 'as required' pain relief is adequately evaluated. Progress the use of specialised pain assessment tools for those with cognitive impairment.

Complete and implement the 'Percutaneous Endoscopic Gastroscopy Nutrition Policy'. Ensure all staff receive an annual appraisal and that there are arrangements for clinical supervision for those who require or request it.

Consider how ward staff could be assured of the clinical competencies of agency staff.

Consider how seven day therapy services could be provided on the stroke unit. Scope the level of service required in ambulatory care to better understand the level of demands and how to meet it.

Audit the dementia friendliness of the design of clinical areas and take appropriate remedial actions. Consider how 'Better Care Together' and matron visit initiatives could be used to drive improvements.

Continue to work towards full provision of seven day services for EOLC. Children's services should enhance play specialist provision in line with national guidance.

Assure itself that staff understand the new duty of Candour regulations.

Outstanding practice and areas for improvement

Assure itself that agency staff are reporting and know how to report an incident.

Conduct a service review of pressure area care and urinary tract infections (UTI's) to identify any care failings or necessary improvements that are required.

Take action to address the excessive temperatures patients and staff are exposed to on McCullough ward.

Ensure that its medication prescribing policy is being followed.

Review the quality of service provided by the new patient transport provider.

Review the staffing levels in the pain team against the demands of the service to ensure it can meet people's pain needs and provide an appropriate level of support for ward staff.

Review theatre start and finish times and staffing arrangements for over runs to ensure the department is working to maximum capacity to meet the demands of the service and to minimise the risk to patients from long referral to treatment times (RTT).

Children's services should enhance play specialist provision.

The ambiance of PALs should be improved.